Handout 1

John Pritchard Interview Digest and Transcript

August 5, 2021

Interview of John Pritchard by Julie Bridenstine

Page #	Description of Pritchard's Interview
3-4	• Claimant John Pritchard (Pritchard) is interviewed by Commission Staff Attorney Julie Bridenstine (JB) at Pender Correctional Institution on August 5, 2021. Commission Staff Attorney Brian Ziegler (BTZ) is also present, in addition to Pritchard's attorney, Emily Thornton (Thornton). JB explains the Commission process to Pritchard and tells him that the Commission does not represent him.
4-5	• In March 2011, Pritchard was living on Turtle Trot Road in Burnsville, NC with Aaron Collins (Aaron), who was the son of his girlfriend, Robbie Brown (Robbie).
5-6	• At that time, Pritchard and Robbie had an incident where Pritchard had to go to court and move out of her house; however, they were still kind of boyfriend and girlfriend and he would stay with her sometimes. Pritchard states it was not a domestic violence incident, but that it was actually his probation that required him to move out of her house.
6-7	• Pritchard met Jonathan Whitson (Victim) through Robbie in September 2010. Pritchard described the Victim and Robbie as acquaintances and said the Victim would take care of Robbie's lawn.
7-8	• Pritchard and the Victim did not hang out together. The Victim and Robbie had a previous relationship back around 2008, and Pritchard thinks they did drugs together. He doesn't know how long they were together and denies that this caused any problems.
8-9	• Pritchard also knew the Victim's stepfather, Nathan Angel (Nathan). Nathan would also do work for Robbie, and believes Nathan sold cocaine to her.
9	• Pritchard moved to Burnsville, NC in 2009.
9	• Pritchard never saw the Victim outside of the times he saw him with Robbie. Before the Victim died, Nathan would come over to Pritchard's trailer because he wanted work, but Pritchard never had any work for him to do.
10	• JB turns Pritchard's attention to March 5, 2011 which was the day before the Victim died. Pritchard recalls speaking to Nathan who told him the Victim was out of jail. Pritchard then told him that Robbie wanted the Victim to do some yardwork for her, and Nathan said he would have the Victim call Pritchard when he got back to the trailer.
10-12	• Sometime between 2:00 p.m. and 2:35 p.m., the Victim called Pritchard and told him he was at Nathan's home. Pritchard then went over to Nathan's to ask the Victim to do the yardwork for Robbie. While there, the Victim asked Pritchard if he would take him to the store. Pritchard agreed to take him and drove the Victim to Riddle's Grocery Store (Riddle's) where Pritchard dropped him off. After he did this, Pritchard left to dump his garbage and then returned to pick the Victim up. Pritchard didn't want to go into Riddle's because it was supposed to have been a "bad place" where people would pick up drugs.
12-13	• After leaving Riddle's, Pritchard and the Victim drove to Fred's where the Victim went inside to get tobacco for Pritchard. Later, Pritchard asked the Victim if he would go take care of Robbie's lawn. The Victim said he needed time because the abscess on his arm was still hurting and had gotten worse. He said he was going to get it checked out but didn't want to do yard work because of the pain. Pritchard then dropped the Victim off at Nathan's trailer, and this was the last time Pritchard saw him.

13	• Pritchard thinks he went to the trailer on one other occasion to drop off the Victim and the Victim's girlfriend at the time, Stephanie Whitson (Stephanie).
13-14	• Pritchard met Stephanie twice: once when he gave her a ride to work, and the other time was at Robbie's. The latter happened after Stephanie and the Victim came over to Robbie's after they sought treatment for the Victim's arm at the ER. Pritchard gave them a ride back to Nathan's trailer. He thinks this happened around the end of November or beginning of December.
15-16	• Pritchard says the ER gave the Victim antibiotics and told him not to shoot drugs into his arm again. Pritchard says the abscess was on the left arm in the crook and that it was swollen, puffy, and black and blue.
16-17	• On March 5, 2011, the Victim went to Riddle's to meet up with friends. When Pritchard came back to get the Victim, the Victim was standing by the road and didn't have anything with him. Pritchard didn't know what the Victim was doing, but Pritchard said Riddle's was a "… bad place for drugs and stuff like that." While there, Pritchard wasn't paying attention to anyone else.
17-18	• At Fred's, Pritchard gave the Victim $1.50 or $1.56 to get the tobacco. The Victim bought it because Pritchard didn't know much about tobacco chewing. He's not sure if the Victim bought anything else.
18-19	• Pritchard didn't see anyone else at Nathan's trailer when he picked the Victim up, but Stephanie was there when Pritchard dropped him off. He didn't speak to her. While dropping the Victim off, Nathan offered to do some work for Robbie.
19	• Pritchard picked the Victim up around 2:35 p.m. and dropped him off at 3:20 p.m. He didn't see the Victim after dropping him off. The Victim's mother came over later that night.
19-21	• Nathan's trailer is 25-30 feet behind the home of Christine Angel (Christine) (*Mother of Nathan*). He didn't have to pass Christine's house to get to Nathan's trailer. You would park right on the side of the road.
21-22	• If Pritchard needed to get in touch with the Victim, he would go through Nathan and then the Victim would call Pritchard's cell phone.
22	• The Victim did not ask Pritchard for drugs on March 5, 2011.
22	• The Victim appeared sick because he was sweating. Pritchard assumed his arm was causing him difficulty and that's why he told the Victim he should have taken care of it. The Victim was a wearing a tan jacket you get from a tractor-trailer place, jeans, and a flannel shirt.
22-23	• The Victim pulled out his arm to show it to Pritchard. It looked really bad. It was black and blue, reddish-purplish, swollen, and filled with pus. It was about as big as Pritchard's leg.
23-24	• JB asks what the arm looked like in comparison to track marks. Pritchard said you could see the track marks in the Victim's arm.
24-26	• In November, the Victim's arm was black and blue, and it looked like someone had hit him. There was pus in the center of the black and blue mark. By March 5, 2011, it looked really bad. You could see red going up his arm and it was worse than it was in November. The black and blue mark was about the same, but the pus was oozing out.
26-27	• Pritchard knew the Victim to be a drug user. Robbie would give the Victim oxymorphone tablets instead of money when he did yardwork for her. Robbie had 40 mg yellow pills and 5 mg blue oxymorphone pills. He doesn't know of Robbie giving the Victim any different pills. When Pritchard was gone prior to March 2011, Robbie had access to his medication because he had it in the safe.

28	• Pritchard moved out of Robbie's house at the end of January because Robbie was a convicted felon, and it was a condition of his probation that he could not reside with a convicted felon. Pritchard went to court on January 26th.
28-29	• Robbie had a safe that Pritchard kept his medication in, so she knew the combination. The safe also had money and rings. He kept his medication in the safe because Robbie's son had stolen all of her medication before. He reported it to the police, but they didn't do anything.
29	• Pritchard had 30 mg of morphine and 5 mg of oxycodone. He got the medication through the PTSD program at the VA.
29-30	• Robbie kept her oxymorphone in her pocketbook because her kids would steal her medication from time to time, and she kept the pocketbook close to her. Robbie also did other drugs, like crack cocaine.
30	• He knew Robbie to be a drug user because he met her at an Alcoholics Anonymous (AA) meeting.
30	• Pritchard knew Robbie to have morphine because she would run out of her pills and use some of Pritchard's to last her until she got her prescription refilled.
31-32	• Ann Whitson Greene (Greene) (*Victim's mother*) came over the night of March 5, 2011 around 6:00 p.m. She would come over to spend the night and take a shower. They were friends that had consensual sex, but they were not dating. Greene stayed until 5:00 a.m. – 6:00 a.m. the next morning. She would sleep on his couch. No one else was there that night. Aaron didn't come home until the next day around 10:00 a.m.
32-33	• On March 5, 2011, Pritchard saw Nathan, the Victim, Stephanie, and Greene. Pritchard said Aaron was also at the trailer that day, and that he and Pritchard cleaned up the home and then put the garbage in Pritchard's trunk. Aaron left that night around 6:00 p.m. – 7:00 p.m.
34	• On March 6, 2011, Pritchard got a call from Greene around 12:00 p.m. She was upset and crying and said that she had been at Nathan's home and the Victim had died. Nathan, Nikki Angel (Nikki) (*Victim's step-sister*), and Greene then came over to Pritchard's trailer where they sat and talked.
34-35	• Pritchard isn't sure why Greene left at 6:00 a.m. Pritchard was at the trailer from the time she left until the time she called about the Victim's death.
35	• Pritchard was sorry the Victim had died.
35	• Greene was yelling about Nathan and thought Nathan "… had done it to him… ." She did not say how the Victim died.
35-37	• Pritchard's understanding of what happened is that the Victim had slept over at Nathan's trailer and drank too much. Greene told him the Victim died while at Nathan's trailer in a call later that night. During the 12:00 p.m. phone call, she only said that he had died and didn't provide any other information about the circumstances.
37-38	• Greene was at Nathan's trailer when the Victim was discovered. Greene and Nathan used to be married. Nikki stayed with Nathan. Greene was homeless most of the time.
38-40	• Greene is the Victim's biological mother. Pritchard doesn't know what kind of relationship they had. Nikki introduced Pritchard to Greene in January or December. Nikki is Greene and Nathan's daughter, and Nikki dated Aaron at one point. Pritchard and Nikki weren't friends, but he met her before he went into the PTSD program. He saw her again at the end of September 2010.

41	• Pritchard thinks Nathan, Nikki, Greene, and a cousin of theirs named Robby Silvers (Silvers) came over to his trailer around 1:30 pm. – 2:00 p.m. Silvers said he thought the Victim had died due to drugs.
41	• Pritchard had not learned anything else about the death between 12:00 p.m. – 1:30 p.m.
42	• Pritchard didn't learn anything else from the family while they were at his home. Greene called him later on that night to see if he would be a pallbearer at the funeral and Pritchard agreed to do it.
42	• The family stayed at Pritchard's for 10 – 15 minutes. He doesn't think they discussed how they had found him dead. They were all heartbroken and crying. Pritchard was telling them he was sorry to hear it.
43	• Pritchard did not know what kind of drugs Silvers was talking about.
43	• The following Monday, Nathan told Pritchard that Stephanie had told the police that Pritchard had been the one to give the Victim the pills. He told Nathan he didn't mess around with that stuff, and Nathan said he knew that and told him if he thought Pritchard had been the one to give him the pills, he "… would have put a cap in [Pritchard]."
44-46	• In the phone call on the night of March 6, 2011, Greene said she thought Nathan and William Angel (William) (*Nathan's brother*) had moved the Victim. She said Christine did not like her kids doing drugs and alcohol in her home. The Victim and Christine had a difficult relationship because the Victim was Nathan's stepson. Greene thought the Victim had been moved from Nathan's trailer to Christine's couch. JB asks why the body would have been moved and Pritchard says when he was in jail, Danny Edwards (Danny) told him that when he took Nikki and his sister to Nathan's trailer, they asked him to come in and they were selling drugs and drinking.
46-47	• Danny is Nikki's ex-husband. Pritchard met him in the Yadkin County Jail. Danny said he knew that the Victim was at the trailer after midnight that night because he walked in on them drinking and doing drugs. Pritchard was locked up on December 1, 2011 and thinks he spoke to Danny around December 22, 2011.
47	• When Pritchard and Danny met in jail, Danny said he had been told that Pritchard gave the Victim the drugs with which he overdosed. Pritchard denied doing this.
48	• Pritchard had never met Danny before and did not recognize him.
48-49	• Danny said Stephanie was telling the police that he (Pritchard) had given the Victim the drugs. Pritchard doesn't know why Stephanie was telling the police this, but thinks it is because Stephanie was also shooting drugs with the Victim and Pritchard is from out of town.
49	• Pritchard does not know who gave the Victim drugs before he died, but he knows the Victim got them at Riddle's. At that time, Pritchard didn't think he should question the Victim about it.
49	• The Victim didn't have money on him when they went to the store. He doesn't know how he got the drugs, but Burnsville is close knit.
49-51	• There is a lot of drug use in Burnsville. Nathan, the Victim, Stephanie, Aaron, and Robbie were using drugs. Robbie smoked crack cocaine but took her medication by mouth. Robbie and Nathan were drug dealers, and sometimes Nathan would get his drugs from Robbie. Robbie used to date a guy named Robin Honeycutt (Honeycutt) who would sell drugs to Aaron, who would then sell the drugs.
51	• Pritchard did not talk to the Victim about using drugs on March 5, 2011. Nathan had told Pritchard the Victim had just gotten out of jail that night and was staying at

	Nathan's trailer. In one of his statements, Nathan said that the Victim gave him a pill and that he had left so the Victim and Stephanie could have some alone time.
51-54	• Between November 2010 and March 5, 2011, Pritchard saw the Victim around Christmas but before he left for Charleston. The Victim would mostly come around to buy the 5 mg of oxymorphone from Robbie. When he saw the Victim in December, Pritchard was with Robbie. Stephanie may have also been there. Pritchard did not talk to the Victim about drugs and did not see the Victim's arm or talk to him about his arm on that occasion.
54	• When the Victim would come over, he would go in the back room with Robbie. He assumed they were doing drugs.
54-55	• Before Pritchard moved out of Robbie's in December, the Victim asked Pritchard to sell him morphine. Pritchard told him no because Stephanie's dad was a bondsman and Pritchard thought the police would come to him first if the Victim got caught. The Victim knew Pritchard had morphine because Robbie had given him some when he came to do yardwork. JB asks if Pritchard knew Robbie was doing that, and Pritchard says, "No, not really. I didn't know."
55	• Pritchard doesn't know how many times Robbie gave the Victim his morphine. Pritchard left it in the safe when he was in the PTSD program from July until the middle part of September.
56	• The Victim told Pritchard that Robbie gave him the morphine.
56-57	• Pritchard assumes Greene saw the Victim's arm since she was his mother. Nikki knew about the arm because she was there when the Victim got out of the hospital. Pritchard never discussed the arm with Nikki.
57-58	• JB asks about the significance of moving the Victim's body from Nathan's trailer to Christine's house. Pritchard believes they are lying about the fact that the Victim shot drugs at Christine's house and died there when she didn't allow people to use drugs or drink.
58-59	• The only medical issue of the Victim's Pritchard knows about is the abscess. JB asks about other medical treatment the Victim received, and Pritchard only knows about the ER visit.
59	• Pritchard did not speak to the Victim while he was in jail, which he thought was in late December or early January.
59	• Pritchard and the Victim both talked about their legal issues while in the truck on March 5, 2011. The Victim said he wasn't even getting aspirin while in jail.
59	• No one else talked to Pritchard about the Victim's arm.
59-60	• Pritchard first learned he was a suspect on March 6, 2011 when Nathan told him Stephanie was saying Pritchard gave the Victim the drugs.
60	• Pritchard did not tell anyone he was worried about getting blamed for the Victim's death. He denies telling anyone he gave the Victim morphine pills in the days before the death.
61	• Pritchard called Robbie after he got the call from Greene about the Victim's death and the Victim's family came to his house. He told Robbie that Greene said the Victim came to Robbie's house to get drugs and then came back to Nathan's trailer.
61-62	• Pritchard clarifies that he first heard from Greene that Stephanie was saying he gave the Victim drugs. He told Robbie about this when he called her after Greene and the others left.

62-64	• JB tries to clarify what Pritchard is saying. Pritchard states he received a call at noon from Greene telling him the Victim died. At 1:30 p.m., Nikki, Greene, Nathan, and Silvers came to Pritchard's trailer. They did not talk about the death that much, but Greene did say that Stephanie was saying Pritchard provided the morphine to the Victim. Pritchard called Robbie around 3:00 p.m. He also learned on Monday that Stephanie was implicating him.
64-66	• On March 5, 2011, Pritchard had morphine sulfate and oxycodone. Both were prescribed by the VA and the only drugs he was taking in 2010-2011. He thinks he was first prescribed morphine and oxycodone in May 2009. He was directed to take one morphine pill every 8 hours. He was directed to take oxycodone if he had pain before his next morphine dose. He was consistent about his pills because his back hurt. He had an operation before he got locked up in December.
66-67	• JB asks if he was given oxycodone through any other source. Pritchard says he went to a clinic and a physical therapist in Asheville once in May of 2009, and that a doctor prescribed him 30 pills then.
67-68	• Pritchard had 10 morphine pills on March 5, 2011, and he was sent another 90 pills through the mail on March 6, 2011. He would wait until he ran out to get a refill. He had about 5 oxycodone pills left.
68	• The purpose of the oxycodone was to manage pain in between morphine doses. He called to refill his morphine prescription on March 10, 2011.
69-71	• Pritchard had substance abuse issues with heroin in 1984. He received inpatient treatment at the VA in Atlanta, GA. He worked as a drug counselor in 1993 and was licensed as one from 1995-2005. He was in Narcotics Anonymous (NA) right after he got out of treatment. He was still going to NA meetings 2-3 times a week in March 2011. He was also a sponsor, and although he talked to Aaron about his drug use, he was never Aaron's sponsor.
71-73	• Pritchard has a previous conviction for selling morphine. The confidential informant in that case was Alice Waldrop (Waldrop). Jennifer Black (Black) was a person to whom Robbie was selling drugs. Black got pills from Robbie and took them to the police. Det. Barber arrested Pritchard and Robbie. Pritchard said he was in the bathroom and didn't know anything about it. He was looking out the back window because Black's boyfriend had stolen stuff out of Robbie's yard before. This happened in May or June of 2010.
73-74	• Pritchard was on probation in 2011 related to the charge involving Waldrop. Pritchard gave her drugs after Robbie told him it was okay to give the drugs to her. Pritchard denies being a drug dealer and said he just did this the one time.
74-75	• Pritchard denies providing drugs to the Victim. He denies providing morphine to the Victim when either Stephanie or Robbie were present. The Victim did ask him for morphine once ,and Pritchard told him no because Stephanie was a bondsman's daughter. Stephanie was present and talking to Robbie when the Victim asked for the morphine. This happened in October 2010.
75	• Pritchard denies giving the Victim morphine around Christmas 2010.
75-76	• Pritchard and Robbie were "more or less" broken up on March 5, 2011. Pritchard then started to see Greene. He was also in a sexual relationship with Nikki.
76-77	• After he was arrested and put in jail, Robbie would come see him on the weekends. They would also talk on the phone and write letters and would talk about Pritchard's case. Pritchard said the police had a statement from Robbie saying Pritchard sold the

	Victim eight tablets of morphine. Robbie denied this and said that's why she didn't sign the statement. Robbie also said the same thing in court.
77	• Pritchard talked to a lot of people in jail. Everyone knew each other.
78-79	• JB asks who else visited Pritchard in jail. Pritchard says his daughters, Tracey and Lacey, visited in addition to Nikki. Nikki told Pritchard she knew he hadn't done anything to harm the Victim. By saying she "knew", Nikki meant she had a feeling. He doesn't think anyone else visited him in jail.
79	• Pritchard hasn't really talked to anyone else since he's been in prison. Some people assume he's a pedophile because he's older. When Pritchard tells the other inmates what he's in for, they respond by saying you can't do drugs at 9:30 p.m. and die at 10:30 a.m. of an overdose.
79-80	• Right before trial, Pritchard was offered a plea that involved three years of probation. He doesn't remember what the charge offered in the plea was, but he thinks the original charge may have been dropped to manslaughter. He didn't take the plea because he didn't do it. JB explains what an Alford plea is, and Pritchard says he was not offered one.
80-81	• The only statement Pritchard gave was to his attorney, Daniel Hockaday (Hockaday), who then gave the statement to Sheriff Banks on December 21, 2011. When Pritchard asked Hockaday about this, Hockaday denied giving the statement to the Sheriff.
81-82	• Pritchard tried to get Hockaday to use Nikki and Greene as witnesses, but Hockaday told him they wouldn't be able to help. Pritchard isn't sure if Hockaday talked to them.
82-83	• JB asks about other witnesses, and Pritchard names Danny. Hockaday didn't talk to Danny, as far as Pritchard knows. Danny was subpoenaed but Pritchard didn't see him at court.
83	• JB asks if Hockaday consulted with any experts. Pritchard said Hockaday told him he needed $1,600 to pay the medical examiner to explain the autopsy to him. Pritchard paid him but doesn't know if Hockaday talked to a medical examiner or not.
83-84	• A sheriff's deputy in jail told Pritchard to get another lawyer.
84	• During the trial, Pritchard saw Sheriff Banks, ADA Michael Holmes, and Hockaday texting each other.
84	• Tammy McIntyre, the Clerk, saw Pritchard looking over Hockaday's shoulder and said Hockaday's wife had been trying to get in touch with him because their son got into an accident.
84-85	• Pritchard assumes they were communicating about him but didn't get to read the messages. The judge would always look at the jury rather than the courtroom.
85	• JB asks what the significance of the communication is to Pritchard, and Pritchard says it's because of the interrogation of Stephanie and other witnesses. Pritchard would give Hockaday questions to ask and he wouldn't ask them.
85-86	• Pritchard does not know what they were communicating about but believes it was about him.
86	• Hockaday told him that if he took the plea, he and Pritchard could go get a beer. Pritchard told him he wasn't going to take it. He didn't understand that he could get up to 20 years and thought the most he could receive was 10 years.
86-87	• Hockaday wouldn't let Pritchard testify at the trial despite Pritchard wanting to, and the judge wouldn't let Pritchard talk during sentencing.
87	• Pritchard thought it was his decision whether to testify or not.

87-88	• Pritchard didn't talk to police until after he got out of the PTSD program in October 2011. An SBI agent and a deputy came over to his trailer, but Pritchard said he was on medication and didn't want to be questioned.
88-89	• JB asks about the letter marked Exhibit 1 during Robbie's testimony at trial. Robbie told Pritchard she didn't say those things about him and that's why she wouldn't sign the paper. Pritchard thinks he gave the letter to Hockaday.
89-90	• Pritchard saw Hockaday three times prior to the trial. The first time was when Pritchard hired him. The next time was when Pritchard gave him information. The last time was for Hockaday to tell Pritchard what he thought.
90	• The letter from Robbie is the only thing Pritchard gave to Hockaday.
90	• Pritchard spoke to Hockaday over the phone before trial.
90	• When he first met Hockaday, Hockaday said he could get Pritchard off and had just done so for a person in this situation.
90-91	• Robert Sirianni (Sirianni) did the appeal and missed the date for it. David Belser (Belser) came along after Pritchard lost the appeal to do an MAR.
91-92	• Pritchard never saw Sirianni but did speak to him over the phone.
92-93	• Christine Vance (Vance) worked for Sirianni. Other attorneys worked for Sirianni but didn't stay. Brandi Bullock Jones (Jones) tried to get him out on bond.
93	• Sophia Hernandez (Hernandez) was the other attorney listed on the appeal, but Pritchard never spoke to her or Vance.
93-94	• Pritchard didn't know about appeal deadlines.
94-95	• JB confirms with Pritchard that the attorneys he actually spoke to were Sirianni, Jones, and Belser.
95-96	• He talked to Hockaday and Sirianni about the facts of his case. Pritchard wanted an explanation as to how someone could die of a drug overdose 13 and ½ hours later.
96-97	• Pritchard is claiming innocence on all the charges in this case. He has told all of his attorneys he is innocent and has never admitted guilt to anyone.
97	• Dr. Christina Roberts (Dr. Roberts) got involved with this case through Belser. Pritchard says there was an issue with Belser over fees.
97-98	• Pritchard sent a letter to Dr. Roberts but doesn't think he spoke to her on the phone. Dr. Roberts never visited him in prison.
98	• Pritchard has heard that Dr. Roberts believes the Victim died from other causes.
99	• JB asks Pritchard who he thinks the Commission should speak to, and Pritchard names Greene and Nikki. Nathan and Robbie are both dead. Pritchard also mentions Danny as the one who told Pritchard there was no way the Victim died at Christine's house.
99-100	• Pritchard says his daughter, Lacey, knows everything and was around at the trial. Lacey's knowledge comes from talking to Robbie. Lacey believes Robbie is the one who is responsible. Nikki also spoke to Robbie.
100	• Robbie wrote Pritchard a letter saying he needed to get Nikki and Greene to be subpoenaed for court because they would testify on his behalf.
100	• Nathan never told Pritchard anything else about what happened the night the Victim died, and he didn't say anything about a spoon.
100-101	• Tammy Ayers (Tammy) got Robbie busted for selling drugs to her. Pritchard thinks Tammy is a confidential informant. Pritchard didn't know until later that Greene and Nathan might be her parents. Pritchard never met Tammy and denies seeing her on March 5, 2011 or talking to her about this case. He did hear in jail that Hockaday broke up with his wife and dated Tammy.

101	• Pritchard last spoke to Greene the week of the burial.
101-102	• Pritchard has heard that Nikki has mental health issues but doesn't know a diagnosis. He knows she went to treatment for drugs after the Victim died. He isn't sure if mental health issues were involved and isn't sure if she had intellectual disabilities. She had told him previously that Nathan was abusive when she was growing up.
102-103	• Pritchard last spoke to Nikki right before the trial when she came to visit him in jail. She told him that Greene was having cold feet about coming to the courtroom and didn't want to see Russell (*father of Victim*).
103	• Pritchard may have told Nathan he was afraid of being blamed in this case after Nathan told him Stephanie had told police that Pritchard was the person who gave the drugs to the Victim.
103-104	• Pritchard continued to live with Aaron but told him he needed to leave around April or May because he couldn't be around drugs while on probation. Pritchard had to call the police and his probation officer to tell Aaron he had to leave.
104	• Pritchard denies sharing pills with Aaron but says Aaron may have stolen them.
104	• Aaron told Pritchard that Pritchard should say that Aaron was with him and the Victim when they went to get tobacco. Pritchard did not want to lie; Aaron was home at their trailer at the time.
104-105	• Aaron knew later on that Pritchard was with the Victim on March 5, 2011. He doesn't know what Aaron knew on that date, however.
105	• Aaron and the Victim grew up together and used drugs together at an early age.
105	• Pritchard does not know if Aaron ever shot the Victim up with drugs prior to his death.
105-106	• Pritchard might have told Aaron he was concerned they were going to get him for murder on March 6, 2011 because Nathan had told him what Stephanie was saying. Pritchard denies telling Aaron that he gave the Victim 10 morphine pills.
107	• Pritchard last spoke to Danny in the Yancey County Jail. He told Danny he wanted to subpoena him to testify about what he saw at Nathan's trailer that night. Danny told Pritchard he saw the Victim, William, and Nathan doing drugs, and that they asked Danny if he wanted some.
107	• No one else has told Pritchard what the Victim was doing that night.
107-108	• Pritchard doesn't know about a Riverside Gas Station. He only knows about Riddle's. Riddle's is located across from the dump on Jack's Creek. He didn't see Danny at Riddle's on March 5, 2011 and only really met him in jail.
108-109	• Pritchard thinks Roxicet or "Roxies" is Percocet. He's never given them to anyone. He only got Percocet after he had the accident and was taken to an emergency room.
110	• Pritchard states that although he had Percocet prescribed before, he didn't give them to anyone.
110	• Pritchard denies telling anyone what to say in this case but says he did question Robbie about her unsigned statement.
111	• Pritchard denies giving the Victim any drugs after the Victim got out of jail on March 4, 2011.
111	• Pritchard asked Danny to testify for him but denies asking him to lie.
111-112	• JB asks if there is anything else the Commission should know. Pritchard says that Belser got his case in 2017 but that he didn't see Belser until 2019. In that time, Sheriff Banks retired. Pritchard thinks Sheriff Banks asked Belser to delay Pritchard's MAR until he retired because it would be brought up that the Victim didn't die from an overdose.

112	• Pritchard has told the Commission everything he knows about this case. He has told the truth.
113	• William is Nathan's brother. William used to get the original "good" morphine from Tennessee. Pritchard was getting generic. It was purple with a number on it.
113-114	• JB asks who else the Victim would have gotten drugs from and Pritchard says William. Pritchard also said there was a husband and wife in Riddle's Park who had a morphine prescription. The Victim would also get oxymorphone from Robbie.
114	• Aaron used to talk about doing drugs with the Victim, but Pritchard never saw them together. Pritchard knew Aaron was upset that the Victim was having sex with Robbie.
115	• Pritchard doesn't think there is a William Angel, Jr. or a William Angel, Sr., but knows that Wade was the father's name.
115-116	• Pritchard thinks it is odd that Christine said Wade was in the house when the Victim was there and told them he loved them. Danny said that didn't happen because the Victim and his grandparents didn't have that kind of relationship.
116-117	• Pritchard is going to mail the Commission letters from Robbie and Nikki that they sent to him while he was in jail.
118-119	• Pritchard explains why he thought the correctional officer took parts of his discovery from his daughter.

STATE OF NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
COUNTY OF YANCEY	
STATE OF NORTH CAROLINA, Petitioner, -vs- JOHN PRITCHARD, Defendant.	File No. 11 CRS 304 File No. 11 CRS 305

INTERVIEW

OF

JOHN PRITCHARD

August 5, 2021

This is the transcript of the audio recording of an interview with JOHN PRITCHARD. The interview was conducted by Julie Bridenstine, Staff Attorney for the North Carolina Innocence Inquiry Commission, and Brian Ziegler, Staff Attorney for the North Carolina Innocence Inquiry Commission. The interview took place at Pender Correctional Institution in Burgaw, North Carolina, on Thursday, August 5, 2021.

A P P E A R I N G

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Mr. John Pritchard

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I N T E R V I E W

JOHN PRITCHARD

MR. ZIEGLER: Hi, Mr. Pritchard. I'm Brian.

MR. PRITCHARD: Hi, Brian. How you doing?

MS. BRIDENSTINE: Hi, Mr. Pritchard. My name is Julie Bridenstine. I've sent you some correspondence.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Yeah. Brian and I work at the North Carolina Innocence Inquiry Commission.

MR. PRITCHARD: Okay.

MS. BRIDENSTINE: We're investigating your post-conviction claim of innocence, as you know.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Just so you're aware, we don't represent you, Ms. Thornton does.

MR. PRITCHARD: I understand.

MS. BRIDENSTINE: We are not prosecutors, we are not law enforcement, and we are not defense attorneys. We're just a neutral state agency, and we're looking for the truth in this case.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: And so we are here because, as part of our investigation, we would like to interview you about your claim.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Your case is in formal inquiry, which means that we anticipate that it will go to a Commission hearing. Of course, that's not a guarantee, but that's the posture that your case is in today.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: All right. First I wanted to start with some background. Where were you living in March 2011?

MR. PRITCHARD: So in March 2011, I was living on Rabbit -- no, Turtle Trot Road, in a trailer, off of Jacks Creek Road.

MS. BRIDENSTINE: Is that in Burnsville?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: And who were you living with?

MR. PRITCHARD: I was living by myself. No, no. No, I wasn't. I was living with my girlfriend's son.

MS. BRIDENSTINE: Who was your girlfriend?

MR. PRITCHARD: She was Robbie Brown.

MS. BRIDENSTINE: And what was her son's name?

MR. PRITCHARD: Her son's name was Aaron.

MS. BRIDENSTINE: Is that Aaron Collins?

MR. PRITCHARD: Yeah. Aaron Collins. Yes.

MS. BRIDENSTINE: Were you living with just Aaron Collins, or was anyone else staying?

MR. PRITCHARD: Every now and then he would bring over his female friends. But just me and him was supposed to be the only ones staying in there.

MS. BRIDENSTINE: What was the status of your relationship with Robbie Brown in March 2011?

MR. PRITCHARD: Well, we had had an incident where I had to go to court. And they went and mandated that I move out of Robbie Brown's house. But at times, we was -- we was kind of boyfriend and girlfriend. You know, I was staying over there with her and everything. And I guess she was a little bit, you know, back taken in the fact that they made me move out of her house and everything.

MS. BRIDENSTINE: Are you talking about a domestic violence incident?

MR. PRITCHARD: No, ma'am. Huh-uh. No.

MS. BRIDENSTINE: Was there a restraining order?

MR. PRITCHARD: No, ma'am. It was the probation -- probation office had said that.

MS. BRIDENSTINE: Okay. Were you on

probation at that time?

MR. PRITCHARD: Yes, ma'am, I was.

MS. BRIDENSTINE: Was Robbie Brown on probation at that time?

MR. PRITCHARD: No, she wasn't.

MS. BRIDENSTINE: How did you know Jonathan Whitson?

MR. PRITCHARD: How? It was through Robbie Brown.

MS. BRIDENSTINE: When did you meet Mr. Whitson?

MR. PRITCHARD: It was in -- I want to say, September.

MS. BRIDENSTINE: Of what year?

MR. PRITCHARD: Of 2010.

MS. BRIDENSTINE: What was your relationship to Jonathan Whitson?

MR. PRITCHARD: I just knew him as -- Robbie actually -- it was Robbie's friend. And she just more or less introduced us.

MS. BRIDENSTINE: So you met him in September of 2010?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Were you friends with him, acquaintance with him?

MR. PRITCHARD: Just acquaintance, you know.

MS. BRIDENSTINE: How would you describe your interactions with Jonathan Whitson?

MR. PRITCHARD: Well, the -- the thing is, with Jonathan and everything, he came over there to Robbie's place to cut her grass and, you know, keep her lawn and stuff. At the time, I was in the process of being in the PTSD program in Salisbury. Okay. And I came home for a weekend, get my truck, which -- you know, I got my truck and then went back to the program. And that's when I met him is, they were doing yardwork outside and everything. So -- but that's when I met him and everything.

MS. BRIDENSTINE: Would you hang out with him?

MR. PRITCHARD: No. Huh-uh. No, I didn't.

MS. BRIDENSTINE: Would you consider him a friend of yours?

MR. PRITCHARD: No, not really. I mean, he also had history with the girl I was dating. You know, Ms. Robbie Brown.

MS. BRIDENSTINE: What was his history with Robbie Brown?

MR. PRITCHARD: He was one of her lovers at one time.

MS. BRIDENSTINE: When was he her lover?

MR. PRITCHARD: Before -- I think it was back in 2000 -- I want to say '08, 2008. I think that they were doing drugs together and everything. And she ended up, you know, ending her -- you know, pairing off each other.

MS. BRIDENSTINE: How long did their relationship last?

MR. PRITCHARD: I'm not sure. She never would tell me, you know, exactly. She just said that he was over the age, and this here and that there. And that, you know. So I didn't really -- I didn't, you know, ask her too much about it.

MS. BRIDENSTINE: Did that cause any problems for you?

MR. PRITCHARD: No. Huh-uh. No.

MS. BRIDENSTINE: Did you care?

MR. PRITCHARD: No, not really. Because, you know, that was before I even met her and everything.

MS. BRIDENSTINE: Did you know anyone else in Jonathan Whitson's family?

MR. PRITCHARD: The only person that I knew of was his stepfather, which was Nathan Angel.

MS. BRIDENSTINE: What was your relationship to Nathan Angel?

MR. PRITCHARD: Nathan Angel, he came over and did some work for Robbie, also. And I think at one time that he had -- he had dealt some drugs to Robbie, some cocaine.

MS. BRIDENSTINE: Was he a friend of yours, an acquaintance?

MR. PRITCHARD: Huh-uh. No. I just knew -- I just, you know -- I was -- I was just moving into that town, and I didn't know anybody there.

MS. BRIDENSTINE: When did you move there?

MR. PRITCHARD: I moved there in 2009.

MS. BRIDENSTINE: Did you see Jonathan Whitson outside of the times you saw him with Robbie Brown?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you see Nathan Angel outside of the times Nathan Angel was with Robbie Brown?

MR. PRITCHARD: Yes. He came over to my trailer. He wanted to do some work over at my trailer and everything. And I told him that I didn't have anything for him.

MS. BRIDENSTINE: Was that before or after Jonathan Whitson died?

MR. PRITCHARD: That was before.

MS. BRIDENSTINE: All right. I want to now

focus on March 5th, 2011.

MR. PRITCHARD: Okay.

MS. BRIDENSTINE: And that is the day before Jonathan Whitson died.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: So if you could -- well first, do you know when Jonathan Whitson got out of jail in March of 2011?

MR. PRITCHARD: Well, that's the thing. See, Saturday, which was, I think, March the 5th was Saturday. And I had run across Nathan coming back from the mailbox. He was driving the four-wheeler. And he stopped and we talked. And he was asking me if I had some work over there at the trailer to do. And I said no, I still -- you know, I still don't have anything.

And then he said that Jonathan was out of jail. And I said really. And he said yeah. I said, well, Robbie, which was the girl that I was dating, she wants him to come over and do some yardwork. And he said, well, he'll tell Jonathan when he gets back to the trailer to call me.

So I went to the trailer, and Nathan went home. And about, I'd say around 2:00, 2:30, 2:35, somewhere around there, Jonathan went and gave me a call. And I was sitting -- at the time, I was just coming out

of Rabbit [sic] Trot Road, and onto English Branch Road. And they live right there, you know, within 100 feet of there. And Jonathan said that he was at Nate's trailer. So I told him, I said I'll be there in a second, because I wanted to ask him if he was going to do the work for Robbie.

And when I got there, he was standing outside. And he got into the truck, and he says, can I get you to take me to the store. And said, sure, I've got to go to the store anyway. I'm going to drop off this garbage and everything.

So we went down Jacks Creek Road. And we got to the end of Jacks Creek Road, and I was going to take a left and go to Fred's downtown near Burnsville. And Jonathan said that, you know, I could get the same thing from -- which was tobacco for Aaron -- from the Riddle's store, which is right to the right there, the little Amoco station. And I said, well, no, Aaron gave me enough money just to, you know, more or less pick it up from Fred's. And I don't know if, you know, Riddle's would be the same price or whatever, you know.

And so he said, well, I need to go to Riddle's. And I said, okay, I'll drop you off and I'll go up and dump my garbage. And they've got a public dump there. So I went and took my garbage and dumped it, and

came back and picked him up. Because I didn't want to go into that store, because it's supposed to have been a bad place is what it was, in Burnsville.

MS. BRIDENSTINE: What do you mean by a bad place?

MR. PRITCHARD: They -- that people would, you know, pick up drugs and things like that. And so, anyway, I picked him up. And he was outside at the road there, and I picked him up, and we went to Fred's. And he went in Fred's for me, and got the tobacco. And then on the way back to English Branch, I asked Jonathan if he would go over to Robbie's and, you know, cut her grass and everything.

And he said, sure, he wouldn't, you know, mind doing that. And he said, but I need some time, because my arm is still hurting. I said, your arm is hurting. I said, what's the matter with your arm. He says, you know, when I showed you that thing that it would have an abscess. I said, Jonathan, you hadn't took care of that thing yet. He says, it's gotten, you know, worse and everything, he said, but I'm going to go get it checked out. He said, but I don't want to do any work right now because it hurts. And I said okay.

So he was supposed to call me whenever, you know, it stopped hurting him and everything, and you

know, could do it, do the work and all. And then I let him out at the trailer. And that was the last time I seen him.

MS. BRIDENSTINE: Had you been to Nathan's trailer before March 5th, 2011?

MR. PRITCHARD: Yes, I have. I have. I've been there one time before. I think it was drop off Jonathan and Stephanie. Drop them off at Nate's trailer.

MS. BRIDENSTINE: Who is Stephanie?

MR. PRITCHARD: Stephanie was a girl that he was dating before he got locked up in Madison County.

MS. BRIDENSTINE: How did you know Stephanie?

MR. PRITCHARD: She was with him whenever I was introduced.

MS. BRIDENSTINE: You met Stephanie through Jonathan Whitson?

MR. PRITCHARD: No. At the same time that Robbie introduced me, you know, she was there, and he introduced her.

MS. BRIDENSTINE: Okay. How many times did you see Stephanie Whitson?

MR. PRITCHARD: I would just say about twice. Two times I seen her. Because of the fact that she needed a ride to work one day, and they was over at

Robbie's house. And I said, I'll give you a ride out there. And I gave them a ride. And then the other time is when they came back from the Mission Memorial Hospital, from the emergency room, seeing about his arm. Anyway, he was at Robbie's house. And he came to Robbie's house. And it was kind of snowing and stuff. And so he asked me if I'd give him a ride back home, him and Stephanie. I said sure, and I give them a ride back to Nate's trailer.

MS. BRIDENSTINE: Who was with you when you gave him a ride?

MR. PRITCHARD: Stephanie and Jonathan. I just had a little pickup truck.

MS. BRIDENSTINE: What time of year was that?

MR. PRITCHARD: It was around about, I'd say November, end of November, first of December. Somewhere around there.

MS. BRIDENSTINE: And you said he had just gotten out of the hospital?

MR. PRITCHARD: No. He had just gotten back from the emergency room.

MS. BRIDENSTINE: Emergency room. Okay.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: Yes. He went there to get his -- the abscess checked out. And they, you know, told him --

MS. BRIDENSTINE: What -- go ahead.

MR. PRITCHARD: They told him to go ahead and, you know, get this here antibiotics. And whatever you do, don't shoot no drugs in your -- in your arm again or anything like that. So --

MS. BRIDENSTINE: Did he tell you anything else about it?

MR. PRITCHARD: He told me that this is -- was the first time of him having an abscess in his arm like that. And I told him it's not nothing -- you know, to mess around with. I said, you need to go and get that thing taken care of.

MS. BRIDENSTINE: When you saw it in November, what did it look -- did you see it in November?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: What did it look like?

MR. PRITCHARD: It looked like it was swollen up. It was real puffy, and black and blue in that area, and everything.

MS. BRIDENSTINE: And you're motioning to your arm. Where on his arm did you see it?

MR. PRITCHARD: It was on his left arm.

MS. BRIDENSTINE: Okay. What part of his arm?

MR. PRITCHARD: Right around to the elbow area. Right here where the joint is.

MS. BRIDENSTINE: Yeah. You're motioning to what I would call maybe, like, the crook of the arm.

MR. PRITCHARD: Yes.

MS. BRIDENSTINE: Not the elbow.

MR. PRITCHARD: Yes. Crook.

MS. BRIDENSTINE: The inside.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Is that right?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: When you saw him on March 5th, 2011, I -- correct me if I'm wrong. You said you dropped him off at a different store he wanted to go to.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: And you went to the dump?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Okay. The name of that store was?

MR. PRITCHARD: Riddle's Grocery Store.

MS. BRIDENSTINE: What was he doing there?

MR. PRITCHARD: He was supposed to be meeting some friends or something. I don't know. I

didn't really ask him a lot. All I knew is he just asked me to drop him off there.

MS. BRIDENSTINE: Did he come out of the store with anything?

MR. PRITCHARD: No. Like I said, he was standing by the road by the time I got back around. Because I told him I didn't even want to pull into that place. So he was standing outside up at the road.

MS. BRIDENSTINE: Do you know what he did there?

MR. PRITCHARD: I don't know what he -- what he would -- you know, what he was doing. I don't -- I didn't know that much. All I knew was that that place was a bad place for drugs and stuff like that. And he was right there, close to the road, so --

MS. BRIDENSTINE: Did you see him with anyone else there?

MR. PRITCHARD: I didn't really pay attention. No, ma'am.

MS. BRIDENSTINE: And the next stop was Fred's store. Is that right?

MR. PRITCHARD: Yes, ma'am. Uh-huh. And he went in Fred's store for me.

MS. BRIDENSTINE: How did he pay for that tobacco?

MR. PRITCHARD: I give him -- I think it was a dollar fifty. I think a dollar fifty, or fifty-six, I think. And he purchased the tobacco.

MS. BRIDENSTINE: Why did he purchase instead of you?

MR. PRITCHARD: Well, I just didn't -- you know, I didn't really know that much about tobacco chewing and stuff like that, and he did. And so he went in and got it.

MS. BRIDENSTINE: Did he get anything else?

MR. PRITCHARD: I'm not sure if he did or not. He just came back with the tobacco and give that to me.

MS. BRIDENSTINE: When you dropped -- or when you picked him up at Nathan's, you're talking about Nathan Angel's trailer. Correct?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you see anyone else other than Jonathan Whitson when you picked him up?

MR. PRITCHARD: No.

MS. BRIDENSTINE: When you dropped him off, did you see anyone else?

MR. PRITCHARD: Yes. I seen Stephanie. She was sitting on the porch.

MS. BRIDENSTINE: Did you talk to her?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you talk to anyone there?

MR. PRITCHARD: Huh-uh. Oh, Nathan came back out, and he was asking me -- he said to tell Robbie that he can do some work, you know, for her, if he wanted -- you know, she wanted him to.

MS. BRIDENSTINE: Meaning Nathan could do some work for Robbie Brown?

MR. PRITCHARD: Uh-huh. Yeah.

MS. BRIDENSTINE: How long were you gone with Jonathan Whitson on March 5th, 2011?

MR. PRITCHARD: Okay. I picked him up about, I'd say 2:35. And I dropped him off at 20 after 3:00.

MS. BRIDENSTINE: How do you know what time it was?

MR. PRITCHARD: Because of my clock right there on the dashboard there.

MS. BRIDENSTINE: Did you see Jonathan Whitson after you dropped him off at Nathan Angel's trailer?

MR. PRITCHARD: No. Huh-uh. His mother -- now, his mother came over later that night.

MS. BRIDENSTINE: Okay. So you talked to

Nathan Angel that day.

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: And you saw Stephanie Whitson that day?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: But you did not talk to Stephanie?

MR. PRITCHARD: Not at all. Huh-uh.

MS. BRIDENSTINE: So the only people you spoke to are Jonathan Whitson and Nathan Angel?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: How far away was Nathan Angel's trailer when you compare it to Christine Angel's?

MR. PRITCHARD: I want to say approximately about 25 to 30 feet behind her house.

MS. BRIDENSTINE: Did you have to drive to a separate entrance to get to Nathan Angel's trailer?

MR. PRITCHARD: No. It's -- there was a trail that went back there for all the other trailers, you know. There was his trailer, it was double-wide, which was on the left. And then if you went on around a little bit, you can go back there to the other trailers that they have to rent.

MS. BRIDENSTINE: I guess what I'm trying to get at is, did you have to pull up to Christine Angel's

residence in order to get to Nathan Angel's trailer, or could you pass her residence?

MR. PRITCHARD: No. I didn't have to pass her -- her residence is over here. His trailer is right here.

MS. BRIDENSTINE: Okay. Where would you park your car?

MR. PRITCHARD: Right in front of -- right on the side of the road right there. It's a dirt road that goes, like, to the thing, and then cuts off for his -- a little bit of a dirt road cuts off to his.

MS. BRIDENSTINE: Okay. So you were next to Nathan Angel's trailer?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: What car were you driving?

MR. PRITCHARD: I was driving my Ford pickup.

MS. BRIDENSTINE: What color is that?

MR. PRITCHARD: It's silver.

MS. BRIDENSTINE: How would you get in touch with Jonathan Whitson?

MR. PRITCHARD: It was -- it was through Nate. Nate went and told him that I needed him to call me.

MS. BRIDENSTINE: And then Jonathan called

you on your cell phone?

MR. PRITCHARD: Uh-huh. Yes, ma'am. Uh-huh. And he'd have that -- have that cell phone number.

MS. BRIDENSTINE: Did Jonathan Whitson ask you about drugs on March 5th, 2011?

MR. PRITCHARD: No, he did not.

MS. BRIDENSTINE: How did he appear to you on March 5th, 2011?

MR. PRITCHARD: Well, he appeared sick, because he was sweating. And I figured that that arm was giving him a hard time, you know. And like I said, when I seen him, I told him, I said, you should have gotten that thing taken care of a long time ago, you know. And -- but he just seemed sick, you know. You know, like sweating and stuff like that.

MS. BRIDENSTINE: What was he wearing?

MR. PRITCHARD: He was wearing a -- one of those jackets that you get from a tractor-trailer place. Tan kind of jacket, you know. And he was wearing blue jeans and a flannel shirt.

MS. BRIDENSTINE: Are you talking about, like, a long-sleeve jacket?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you see his arm on

March 5th, 2011?

MR. PRITCHARD: Yes. When he went and pulled it out. He went and showed it to me.

MS. BRIDENSTINE: How did it look?

MR. PRITCHARD: It looked -- it looked bad. I mean, it really looked bad. It was, like, black, and bluish, reddish, kind of purplish type. And then it was, you know, swollen and everything. It was about as big as my leg.

MS. BRIDENSTINE: And how did his arm appear in comparison to his other arm?

MR. PRITCHARD: You could tell that it was swollen up.

MS. BRIDENSTINE: And which arm was it again?

MR. PRITCHARD: In the left arm.

MS. BRIDENSTINE: Have you seen track marks on someone before? Like needle track marks?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: How did it look in comparison to track marks?

MR. PRITCHARD: You could see the track marks, you know, from where he kept in that one particular place shooting the drugs and everything.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: And you could see them there.

MS. BRIDENSTINE: Could you see -- you said that when you saw him in November, I think you said it was black and blue?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: Are you talking about, like, it looked bruised?

MR. PRITCHARD: Yes, ma'am. It just looked like -- you know, like it -- like somebody hit it or something like that, you know. It looked like that type of bruise.

MS. BRIDENSTINE: And correct me if I'm wrong. I think you also said something about -- did you say pussy or something?

MR. PRITCHARD: Yes. Uh-huh.

MS. BRIDENSTINE: Where was the pus?

MR. PRITCHARD: Right there in the center.

MS. BRIDENSTINE: Was it in the center of the black and blue -- black-and-blue mark?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: And again, you motioned to the crook of your arm, like the inside of an elbow?

MR. PRITCHARD: Yes, ma'am. The crook. Right here. Uh-huh.

MS. BRIDENSTINE: What did that area look like on March 5th, 2011?

MR. PRITCHARD: It looked like it was really bad. I mean, it was -- like I said, it was black and blue, and had like a reddish, purplish type thing, and it was pussy, and it was swollen.

MS. BRIDENSTINE: Did it look the --

MR. PRITCHARD: And red. You could see some red and everything going up his arm.

MS. BRIDENSTINE: What do you mean red?

MR. PRITCHARD: It was just like a -- you know, light color red on your skin --

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: -- going up his arm.

MS. BRIDENSTINE: How did that compare to when you saw it in November?

MR. PRITCHARD: It was worse.

MS. BRIDENSTINE: Was the black-and-blue mark bigger, the same?

MR. PRITCHARD: It was about the same.

MS. BRIDENSTINE: And the pus, was that the same?

MR. PRITCHARD: Yes, ma'am. It was oozing out.

MS. BRIDENSTINE: What looked worse?

MR. PRITCHARD: It looked worse in March than it did in November.

MS. BRIDENSTINE: What about it looked worse? What made you think that it looks worse?

MR. PRITCHARD: It was, you know, more swollen. Like I said, the black and blue, it's not just black and blue, it was like the reddish, purplish kind of color.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: And it was swollen and real pussy-like. You could see the pus and stuff.

MS. BRIDENSTINE: Did you know Jonathan Whitson to be a drug user?

MR. PRITCHARD: Yes. Uh-huh. I sure did.

MS. BRIDENSTINE: When did you know he was a drug user?

MR. PRITCHARD: He -- he came to Robbie's place, and Robbie would -- instead of paying him in money for the work that he had done, she's give him some oxymorphone tablets for the work he did.

MS. BRIDENSTINE: And does oxymorphone have a different name?

MR. PRITCHARD: I can't remember if it does or not. I never -- never did ask her about that.

MS. BRIDENSTINE: What kind of pills did

Robbie Brown have?

MR. PRITCHARD: She had the 40 milligram and the 5 milligram.

MS. BRIDENSTINE: Of oxymorphone?

MR. PRITCHARD: Oxymorphone. The 5 milligram was blue. And the morphone, oxymorphone, I believe it was 40 milligram, it was yellow.

MS. BRIDENSTINE: So you knew Robbie Brown to give oxymorphone to Jonathan Whitson?

MR. PRITCHARD: Yeah. It was more or less, you know, paying him for what he did to work. He didn't want the money, he wanted the drugs.

MS. BRIDENSTINE: All right. So it was an exchange for work that he did. She would pay him with pills?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: Did she ever give him any different pills than oxymorphone?

MR. PRITCHARD: Not that I know of, no. When I was gone, she had access to my medication, because I had it in the safe.

MS. BRIDENSTINE: This was prior to March 2011, though. Correct?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: When did you move out of

Robbie Brown's place?

MR. PRITCHARD: It was in -- I want to say, the end of January. Because I went to court, like on the 26th, and they told me that I had to move out.

MS. BRIDENSTINE: Why did you have to move out?

MR. PRITCHARD: Because she was a convicted felon. And they said that I couldn't be in the same house as a convicted felon.

MS. BRIDENSTINE: That was a condition of your probation?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: How did Robbie Brown have access to your medication when you lived with her?

MR. PRITCHARD: Well, I had a safe that I put it in. It was actually her safe. And she knew the combination to it and everything.

MS. BRIDENSTINE: What else was in the safe?

MR. PRITCHARD: She had some money in there, and I think some -- her rings and stuff like that. She had some of them in there.

MS. BRIDENSTINE: Why did you keep your medication in her safe?

MR. PRITCHARD: Because of the fact, when I was gone, her son had stole from me before. Not Aaron,

but David. He stole all my medication one time before. I went to the police and reported it. Police didn't do nothing. And so I figured I'd lock it in her safe. That way I can -- you know, wouldn't have to worry about it.

MS. BRIDENSTINE: What medication did you have?

MR. PRITCHARD: I had the morphine, 30 milligram. And see, when you go to the PTSD program, they give you the medication there at the VA program. And I had oxycodone, 5 milligram.

MS. BRIDENSTINE: And those were -- those two medications, that's what you stored in Robbie Brown's safe?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Where did Robbie Brown keep her oxymorphone?

MR. PRITCHARD: I think she kept it right in her pocketbook, you know. And she always had her pocketbook right there close to her. Because her kids would steal her medication from time to time.

MS. BRIDENSTINE: You mentioned she might have had access to other drugs. Is that right?

MR. PRITCHARD: She did other drugs. She was, like, on crack cocaine.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: Yeah. She would buy crack cocaine.

MS. BRIDENSTINE: She was a drug user?

MR. PRITCHARD: Yes, ma'am. Uh-huh. At first, I didn't know she was a drug user. I mean, I knew she had used drugs, because we was at -- we met at an AA meeting. But I didn't know she was still using.

MS. BRIDENSTINE: Did you ever know her to have morphine?

MR. PRITCHARD: I believe so. Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: What makes you believe so?

MR. PRITCHARD: Okay. Because she would run out of her pills and everything. And then she would take a couple of my pills to last her till she got to the doctor to get another prescription filled.

MS. BRIDENSTINE: All right. Going back to March 5th, 2011. Correct me if I'm wrong. I think you brought up that you saw Ann?

MR. PRITCHARD: Yeah. Stephanie.

MS. BRIDENSTINE: No. Ann.

MR. PRITCHARD: Ann?

MS. BRIDENSTINE: Whitson Green.

MR. PRITCHARD: Yeah. Ann Whitson Green. Yes, ma'am. Uh-huh. Uh-huh.

MS. BRIDENSTINE: Okay. Tell me about that.

MR. PRITCHARD: Well, Ann, she -- more or less, she came over that night after I had -- you know, had dropped Jonathan off, a little later on, about around six o'clock or so. But she would come over there to spend the night, take a shower and stuff.

MS. BRIDENSTINE: What was your relationship to Ann Whitson Green?

MR. PRITCHARD: Well, there wasn't -- you know, just more or less like friends and everything, you know. But we -- we had consensual sex.

MS. BRIDENSTINE: Okay. You had a sexual relationship with her?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Were you dating her?

MR. PRITCHARD: No, I wasn't dating her.

MS. BRIDENSTINE: What -- you said she came over that night?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: And how long did she stay?

MR. PRITCHARD: She stayed until next morning at about, I'd say around six o'clock, five o'clock, somewhere around there, 5:30.

MS. BRIDENSTINE: Did she stay with you?

MR. PRITCHARD: Yes, ma'am. Uh-huh. I had

that big old green couch in there, too, that she could sleep on when she wanted to.

MS. BRIDENSTINE: Was anyone else there?

MR. PRITCHARD: Not that night. No, ma'am. Aaron, I think he was off somewhere or something or another. But he didn't come in until, I think the next day --

MS. BRIDENSTINE: Okay. So if we --

MR. PRITCHARD: -- around 10 o'clock or so.

MS. BRIDENSTINE: If we recount the people that you saw on March 5th, 2011.

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You saw Nathan Angel?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: You saw Jonathan Whitson?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: You saw Stephanie Whitson?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You saw Ann Whitson Green?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Did you see anyone else?

MR. PRITCHARD: Aaron. Aaron Brown [sic].

MS. BRIDENSTINE: All right. When did you see Aaron?

MR. PRITCHARD: Aaron was at the trailer, 10

o'clock. And when I went back from talking to Nate, he was in there, and we cleaned up the trailer a little bit. And that's where I got the garbage and all, and put it in the back of the truck to take it to the dumpster thing.

MS. BRIDENSTINE: When did Aaron leave?

MR. PRITCHARD: When did he leave?

MS. BRIDENSTINE: Did you just earlier say he had left. You weren't sure if he was around.

MR. PRITCHARD: You talking about at --

MS. BRIDENSTINE: On March 5th, 2011.

MR. PRITCHARD: March 5th. No, he was at the trailer.

MS. BRIDENSTINE: Okay. So was he there that night, as well?

MR. PRITCHARD: Yes -- no. Then he left. He left right -- I'd say around 6:00, 6:30, 7:00 probably.

MS. BRIDENSTINE: In the evening?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: All right. So you were there at the trailer with Ann overnight?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: I think you mentioned she left early the next morning.

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: And what's the next thing you remember happening on March 6th, 2011?

MR. PRITCHARD: March 6th is -- I got a call from Ann. And she said that she had been over at Nate's house, and that Jonathan had died. And she was upset, and crying and everything. And then, I guess Nate and Nikki and Ann came back over to the trailer. You know, they were upset and everything. We just sat there and talked a little bit.

MS. BRIDENSTINE: They came over to your trailer?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: What time did Ann call you?

MR. PRITCHARD: In the morning?

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: It was around -- it was actually a little bit after twelve that she called me.

MS. BRIDENSTINE: Why did she leave at five or six in the morning?

MR. PRITCHARD: Why? Because I'm going to guess she had some things to do or something like that. I'm not sure.

MS. BRIDENSTINE: Where were you from five or six in the morning until you heard the news from Ann?

MR. PRITCHARD: I was there at the trailer.

MS. BRIDENSTINE: What was your reaction when you heard about Jonathan Whitson dying?

MR. PRITCHARD: I was, you know -- I was sorry for, you know, him passing away like that. But that was it.

MS. BRIDENSTINE: What did she tell you?

MR. PRITCHARD: She just told me that -- that he had died. And she was -- actually, she was screaming about Nathan. She thought Nathan had done it to him, you know. And so that was --

MS. BRIDENSTINE: Did she tell you how he died?

MR. PRITCHARD: She didn't say anything about it.

MS. BRIDENSTINE: What was your understanding of what had happened?

MR. PRITCHARD: That he had slept over at Jonathan's house, and that they were drinking and something like that. And, you know, they might have drank too much alcohol or something like that.

MS. BRIDENSTINE: Who told you that?

MR. PRITCHARD: What? That he was drinking?

MS. BRIDENSTINE: That -- let me just clarify.

MR. PRITCHARD: Okay.

MS. BRIDENSTINE: You said he was over at Jonathan's house.

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: Where was Jonathan's house?

MR. PRITCHARD: No. I mean Nate's trailer.

MS. BRIDENSTINE: Nate's trailer. Okay.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Who told you that Jonathan Whitson was at Nate's trailer?

MR. PRITCHARD: Ann did.

MS. BRIDENSTINE: When did she tell you that?

MR. PRITCHARD: She told me when she called me.

MS. BRIDENSTINE: So that was at 12 o'clock on March 6th?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: She told you that Jonathan Whitson was at Nate's trailer?

MR. PRITCHARD: No. She said that he had died at Nate's trailer.

MS. BRIDENSTINE: He had died at Nate's trailer?

MR. PRITCHARD: Yes, ma'am. And then she said that she was -- like I said, she was hollering about Nathan. I couldn't figure out what she was hollering about. But anyway, she's the one that said that they moved him from the trailer over to Christine's house.

MS. BRIDENSTINE: Ann told you that?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: When did Ann tell you that?

MR. PRITCHARD: She told me that when she called me later on that night.

MS. BRIDENSTINE: What information did you have in that 12 o'clock phone call?

MR. PRITCHARD: That he just died.

MS. BRIDENSTINE: Did you know where?

MR. PRITCHARD: No. No.

MS. BRIDENSTINE: Did you know it was -- he died -- how he had died, what the circumstances were?

MR. PRITCHARD: No, ma'am, I didn't. I didn't even ask her why.

MS. BRIDENSTINE: Did Ann tell you where she was going when she left?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Do you know if Ann was there when it was discovered that Jonathan Whitson had

died?

MR. PRITCHARD: She was at Nate's trailer.

MS. BRIDENSTINE: Do you know why she was at Nate's trailer?

MR. PRITCHARD: They use -- they used to be married or something. I don't know. It was some crazy stuff that they -- and Nikki is one of her children, you know. And they -- she stays at Nathan's house. But Ann was -- she was, like, living out of her vehicle, you know, most of the time.

MS. BRIDENSTINE: She was homeless?

MR. PRITCHARD: Yeah, she was homeless. Uh-huh.

MS. BRIDENSTINE: And how is Ann Whitson Green related to Jonathan Whitson?

MR. PRITCHARD: She's his mother.

MS. BRIDENSTINE: Biological mother?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: What was their relationship like?

MR. PRITCHARD: I don't really know. I just know that, you know, she's Jonathan Whitson's mother, and that's it.

MS. BRIDENSTINE: How did you meet Ann Whitson Green?

MR. PRITCHARD: It was up at the store, I met her. Nikki was there. In fact, Nikki was getting into a car or something like that, and we said hello and everything. And Nikki went and introduced us.

MS. BRIDENSTINE: When did you meet Ann?

MR. PRITCHARD: I want to say in January. December or January, one or the other.

MS. BRIDENSTINE: Is that just a few months before Jonathan Whitson passed?

MR. PRITCHARD: Yes, ma'am. Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: Who is Nikki?

MR. PRITCHARD: Ma'am?

MS. BRIDENSTINE: Who is Nikki?

MR. PRITCHARD: Nikki is Ann's daughter. Nathan's daughter, too. They're parents to Nikki.

MS. BRIDENSTINE: What was your relationship with Nikki?

MR. PRITCHARD: She was a -- at one time, she dated Aaron and everything. So I knew her from that.

MS. BRIDENSTINE: Okay. So she was Aaron's previous girlfriend?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Was she a friend of yours?

MR. PRITCHARD: No, not really. I mean --

you know, I mean, I just knew of her, you know. But I mean, I didn't --

MS. BRIDENSTINE: When did you meet Nikki?

MR. PRITCHARD: It was -- like I said, it was in -- I think it was September or something like that when I met her. And -- no, no, no. Wait a minute. No. I met her before I went to the PTSD program. Because she was with Aaron. And they had moved out of Robbie's place and went somewhere. And then I seen her again in September, in the end of September.

MS. BRIDENSTINE: Okay. So you saw her the second time in September --

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: -- 2010?

MR. PRITCHARD: No -- yes, ma'am. 2010. Uh-huh.

MS. BRIDENSTINE: All right. So just to recap. The information you learned on the 12 o'clock phone call was, again, from Ann, that Jonathan had died at Nate's trailer?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Okay. Did you learn anything else during that phone call?

MR. PRITCHARD: No. That was it.

MS. BRIDENSTINE: After that phone call --

MR. PRITCHARD: I'd say around 1:30, two o'clock, they came over to the house -- to my trailer.

MS. BRIDENSTINE: Who came over?

MR. PRITCHARD: Nathan, Nikki, and Ann.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: And the cousin. And a cousin of theirs.

MS. BRIDENSTINE: What was the cousin's name?

MR. PRITCHARD: It's the last name is Silvers. So I think it was Robby Silvers.

MS. BRIDENSTINE: Robby Silvers came over?

MR. PRITCHARD: Uh-huh. With Nate, and Nikki, and Ann.

MS. BRIDENSTINE: From 12 o'clock to 1:30, did you learn anything else about Jonathan Whitson?

MR. PRITCHARD: About -- Robby Silvers said something about the fact that he think -- he thought he had died from drugs.

MS. BRIDENSTINE: Was that at 1:30 when he came over?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Did you learn any other information about Jonathan's passing from 12:00 to 1:30?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: Okay. So when they came over, Robby Silvers told you --

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: -- that he thought Jonathan Whitson had passed from drug use?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you learn anything else?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did Ann tell you anything?

MR. PRITCHARD: No. She called me, like I said, later on that night, and asked me if I would be the pallbearer for -- you know, at the funeral. And I said yes, I would, you know. And that was about it.

MS. BRIDENSTINE: At that 1:30 meeting, how long were those three people there at your house?

MR. PRITCHARD: I'd say about 10 -- 10 minutes, 10, 15 minutes.

MS. BRIDENSTINE: Did you talk about the fact that Jonathan had just been discovered dead?

MR. PRITCHARD: No. I don't think we did. I think they were just all heartbroken and crying, and stuff like that. And I was just more or less saying, you know, sorry to hear it, and all like that.

MS. BRIDENSTINE: All right. But Robby

Silvers might have talked to you about he thought it was a drug --

MR. PRITCHARD: He said, yeah, he thought it was a drug overdose.

MS. BRIDENSTINE: Overdose. All right.

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: Did you know what type of drugs they were talking about?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: When is the next time that day that you learned any information about Jonathan Whitson?

MR. PRITCHARD: I think it was Monday. Nate came up to me and said that Stephanie had told the police that I was the one that give him the pills.

MS. BRIDENSTINE: Did he say anything else to you?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: And what did you say to Nathan?

MR. PRITCHARD: I said, you know, Nate, I said, I don't mess around with stuff like that. I said, I don't, you know, do that. He said, I know. He says, I know. He said, if I thought that you had, I would have put a cap in you.

MS. BRIDENSTINE: Correct me if I'm wrong.

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: But earlier, I think you said that on March 6th, that later that night, Ann came over to your trailer, or you talked to her again?

MR. PRITCHARD: Talked to her again on the telephone. Yes, ma'am.

MS. BRIDENSTINE: All right. And what did you guys say during that phone call?

MR. PRITCHARD: Well, she was just talking about, you know, Jonathan dying and everything. And how she had thought that Jonathan was moved by William and Nathan.

MS. BRIDENSTINE: Who is William?

MR. PRITCHARD: William is Nathan's brother.

MS. BRIDENSTINE: Okay. William Angel?

MR. PRITCHARD: Yeah. William -- William Angel. Uh-huh.

MS. BRIDENSTINE: Approximately how old was William Angel at the time?

MR. PRITCHARD: I couldn't tell you. Because I knew he was not too much younger than -- than Nathan. And Nathan, I think, was around about 45 or something like that, 46.

MS. BRIDENSTINE: So Ann told you that she

thought William and Nathan moved Jonathan Whitson's body?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did she tell you why she thought that?

MR. PRITCHARD: Well, she said that Christine did not like the fact of her kids doing drugs and alcohol and in her home. And what I picked up from her is that they didn't have too good of a relationship, Christine and Nathan -- I mean, Christine and Jonathan didn't have too good of a relationship. Because he wasn't a real actual son to Nathan. He was the stepson.

MS. BRIDENSTINE: Where was Jonathan Whitson's body moved from?

MR. PRITCHARD: From the trailer.

MS. BRIDENSTINE: From whose trailer?

MR. PRITCHARD: From Nathan's trailer.

MS. BRIDENSTINE: And where was it moved to?

MR. PRITCHARD: Moved to Christine's couch.

MS. BRIDENSTINE: But why?

MR. PRITCHARD: Why?

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: Only thing I could figure out is because, later on, I found out, when I was in jail and everything, Danny Edwards told me, he said that when he took Nikki and his sister home to Nate's trailer, they

asked him to come in. And they were selling drugs and drinking and all like that, and wanted him to buy some drugs.

MS. BRIDENSTINE: And when did -- when was he taken home? Or sorry. You said he took Nikki and Nikki's sister home?

MR. PRITCHARD: Uh-huh. Yeah.

MS. BRIDENSTINE: When did he do that?

MR. PRITCHARD: It was the March the 5th.

MS. BRIDENSTINE: All right. Who is Danny Edwards?

MR. PRITCHARD: Danny Edwards is the guy that I met in jail. He -- he's Nikki's ex-husband. All right. And let's see. I'm trying to think of the -- how else. But anyway, he said that -- you know, that he knew that Jonathan was over at the trailer after 12, after midnight that night. Because he walked in, and they were in there drinking and -- and doing drugs and stuff.

MS. BRIDENSTINE: Are you talking about the night before Jonathan Whitson died?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: When did you meet Danny Edwards?

MR. PRITCHARD: It was December -- around December 22nd, somewhere around there.

MS. BRIDENSTINE: Of what year?

MR. PRITCHARD: Of 2011.

MS. BRIDENSTINE: All right. What jail?

MR. PRITCHARD: It was in Yadkin County jail.

MS. BRIDENSTINE: What was --

MR. PRITCHARD: They locked me up December the 1st.

MS. BRIDENSTINE: Were you his cellmate, around the same block?

MR. PRITCHARD: It was in the same -- in the, you know, where they've got a -- a place in there. They've got beds, you know, up against the wall and everything. And we were all locked up in the same block and everything.

MS. BRIDENSTINE: How did you get talking about this case?

MR. PRITCHARD: Well, you know, because we all introduced ourselves, you know, to each other kind of time, you know. And when I said my name and everything, he said -- you know, he said, they told me that -- that you had given Jonathan drugs, you know, that he OD'd on. And I didn't ask him who told him that. But I told him, I said, no, I didn't. He said, well, that Jonathan had passed away from doing the drugs.

MS. BRIDENSTINE: Had you ever seen Danny Edwards before December 2011?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: Did you recognize him when you saw him in jail?

MR. PRITCHARD: No, ma'am. I didn't even know who he was, really, to tell you the truth, till, you know, we was in the cell block and everything.

MS. BRIDENSTINE: Going back to this conversation you had with Nathan Angel on Monday.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: After Jonathan Whitson died. Right?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: Did he tell you where he got this information that you were the one who provided drugs to Jonathan Whitson?

MR. PRITCHARD: He said Stephanie. He said -- he was the one that told me that Stephanie was going and telling the police that I gave Jonathan the drugs.

MS. BRIDENSTINE: Why do you think Stephanie was telling the police that?

MR. PRITCHARD: I'm not sure. I guess because she was shooting drugs with him, or whatever.

And I'm an out-of-towner, you know.

MS. BRIDENSTINE: Do you know who gave Jonathan Whitson drugs before he died?

MR. PRITCHARD: I couldn't tell you exactly. No, ma'am. But I know about where he got them from.

MS. BRIDENSTINE: Okay. Where is that?

MR. PRITCHARD: At that store, Riddle's. But I didn't want to ask him. I didn't want to -- you know. That's his own personal stuff, you know. I just didn't think I should question him about it.

MS. BRIDENSTINE: Did Jonathan Whitson have money with him on March 5th, 2011, when you took him to that store?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: Do you know how -- if he got drugs there, do you know how he would have been able to do that?

MR. PRITCHARD: No, ma'am. Burnsville is a pretty close-knit place, you know. I mean people, they know each other.

MS. BRIDENSTINE: How prevalent was drug use in that area of Burnsville where you were living back in March of 2011?

MR. PRITCHARD: A lot.

MS. BRIDENSTINE: Out of all the people that

you've mentioned, for instance, who was using drugs?

MR. PRITCHARD: Who was using drugs?

MS. BRIDENSTINE: Uh-huh. At that time.

MR. PRITCHARD: Nate, Jonathan, Stephanie. I want to say Aaron. Yeah, Aaron. And then her son, David, and Robbie. Robbie was -- she more or less did the crack cocaine, smoking that stuff. And she took her medications by mouth and everything.

MS. BRIDENSTINE: Was she a drug dealer?

MR. PRITCHARD: Yes, ma'am. She was.

MS. BRIDENSTINE: Who else was a drug dealer in that area at that time?

MR. PRITCHARD: Nathan.

MS. BRIDENSTINE: Do you know where he would get his drugs from?

MR. PRITCHARD: Sometimes from Robbie.

MS. BRIDENSTINE: Anyone else?

MR. PRITCHARD: Oh, there was a guy in -- what's the name of that -- Marion. And he used to date Robbie. His name was Honeycutt, something -- Robin Honeycutt. And he had drugs that he was selling. And Aaron would sell them for him, actually.

MS. BRIDENSTINE: Aaron Collins would sell drugs --

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: -- for this Honeycutt person?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you have any conversation with Jonathan Whitson on March 5th, 2011, about whether or not he was using drugs?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: Do you know when he got out of jail?

MR. PRITCHARD: Nate told me, when we talked in the road, Nate told me that he had just gotten out that night. And I think it was late that night or so, around 1:30 or something like that. And that he was staying at his trailer. In fact, one of the statements that they had said that Nate said that he -- Jonathan gave him a pill. And he left Jonathan and Stephanie in the trailer so they can have some alone time.

MS. BRIDENSTINE: Did you see Jonathan Whitson from the time you saw him in November of 2010 until you saw him on March 5th, 2011?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You saw him?

MR. PRITCHARD: Yeah. We saw -- right before we went down to Charleston at the end of December, couple of weeks before, about one week before Christmas.

Because I was taking my brother a Christmas tree down there. And I seen Jonathan then. And like I said, they were coming mostly when she -- he would buy drugs. He would by them from Robbie.

MS. BRIDENSTINE: Jonathan Whitson would?

MR. PRITCHARD: Uh-huh. Yes.

MS. BRIDENSTINE: And what drugs would he buy from Robbie?

MR. PRITCHARD: The 5 milligram oxymorphone.

MS. BRIDENSTINE: All right. When you saw him in December, you said we. Who were you with?

MR. PRITCHARD: Robbie. Robbie Brown.

MS. BRIDENSTINE: Was Jonathan by himself?

MR. PRITCHARD: No. I think -- I think he had Stephanie with him. I believe he did have Stephanie with him.

MS. BRIDENSTINE: Did you talk to him about drugs in December 2010?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: How long were you with him?

MR. PRITCHARD: Not long. Just like, you know, a few minutes here. And then they left. And I took Stephanie and Jonathan to the -- where she worked at one night, dropped them off.

MS. BRIDENSTINE: Did you see his arm on that occasion?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: Did you talk about his arm at all?

MR. PRITCHARD: No, ma'am. It was before when I seen his arm. And I just -- you know, I mean, that was his problem. I didn't --

MS. BRIDENSTINE: How did he seem in December?

MR. PRITCHARD: It was in the latter part, and he had just got back from the emergency room. You know, they came over to Robbie's. And they were trying to get Robbie to give them some drugs.

MS. BRIDENSTINE: And I want to clarify. I'm talking about December 2011 [sic], not November.

MR. PRITCHARD: Oh, December of 2011. Okay. No, not --

MR. ZIEGLER: Are you talking about 2010?

MS. BRIDENSTINE: I'm sorry. 2010. Yes.

MR. PRITCHARD: Yeah. 2010 is when I seen him.

MS. BRIDENSTINE: Okay. So at the December time, did you have any conversation about drugs with him?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: But you just mentioned you did in November?

MR. PRITCHARD: No. I just knew that he had -- because he had that abscess and everything. I kind of assumed that he, you know, was doing drugs. I mean, he -- when him and Robbie would get together and everything, she wouldn't do any -- she would go back into her room and everything, and he would go with her.

MS. BRIDENSTINE: Okay. So you assumed he was getting drugs from Robbie?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did he get drugs from Robbie in December of 2010?

MR. PRITCHARD: Yes, ma'am. Uh-huh. See, he asked me one time when I was staying with Robbie, right before I had to move out in December -- I think it was in December -- he asked me if I would sell him some -- some of that morphine.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: And I told him no. I said, your girlfriend, she's the bondsman's daughter in this town. And if he was to get caught, first thing they'd do is check me for the stuff.

MS. BRIDENSTINE: So Stephanie was the daughter of a bondsman?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: And Jonathan Whitson asked you to sell him morphine in December of 2010?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: And you said no?

MR. PRITCHARD: I said no.

MS. BRIDENSTINE: How did he know you had morphine?

MR. PRITCHARD: Because Robbie give him some whenever he would come over cutting grass and stuff.

MS. BRIDENSTINE: Robbie would give him your morphine?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: Okay. Did you know she was doing that?

MR. PRITCHARD: No, not really. I didn't know.

MS. BRIDENSTINE: How many times did Robbie give Jonathan Whitson your morphine?

MR. PRITCHARD: I don't -- I can't -- I couldn't tell you exactly. Because, like I said, I left it in the safe and everything when I was in the PTSD program. And that was from July until the last part of September -- well, middle part of September.

MS. BRIDENSTINE: Okay.

MR. ZIEGLER: How did you learn that she gave him your morphine?

MR. PRITCHARD: How? Because he had come up and ask me, you know, if I would sell him some. And --

MR. ZIEGLER: It sounds like -- it sounds like you're saying Jonathan told you that she gave it to you. Is that what happened?

MR. PRITCHARD: Yes, ma'am -- yes, sir. Uh-huh.

MR. ZIEGLER: Okay.

MS. BRIDENSTINE: Did anyone else see Jonathan Whitson's arm prior to his death that you're aware of?

MR. PRITCHARD: I would say Ann said she seen it, may have seen it.

MS. BRIDENSTINE: How do you know Ann saw it?

MR. PRITCHARD: She was his mother. And --

MS. BRIDENSTINE: So you're assuming. Is that right?

MR. PRITCHARD: Yes, ma'am. That's assuming. Yes, ma'am.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: And Nikki knew it. And --

MS. BRIDENSTINE: How do you know Nikki knew

it?

MR. PRITCHARD: How do I know?

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: Because she was there when I brought him home that night from the -- you know, when he went to the emergency room and came over to Robbie's, and I took him home. And she was there.

MS. BRIDENSTINE: Did you ever talk about his arm with Nikki?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: You've mentioned that you heard that his body was moved --

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: -- from Nathan Angel's trailer down to Christine's house.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: What significance does that have to you? Why do you think that that's something we should know?

MR. PRITCHARD: Because of the fact that they're -- they're lying about the fact that he shot drugs in Christine's house. And they're lying the fact about that he died in there. You know, she wouldn't -- see, before that, when I took him -- when I said that I took him home. All right. It was -- it was

cold, you know, when I took him home one time. It was cold. And they were going in that trailer. And he didn't have -- Nathan didn't have any electricity. But he was staying -- they were staying in that trailer.

And what I come to find out is that Nathan had a drop cord running to his mother's house, and then they had this kerosene burner that they burnt for, you know, heat and stuff. And that's why it just kind of -- it kind of puzzled me that they wanted to say that he was in Christine's house, when she don't -- she don't allow people using drugs or drinking. She don't even let her husband in there drinking. He has to go down to the trailer down the road and stay there until he sobers up and don't smell of alcohol.

MS. BRIDENSTINE: What medical conditions did Jonathan Whitson have other than the abscess that you've described?

MR. PRITCHARD: That's it. That's all I knew of.

MS. BRIDENSTINE: Is that the only one you're aware of?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Did Jonathan Whitson receive medical treatment prior to his death? You mentioned the emergency room visit in November.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: But anything other than that?

MR. PRITCHARD: No, ma'am. And I think he was locked up right there in the first part of -- the last part of December, first part of January.

MS. BRIDENSTINE: Did you speak to him when he was in jail?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: Did you hear how he was doing?

MR. PRITCHARD: No, ma'am. I found out how he was doing when we was together in the truck, and he was talking about -- he was asking about my outcome with the Yancey County police department. And he talked about his, and how he got locked up in Madison County. And that he said they wasn't even giving him any aspirin. And I said, man, that's crazy.

MS. BRIDENSTINE: Did anyone ever talk to you about Jonathan Whitson's arm?

MR. PRITCHARD: No.

MS. BRIDENSTINE: When did you first become aware that police were looking at you as a suspect in this case?

MR. PRITCHARD: Well, December 6th -- I

mean, March 6th is when Nathan came over there and told me that, you know, Stephanie told them that I gave him the drugs.

MS. BRIDENSTINE: So the day that Jonathan Whitson died, you spoke to Nathan Angel?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: And that's when he told you Stephanie was telling the police that the pills came from you?

MR. PRITCHARD: Yes, ma'am. It was later. It was, like, around the afternoon, 6:30 or so.

MS. BRIDENSTINE: Did you tell anyone that you were worried about getting blamed for Jonathan Whitson's death?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you tell anyone that you gave morphine pills to Jonathan Whitson before he died?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: And I just want to clarify. When I say before he died, I'm talking about in the two-day period before Jonathan Whitson died, did you tell anyone that you gave Jonathan Whitson morphine pills?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Those two days before he died?

MR. PRITCHARD: Huh-uh. No. I called Robbie up when I got the phone call from Ann and everything. And I called Robbie up and told her that, you know, that Ann said that, you know, that he came to her house to get the drugs, and then came back to -- and let him off at Nate's trailer.

MS. BRIDENSTINE: You told Ann that you thought he got -- picked up drugs when he was with you?

MR. PRITCHARD: No. She told me that that's what Stephanie said the first time when she talked to her.

MS. BRIDENSTINE: When did Ann tell you that?

MR. PRITCHARD: It was right after when she called about the -- you know, the incident of Jonathan dying and everything. And then when they came over and everything, that's when she went and told me.

MS. BRIDENSTINE: What did she tell you again?

MR. PRITCHARD: She told me, she said that Stephanie said that I had given Jonathan drugs.

MS. BRIDENSTINE: Did you hear that first from Ann or Nathan?

MR. PRITCHARD: I heard it from Ann. Yeah. Ann.

MS. BRIDENSTINE: Did you have a conversation with Robbie Brown about this?

MR. PRITCHARD: Yes. That's when I went --

MS. BRIDENSTINE: When was that?

MR. PRITCHARD: Yeah. That's when I went and called Robbie, after they left and everything. And I told her, I said, listen, Stephanie is going and telling the police that I came over there and got some morphine pills from you and give them to Jonathan.

MS. BRIDENSTINE: You told that to Robbie Brown?

MR. PRITCHARD: Uh-huh. Yeah.

MS. BRIDENSTINE: That was on March 6th?

MR. PRITCHARD: Yes. No. That was on March -- yeah, March 6th. Yeah.

MS. BRIDENSTINE: Okay. So I just want to make sure I'm understanding what you're saying.

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You received a phone call at noon from Ann Whitson, informing you that Jonathan Whitson had died.

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: And then at 1:30, Nikki

Angel, Ann Whitson Green --

MR. PRITCHARD: Ann Green --

MS. BRIDENSTINE: -- and Nathan Angel came over to your trailer.

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: And I think you said Robby Silvers, too.

MR. PRITCHARD: Yes, ma'am. He was with them.

MS. BRIDENSTINE: Earlier you said you didn't really talk about the death that much.

MR. PRITCHARD: No, ma'am. I didn't.

MS. BRIDENSTINE: When did you learn from Nathan Angel that Stephanie Whitson was implicating you as a person who provided drugs to Jonathan Whitson?

MR. PRITCHARD: That was -- that was Monday.

MS. BRIDENSTINE: Monday. So the next day?

MR. PRITCHARD: Yes, ma'am. Yes, ma'am. The next day.

MS. BRIDENSTINE: All right. When did you learn from Ann Whitson Green that Stephanie Whitson was implicating you as a person who provided morphine to Jonathan Whitson?

MR. PRITCHARD: That was that phone call. After the phone call, when they came over to the house.

MS. BRIDENSTINE: So she told you that when they came over at 1:30?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: When did you talk to Robbie Brown?

MR. PRITCHARD: It was around, I'd say three o'clock, somewhere around there.

MS. BRIDENSTINE: Did you have any other conversations about Jonathan Whitson's death with anyone else?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: And what drug prescriptions did you have on March 5th, 2011?

MR. PRITCHARD: I had morphine sulfate and oxycodone.

MS. BRIDENSTINE: Who prescribed those drugs to you?

MR. PRITCHARD: The VA.

MS. BRIDENSTINE: Did you have any other doctors other than the doctors associated with the VA prescribe drugs to you?

MR. PRITCHARD: When I had a accident and everything in Madison County. They took me to the Mission Memorial, and they gave me a pill there to calm me down.

MS. BRIDENSTINE: When was that?

MR. PRITCHARD: I'd say it was in 2009, sometime around -- I'm going to say September.

MS. BRIDENSTINE: So in 2010 and 2011, were any other doctors prescribing you drugs?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: All right. It was always through the VA?

MR. PRITCHARD: Yes, ma'am. Through the VA is what I would, you know, get my medication from.

MS. BRIDENSTINE: And is that the VA hospital in Asheville?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: When were you first prescribed morphine?

MR. PRITCHARD: I want to say -- I want to say in probably May, I think. May of 2009.

MS. BRIDENSTINE: When were you first prescribed oxycodone?

MR. PRITCHARD: Same time.

MS. BRIDENSTINE: How often did you take morphine?

MR. PRITCHARD: It was one tablet every four hour -- or every eight hours.

MS. BRIDENSTINE: Would you consistently

take three pills a day?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: How often did you take oxycodone?

MR. PRITCHARD: Every now and then. It was just sort of to -- you know, if the pain came up before I was supposed to take my next dose, I would take a little bit.

MS. BRIDENSTINE: How consistent were you with taking morphine three times a day?

MR. PRITCHARD: Real consistent. Because my back would really hurt, you know. And they operated on it right before I got locked up in December.

MS. BRIDENSTINE: Why were you prescribed morphine?

MR. PRITCHARD: Because of my back injury.

MS. BRIDENSTINE: Why were you prescribed oxycodone?

MR. PRITCHARD: For my back injury.

MS. BRIDENSTINE: Did you ever get morphine from any other source than through your prescription at the VA?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: Did you ever get oxycodone through any other source than your prescription at the

VA?

MR. PRITCHARD: I want to say that that doctor that I went and seen -- darn. What was his name? He was there at the clinic where they would, you know, check you out and everything. And then the insurance lady that was with me, she would take me to the physical therapy afterwards. But that doctor, he prescribed me, I think, 30 -- 30 pills one time.

MS. BRIDENSTINE: Where was that?

MR. PRITCHARD: That was in Asheville.

MS. BRIDENSTINE: When?

MR. PRITCHARD: I want to say in May. Right around the time of the accident.

MS. BRIDENSTINE: May of 2009?

MR. PRITCHARD: 2009. Yes, ma'am.

MS. BRIDENSTINE: Did you ever visit any doctors out of state and get prescriptions?

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: How many morphine pills did you have on March 5th, 2011?

MR. PRITCHARD: I didn't -- believe I had maybe about, I'd say 10. Because I think Monday, which was March the 6th, they went and send me another 90 in a bottle through the mail.

MS. BRIDENSTINE: Was it your practice to

get your refill when you ran out?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: So you would wait until you ran out, then you would get more?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: How many oxycodone pills did you have on March 5th, 2011?

MR. PRITCHARD: I'd say about maybe five, five or 10, somewhere around there. I was about run out of both of them is what I --

MS. BRIDENSTINE: Were they treating the same type of pain, or were they for different purposes?

MR. PRITCHARD: No. Same type of pain.

MS. BRIDENSTINE: Why would you need oxycodone on top of morphine?

MR. PRITCHARD: The oxycodone was to kind of -- like if I started having severe pain again, attacks before my next does, then I would take it, take the oxycodone to make -- hold over until I took --

MS. BRIDENSTINE: You called to refill your morphine prescription on March 10th, 2011. Is that right?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you ever have any substance abuse issues?

MR. PRITCHARD: Who, me?
MS. BRIDENSTINE: Uh-huh.
MR. PRITCHARD: Back in 1984. Yes, ma'am.
MS. BRIDENSTINE: What was that?
MR. PRITCHARD: It was heroin.
MS. BRIDENSTINE: Did you get treatment for that?
MR. PRITCHARD: Yes, ma'am.
MS. BRIDENSTINE: What kind of treatment?
MR. PRITCHARD: VA in Atlanta, Georgia.
MS. BRIDENSTINE: Was this inpatient, outpatient?
MR. PRITCHARD: Inpatient.
MS. BRIDENSTINE: Did you ever work as a drug counselor?
MR. PRITCHARD: Yes, ma'am.
MS. BRIDENSTINE: Where did you do that?
MR. PRITCHARD: I finally became a counselor in, I want to say in '93.
MS. BRIDENSTINE: 1993?
MR. PRITCHARD: Yes, ma'am. I worked at the -- I wasn't -- I didn't have the title of counselor. But I mean, I worked as a, you know, counselor substitute, whatever, healthcare technician.
MS. BRIDENSTINE: Okay. How long did you

work as a drug counselor?

MR. PRITCHARD: I worked for the state when I finally got my license and everything. And from '95 until 2005.

MS. BRIDENSTINE: Were you ever in NA, Narcot --

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Okay. When were you in NA?

MR. PRITCHARD: Right after I got out of treatment in 1984.

MS. BRIDENSTINE: How long were you -- how long did you attend NA for?

MR. PRITCHARD: I was still attending NA when I was, you know, at Robbie's place. In fact, I would go to meetings.

MS. BRIDENSTINE: Okay. So were you still attending NA in March of 2011?

MR. PRITCHARD: Uh-huh. Yes, ma'am.

MS. BRIDENSTINE: How often would you attend NA?

MR. PRITCHARD: I'd say anywhere from twice to three times a week.

MS. BRIDENSTINE: Were you a sponsor?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Who did you sponsor? Well, I -- I understand that that's supposed to be --

MR. PRITCHARD: I know. I can't say --

MS. BRIDENSTINE: You acted as a sponsor for other people. Is that right?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you ever act as a sponsor for Aaron Collins?

MR. PRITCHARD: No. No. I mean, I'd talk to him about it and stuff like that, but I -- you know. He told me he could get his life together. In fact, one night when he got kicked out of everywhere, and -- even my place, he got kicked out. We had talked about his drug use and how it was just alienating him from other friends and stuff like that.

MS. BRIDENSTINE: You have a previous conviction on your record related to selling morphine. Is that right?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Who was the confidential informant that was used in that case?

MR. PRITCHARD: Her name was Waldrop.

MS. BRIDENSTINE: What was it?

MR. PRITCHARD: Waldrop. Her last name was Waldrop. I think her first name was Alice. Alice

Waldrop.

MS. BRIDENSTINE: Does the name Jennifer Black mean anything to you?

MR. PRITCHARD: Huh-uh.

MS. BRIDENSTINE: No? Okay. What were the circumstances of that case?

MR. PRITCHARD: Oh, no. Jennifer Black. Okay. Now I know who you're talking about. That was Robbie's person that she was selling drugs to. Okay. And she came up there one morning, and I seen her, you know, coming up to the door and everything. So I opened the door and let her in since she'd usually wait and talk to Robbie while Robbie was in the bedroom, and I went to the bathroom.

Well, come to find out, she got some pills from Robbie, and went to the police station and turned them in. And then what's his name? Sheriff Barber -- no. Detective Barber, he came over to the house, and he arrested both of us. And I told him, I said, I didn't have anything to do with it, you know. I mean, that was Robbie's friend. And I was in the bathroom taking a crap. And actually, I went and looked at the back window, because the boy that Jennifer Black was dating and everything stole some stuff out of Robbie's yard when he came up before.

MS. BRIDENSTINE: Were you arrested for this?

MR. PRITCHARD: Yeah. They arrested me. Uh-huh.

MS. BRIDENSTINE: Is this the -- when was this? When is the offense date for what you're talking about at Robbie's house?

MR. PRITCHARD: At Robbie's house, it was -- I want to say 2010, around May or June.

MS. BRIDENSTINE: Okay. Is that what you were on probation for in March 2011?

MR. PRITCHARD: No. No. 2011 was when I finally went to court for my first charge, one where I sold to that Alice Waldrop.

MS. BRIDENSTINE: Was that a -- where she was a confidential informant?

MR. PRITCHARD: An informant. Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you sell her drugs?

MR. PRITCHARD: I gave her drugs. Yes, ma'am. Yes, ma'am. She was a friend of Robbie's. And she was dating Robbie's cousin. So, you know, Robbie said, yeah, go ahead, you know, she'd be all right.

MS. BRIDENSTINE: So you admit that you were a drug dealer back in 2010?

MR. PRITCHARD: I wasn't a drug dealer. I just -- just that one time I did that.

MS. BRIDENSTINE: All right. So it was just one time?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Had you ever provided drugs before to Jonathan Whitson?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you ever give Jonathan Whitson morphine when Stephanie Whitson was present?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: Did you ever give Jonathan Whitson when Robbie Brown was present?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did Jonathan Whitson ever ask you for morphine?

MR. PRITCHARD: Yes. That's when I went and told him, I said, no, your girlfriend is a bondsman's daughter.

MS. BRIDENSTINE: Was Stephanie Whitson there when that happened?

MR. PRITCHARD: She was in there talking to Robbie. Yes, ma'am.

MS. BRIDENSTINE: She was what?

MR. PRITCHARD: She was in there talking to

Robbie. And Jonathan and I was in the other part of the house. That was in the kitchen.

MS. BRIDENSTINE: Approximately when was that?

MR. PRITCHARD: That was in, I'd say October. Around in October.

MS. BRIDENSTINE: Okay. Of 2010?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Did you ever give morphine to Jonathan Whitson around Christmas of 2010?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: Okay. So we've gone over this a little bit before. But it sounds like on March 5th, 2011, you were dating Robbie Brown. Is that right?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You also had a sexual relationship --

MR. PRITCHARD: Well, I wasn't really dating Robbie Brown. Because when I got kicked out and everything, she kind of got upset. And so we were more or less, like, broke up, you know.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: Then Ann started -- I started seeing Ann.

MS. BRIDENSTINE: All right. Were you

seeing anyone other than Ann Whitson Green?

MR. PRITCHARD: Nikki.

MS. BRIDENSTINE: Nikki Angel?

MR. PRITCHARD: Uh-huh. Yeah.

MS. BRIDENSTINE: Anyone else?

MR. PRITCHARD: That was it.

MR. ZIEGLER: Mr. Pritchard, just to clarify.

MR. PRITCHARD: Uh-huh.

MR. ZIEGLER: When you say seeing Nikki Angel --

MR. PRITCHARD: I was having consensual sex with her.

MR. ZIEGLER: Okay.

MS. BRIDENSTINE: After you were arrested and you were in jail, did you correspond with Robbie Brown?

MR. PRITCHARD: She would -- yeah. She would come up on the weekends to see me. And when she could, she would -- you know, I'd call her and talk to her on the telephone, you know. And it was both -- mostly about my stuff. I had given her -- you know, I asked her to put them into a warehouse and everything. But she took them over to her house. And I was asking about my stuff, you know, how was -- was there any

problem there and all like that. And if it was, let me know. But --

MS. BRIDENSTINE: Did you talk to her on the phone?

MR. PRITCHARD: Yes.

MS. BRIDENSTINE: Did you write letters with her?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you ever talk about your case?

MR. PRITCHARD: Yes, ma'am. Uh-huh. We sure did.

MS. BRIDENSTINE: What did you guys talk about?

MR. PRITCHARD: Well, she was trying to tell me -- I told her, I said, listen, they've got a statement saying that you said that I went and sold Jonathan eight tablets of morphine. And she swore up and down that she did not. She said that's why she did not sign that statement, because she did not say that. And when she got up into the courtroom, she said the same thing.

MS. BRIDENSTINE: Did you see or talk to anyone else when you were in jail waiting for your trial?

MR. PRITCHARD: Yeah. I was talking to a lot of people in there. They all knew each other. Like

I said, it was almost like a -- you know, they were having a family reunion when they coming to jail.

MS. BRIDENSTINE: Did you have -- did you receive visits from anyone other than Robbie Brown?

MR. PRITCHARD: Yes.

MS. BRIDENSTINE: Who?

MR. PRITCHARD: My daughters.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: Tracy and Lacey.

MS. BRIDENSTINE: Anyone else?

MR. PRITCHARD: Nikki came up there one time and visited with me.

MS. BRIDENSTINE: What did you talk about with Nikki?

MR. PRITCHARD: Nothing. Just -- she just said that she knew that I didn't do anything, you know, to harm Jonathan. She knew that.

MS. BRIDENSTINE: How did she know that?

MR. PRITCHARD: She just knew. She said that, you know, she just had this feeling that, you know, nothing ever transpired between me and Jonathan.

MS. BRIDENSTINE: So other than Nikki, Robbie, and family --

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: -- anyone else?

MR. PRITCHARD: I don't think so.

MS. BRIDENSTINE: What about since you've been in prison?

MR. PRITCHARD: Since I've been in prison?

MS. BRIDENSTINE: Have you talked to anyone about your case?

MR. PRITCHARD: No. Not really. I mean, the guys would ask me in the rooms, in the dorms and stuff like that, what are you in for, you know, because they -- automatically, they assume that you're a pedophile, you know, being an older person and everything. So I tell them no, I ain't no -- I'm charged with something different. And when I tell them what they charged me for, they said, there's no way. They said no way you can do drugs at 9:30 at night and die at 10:30 the next morning from an overdose.

MS. BRIDENSTINE: All right. I want to move on to talk about your relationship with your attorney, your trial attorney, Daniel Hockaday.

MR. PRITCHARD: Okey-doke. Uh-huh.

MS. BRIDENSTINE: Were you ever offered any plea agreements in this case?

MR. PRITCHARD: Yes, ma'am. Right before we went out -- you know, we went and had a plea agreement.

MS. BRIDENSTINE: What was your plea?

MR. PRITCHARD: It was if I admit that I had done it, and I would walk out of -- walk out of the courtroom that day, and do three years probation.

MS. BRIDENSTINE: This was offered to you right before trial?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: What was the charge that they offered you to plea to?

MR. PRITCHARD: I don't know about a charge. I think they would drop the -- I mean, I'm just thinking now. I'm not sure. But I think they would have dropped it to, like, manslaughter.

MS. BRIDENSTINE: Why didn't you take that offer?

MR. PRITCHARD: Why? Because I didn't do it.

MS. BRIDENSTINE: Did they ever discuss that you could do something called, like, an Alford plea?

MR. PRITCHARD: No. What is that?

MS. BRIDENSTINE: That's where you plead guilty, but you specifically do not admit that you are guilty. You maintain innocence.

MR. PRITCHARD: I didn't. In fact, when I -- the only statement that I gave was to Daniel Hockaday. And Daniel Hockaday took that statement. And

after he sent me back to the dorm, there's a glass mirror -- a glass window between the room where I was at and going back to the dorm. And Daniel Hockaday handed my letter that I had just give him over to Sheriff Banks.

MS. BRIDENSTINE: When did that happen?

MR. PRITCHARD: That was -- let's see. I want to say December the 21st.

MS. BRIDENSTINE: Of what year?

MR. PRITCHARD: 2011.

MS. BRIDENSTINE: You saw your attorney takes notes about what you told him and hand it to the sheriff?

MR. PRITCHARD: Yes, ma'am. After he sent me back to the -- to my block.

MS. BRIDENSTINE: Did you ever talk to him about that?

MR. PRITCHARD: Yes, ma'am. I asked him, and he said no, he didn't do that.

MS. BRIDENSTINE: Did Daniel Hockaday talk to any witnesses in your case?

MR. PRITCHARD: No. I tried to get him to put Nikki on -- on witness. And I tried to get him to put Ann on witness.

MS. BRIDENSTINE: Who? Nikki --

MR. PRITCHARD: Ann Whitson and Nikki.

MS. BRIDENSTINE: Did he talk to either Nikki Angel or Ann Whitson Green?

MR. PRITCHARD: He just said to me, he said that they wouldn't be able to help.

MS. BRIDENSTINE: Do you know if he ever talked to them?

MR. PRITCHARD: I don't know if he did or not.

MS. BRIDENSTINE: Did you talk to him about anyone else who could be a witness for you?

MR. PRITCHARD: Yeah. Danny Edwards.

MS. BRIDENSTINE: Did he talk to Danny Edwards?

MR. PRITCHARD: Did he?

MS. BRIDENSTINE: Did Daniel Hockaday talk to Danny Edwards?

MR. PRITCHARD: Not that I know of. You see, they've got -- they've got this little thing into my trial transcripts and stuff.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: They've got a thing saying that he was subpoenaed to court. And I didn't see him nowhere. I mean, the whole time that I was sitting in court, he never showed up.

MS. BRIDENSTINE: Did you ask your attorney

to subpoena Danny Edwards?

MR. PRITCHARD: I did. Uh-huh.

MS. BRIDENSTINE: Did Daniel Hockaday consult with any experts in your case?

MR. PRITCHARD: No. He said that we need -- he needed $1600 so that he could pay the medical examiner for the information on the autopsy or something.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: And he needed that payment. So I paid him in full. And so he just -- and then I --

MS. BRIDENSTINE: Did he talk to a medical examiner?

MR. PRITCHARD: I don't know if he did or not. I would always -- they would -- they didn't let me out. They kept me in there the whole time, in jail.

MS. BRIDENSTINE: Pending trial. So you believed you gave him money to hire an expert to take a look at the autopsy, but you don't know if he did so?

MR. PRITCHARD: I don't know if he did or not. He said to explain it to him. Not hire him. But he said he needed them to explain it to him. What he needed the $1660 for. And see, and the thing about it is that Randolph, which was a sheriff deputy there, and he would -- you know, doing shifts in the jail and all. He told me, he said, John, you better get you another

lawyer. And I said why is that? And he says, you just need to get you another lawyer.

MS. BRIDENSTINE: You've written some letters to us where you've indicated you thought that people were communicating with each other during your trial, like your attorney with the prosecutor.

MR. PRITCHARD: Oh. They weren't -- I didn't think about it, I seen it. They had their cell phones, okay. And they were texting to each other. The sheriff to my attorney, to the DA, Michael Holmes. All right. And they was going back and forth the whole time during the trial and everything, back -- I got up one time, and I stood over, and was looking at Daniel Hockaday's text message thing that came from Sheriff Banks.

Anyway, the -- Tammy McIntyre, which is the Clerk of Courts, she seen me do it, stand up and look over his shoulder. And she said, Mr. Hockaday, did you just get a call that your wife has been trying to get in touch with you, your son got in an accident up at Fun World.

MS. BRIDENSTINE: Did you ever seen what they were communicating about?

MR. PRITCHARD: I -- I assume it was about me, you know. But I don't know for sure. I mean, I

didn't get to read the messages. They would keep them from me and all. But every time, when the judge would start the court trial, he would turn to the left and look straight at the jury, so he wouldn't look at the courtroom. And I always thought that was kind of odd, you know. I mean, not for the whole entire time, you know, not look back, except when he was getting ready to close trial up. Then he'd turn back around.

MS. BRIDENSTINE: So what significance does it have to you, the fact that you believe your attorney was communicating with the District Attorney and with the Sheriff?

MR. PRITCHARD: Because of the way he did the interrogation with Stephanie and the other witnesses.

MS. BRIDENSTINE: Who did what interrogation?

MR. PRITCHARD: Daniel Hockaday. When he was, you know, when they were on the stand, on the witness stand, and he was questioning them. You know, I would give him questions to ask them, and he wouldn't ask them.

MS. BRIDENSTINE: Okay. But you don't know, if they were communicating, what they were communicating about?

MR. PRITCHARD: I don't know what they were

communicating about. No, ma'am. Not for sure. I just know it -- I believed it was because of me.

MS. BRIDENSTINE: What did Mr. Hockaday tell you about the plea agreement?

MR. PRITCHARD: He just said that, you know, if you take this plea agreement, we can go and have us a beer. You know, I said no, I'm not going to take it

MS. BRIDENSTINE: Did you understand how much time you were risking?

MR. PRITCHARD: Huh-uh. I didn't know they were going to go up to 20 years.

MS. BRIDENSTINE: How much time did you think you could have at the max?

MR. PRITCHARD: I thought it was about maybe 10 years, you know.

MS. BRIDENSTINE: Why didn't you testify at trial?

MR. PRITCHARD: Why didn't I?

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: They wouldn't let me.

MS. BRIDENSTINE: Who wouldn't let you?

MR. PRITCHARD: Daniel Hockaday. Every time I asked him, I said, put me on the stand. Put me on the stand, I want to talk to these people and tell them, you know. And he wouldn't do it. And then, when the trial

ended and everything, and they were starting to give me the sentence, and I was starting to ask the judge some questions, he told me, no, don't be doing -- sit down, just be quiet. Sit down. Sit down.

MS. BRIDENSTINE: Whose decision is it to testify at trial or not?

MR. PRITCHARD: I thought it was mine. I mean, I didn't know. But I thought it would be mine. I mean, other guys down there told me that you get a chance to testify. And so I just believed it was -- you know, that I would get to do it, also.

MS. BRIDENSTINE: So going back before you were arrested.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: This case happened in March 2011. But it took some months for you to be arrested. Is that right?

MR. PRITCHARD: Yes, ma'am, it did.

MS. BRIDENSTINE: Did you ever have any interaction with any law enforcement officers --

MR. PRITCHARD: No, ma'am.

MS. BRIDENSTINE: -- about this case?

MR. PRITCHARD: No, ma'am. Not until I had just gotten out of the PTSD program. Right.

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: And I think it was the SBI agent -- what's his name? Him and the deputy came over to my trailer. They were wanting to take me and talk to them. I told them, I said, listen, I just got out of the PTSD program. I'm on medication, and I'm -- you know, wouldn't like to be questioned right now.

MS. BRIDENSTINE: When was that?

MR. PRITCHARD: It was around in, I'd say October.

MS. BRIDENSTINE: October of 2011?

MR. PRITCHARD: 2011. Yes, ma'am.

MS. BRIDENSTINE: They came to your house?

MR. PRITCHARD: They came to the trailer. Yes, ma'am.

MS. BRIDENSTINE: There was a letter that was marked at trial as defense exhibit 1. It wasn't entered. It was during Robbie Brown's testimony.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: What is your understanding of what was in that letter?

MR. PRITCHARD: Robbie was telling me that she did not say those things to them about me. That she did not write that. Didn't say it, and she didn't write it. She said that they did. And she said, but that's the reason why I didn't sign the paper, sign the

statement.

MS. BRIDENSTINE: She was telling you that they, meaning the police officers?

MR. PRITCHARD: Yes. Uh-huh. SBI Agent Vines is his name.

MS. BRIDENSTINE: How did the -- how did your attorney get that letter?

MR. PRITCHARD: I think I gave it to him.

MS. BRIDENSTINE: Did you give him anything else?

MR. PRITCHARD: No. Because he would never hardly ever see me. I mean, took me like an act of congress to get him to even come over.

MS. BRIDENSTINE: How often would you see him?

MR. PRITCHARD: And I only seen him three times since the whole -- the beginning, from when I got locked up. He took the case, and then I think a couple times right after that. But I mean, that was -- you know, in between 2014's trial.

MS. BRIDENSTINE: So you saw him three times before trial, and a couple times after trial?

MR. PRITCHARD: No. I seen him before trial three times. One was to hire him. And then one time to give him some information. And then the third time, we

just talked about what was going on, you know, what he -- what he thought.

MS. BRIDENSTINE: Is the letter the only thing you ever gave him?

MR. PRITCHARD: Yes, ma'am. And he slid it back to me. He didn't really slide -- he didn't -- he had his book out there like this. Right. And he acted like it fell out of his book and slid over to me.

MS. BRIDENSTINE: Did you talk to him on the phone before trial?

MR. PRITCHARD: Yes, ma'am. I think one time I did.

MS. BRIDENSTINE: Did you correspond with him?

MR. PRITCHARD: He -- he -- like I said, he told me when I first met him, he says, I can get you off of this. No problem. I just did it for another person that was in this situation. And that, you know, he had it, and I was going to be pled not guilty and leave.

MS. BRIDENSTINE: How did David Belser get involved in your case?

MR. PRITCHARD: He's the one that I finally, after the Robert Sirianni, who did the appeal and did it late, I -- see, I'm not too hipped on all of this stuff, legal stuff. You know what I'm saying. And anyhow,

Robert Sirianni took over a year to finally get me a plea -- plea trial thing, or to request it. And he missed the date altogether.

MS. BRIDENSTINE: For the appeal?

MR. PRITCHARD: Yeah, for the appeal. And then he -- about a year later, around in, I'd say May, April, somewhere around there, they did it with no contest. I mean, nobody was going to argue back and forth. So we waited for the judge's decision that came back no, they wouldn't give me a plea trial -- I mean, an appeal.

MS. BRIDENSTINE: So you had actually several different appellate attorneys.

MR. PRITCHARD: Uh-huh. No. I just had that one, Robert Sirianni. And then David Belser came along, because when Sirianni said that, you know, we didn't win the case and everything. So the guys told me, said what you need to do now, John, is get you somebody and do a motion for appropriate relief.

MS. BRIDENSTINE: Did you speak to Robert Sirianni?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Did you see him in person, or speak to him on the phone?

MR. PRITCHARD: Never have seen him. No.

It's always been on the telephone.

MS. BRIDENSTINE: So there were some other attorneys who were entered as your counsel. And give me a second, and I will find all their names. But you had someone named Christine Vance who --

MR. PRITCHARD: Oh, yeah. Okay. Because they worked for Robert Sirianni. He couldn't keep help for some reason.

MS. BRIDENSTINE: All right. So you understanding was Christine worked for Robert Sirianni?

MR. PRITCHARD: Yes, ma'am. Uh-huh. Those other attorneys, the same thing. And the only people that actually I knew about was Hockaday, Robert Sirianni, and David Belser.

MS. BRIDENSTINE: Do you remember Brandi Bullock Jones?

MR. PRITCHARD: Yes. She's the one that went up to -- before we didn't -- did the appeal. She went up there to see about getting me out on bond. And they turned around, said no, we're not going to let him go out on bond and everything. But that was the first time and only time I've seen --

MS. BRIDENSTINE: Did you talk to her?

MR. PRITCHARD: We just more or less, you know, like I said, you're here from Robert Sirianni. She

said yes. And that was it. We went up to trial. And they didn't give me any time to talk to her afterwards, or before.

MS. BRIDENSTINE: Did you talk to Sophia Hernandez?

MR. PRITCHARD: I don't think so.

MS. BRIDENSTINE: She and Christine Vance were listed as attorneys for you for appeal. But they both withdrew. So I'm just trying to figure out how much you spoke to either Christine Vance --

MR. PRITCHARD: I spoke to each one of --

MS. BRIDENSTINE: -- or Sophia Hernandez.

MR. PRITCHARD: No. I didn't speak to them at all. I mean, the way I found out is that when I get a letter from Robert Sirianni, it would have their name on it. See, I didn't even know about the deadline, you know, that you had so long to get the appeal in right after you've gone to trial and everything. I didn't know that.

And so when Robert Sirianni called me up and says, oh, what's her name quit, she's going to have -- she's getting ready to have a baby, and she's not going to come back. And he said, do you still want me to do your case. And I said sure. I said, you know more about it than, you know, anybody. I said, yeah, go ahead. I

didn't know he was asking me for permission, because he had messed up and had to turn in the -- what do you call that? Certiorial -- writ certi --

MS. BRIDENSTINE: Right.

MR. PRITCHARD: Yeah. Whatever that is.

MS. BRIDENSTINE: Petition for certiorari.

MR. PRITCHARD: Writ certiorial or something.

MS. BRIDENSTINE: Okay. So they were already getting you --

MR. PRITCHARD: Get permission to do --

MS. BRIDENSTINE: -- to file the appeal late?

MR. PRITCHARD: Uh-huh. Yes.

MS. BRIDENSTINE: Okay. Out of all of the attorneys that you had, how many did you actually speak to? You spoke to Daniel Hockaday?

MR. PRITCHARD: Yes.

MS. BRIDENSTINE: You spoke to Robert Sirianni?

MR. PRITCHARD: Uh-huh.

MS. BRIDENSTINE: You spoke to Brandi Bullock Jones, because you saw her one time in court?

MR. PRITCHARD: Yes. Uh-huh.

MS. BRIDENSTINE: You did not speak to

Christie Vance?

MR. PRITCHARD: I don't think I did. No. Huh-uh.

MS. BRIDENSTINE: You did not speak to --

MR. PRITCHARD: Not unless when I called the place on the telephone, she picked it up, and, you know, said that Robert wasn't there or something like that, you know.

MS. BRIDENSTINE: You did not speak to Sophia Hernandez?

MR. PRITCHARD: No, ma'am. Huh-uh.

MS. BRIDENSTINE: You spoke to David Belser?

MR. PRITCHARD: Yes. On the phone. On the phone only. And it took me two and a half -- no. Took me a year and a half to get him to finally come up. He said he would do a face contact with me. I'd pay him an extra -- I think it was an extra $100 or $1,000. Might have been an extra $1,000 to come see me in person, and we can talk. And he didn't get here until February 219 -- 2019.

MS. BRIDENSTINE: How many attorneys did you talk to about the facts of your case?

MR. PRITCHARD: Daniel Hockaday. I thought I explained myself clearly to Robert Sirianni. But evidently, I didn't, because he still didn't do what I

asked him to do. And that was to get them to explain how can they have an overdose for that amount of time. And he didn't do any drugs in between then. How can a person overdose. Because I know for a fact that, you know, you shoot some drugs, within a couple minutes, you're going to overdose. Not no 13 and a half hours later. Y'all are lucky you got here today. Because we're getting ready to do away with all visitation.

MS. BRIDENSTINE: Oh, really?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: I'm so glad you made it.

MS. BRIDENSTINE: All right. So, Mr. Pritchard, you are claiming innocence for all the charges in this case. Is that right?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Which attorneys did you tell you were innocent?

MR. PRITCHARD: All of them.

MS. BRIDENSTINE: Have you ever admitted to guilt at any point?

MR. PRITCHARD: Never. No.

MS. BRIDENSTINE: And I'm not just talking about your attorneys. I mean to anyone.

MR. PRITCHARD: To anybody? No. Huh-uh.

Because it -- I mean, I didn't.

MS. BRIDENSTINE: How did Dr. Christina Roberts get involved in your case?

MR. PRITCHARD: David Belser. It was when I went, and he told me that day, John, your daughters only paid me $4,000. And I said, well, that's -- I said, I gave them 6,000. I said that's what the price was, was 6,000. He said no, no. He said no, it's more than that, it's 10,000. I said, so are you telling me now, a year and a half later that it's $10,000, and before it was $6,000. He said, I don't know where they got that from, but they only gave me $4,000. So I wrote him another check for the $1,000.

MS. BRIDENSTINE: Did you ever speak to Dr. Roberts?

MR. PRITCHARD: I never have. No.

MS. BRIDENSTINE: Did you ever send her a letter?

MR. PRITCHARD: I did send her a letter. I believe I did. Yes, ma'am. And explained the situation. But no --

MS. BRIDENSTINE: You never spoke to her on the phone?

MR. PRITCHARD: No. I don't think I did.

MS. BRIDENSTINE: She never visited you?

MR. PRITCHARD: No, ma'am. No, ma'am.

MS. BRIDENSTINE: Are you aware of what her opinion is in this case?

MR. PRITCHARD: I heard from -- I think it was -- I'd say from one of the inquiry places, the innocent places, that she believed that he died from something else.

MS. BRIDENSTINE: Something other than morphine toxicity?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Do you know anything other than that?

MR. PRITCHARD: That's about it.

MS. BRIDENSTINE: Who do you think has information about your case that we should talk to?

MR. PRITCHARD: I want to say Ann, Nikki, William -- I mean, Nate Angel, he's dead. And Robbie, she's dead. David [sic] Edwards. Because he's the one that told me, he says -- when I told him, I said, yeah, he died at Christine's house. He said no way. No way did he die there. Because he knew, he understood that -- you know, they didn't have that kind of relationship with each other.

MS. BRIDENSTINE: Anyone else?

MR. PRITCHARD: My daughter, Lacey.

MS. BRIDENSTINE: What information does she have?

MR. PRITCHARD: She knows all of it. She was at the trial and everything. She seen everything.

MS. BRIDENSTINE: Was she around when the case happened?

MR. PRITCHARD: No. No.

MS. BRIDENSTINE: Does she have any direct knowledge or personal knowledge of what happened in this case?

MR. PRITCHARD: She only picked it up what she, you know, perceived when she talked to Robbie and stuff like that. That she really believed that Robbie did all this, and, you know, testified that I did it.

MR. ZIEGLER: Mr. Pritchard, you said David Edwards a minute ago. Is that --

MR. PRITCHARD: It's Danny Edwards. Not David.

MR. ZIEGLER: Okay.

MR. PRITCHARD: I'm sorry. I'm getting David Belser and Danny Edwards mixed up.

MS. BRIDENSTINE: So Lacey Pritchard spoke to Robbie Brown about your case before Robbie died?

MR. PRITCHARD: Uh-huh. Yes. Uh-huh. Nikki did, too.

MS. BRIDENSTINE: Nikki spoke to --

MR. PRITCHARD: To Robbie.

MS. BRIDENSTINE: -- Robbie Brown. Okay.

MR. PRITCHARD: Uh-huh. In fact, Robbie wrote me a letter saying that you need to get Nikki and Ann to the sheriff to subpoena them to court. Because they're going to go for your behalf, but, you know, claiming your innocence.

MS. BRIDENSTINE: Did Nathan Angel ever tell you anything else about what was going on the night before Jonathan Whitson died, and the day that he died?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did he ever tell you anything about a spoon?

MR. PRITCHARD: Huh-uh.

MS. BRIDENSTINE: Who is Tammy Ayers?

MR. PRITCHARD: Tammy Ayers is -- she was a girl that busted Robbie for selling drugs to her. And I think she was a confidential informant. But I didn't know until afterwards that I think Ann is her mother, too, if I'm not mistaken. Ann or Nathan. Because, you know --

MS. BRIDENSTINE: Oh, okay.

MR. PRITCHARD: -- their parents or something.

MS. BRIDENSTINE: Did you know Tammy Ayers?

MR. PRITCHARD: No. Never met her, never seen her.

MS. BRIDENSTINE: Did you ever see her on March 5th, 2011? Tammy Ayers.

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you ever talk to her about this case?

MR. PRITCHARD: Nope. I know that there was some -- down there in the block, where I was at in the jail, that there was some talk about Daniel Hockaday, and when he had probably in the past broke up with his wife or whatever, that he was seeing this girl. That he bought her a Volkswagen. And then he was seeing Tammy Ayers, too.

MS. BRIDENSTINE: When is the last time you spoke to Ann Whitson Green?

MR. PRITCHARD: It was the -- I want to say the week of the burial and everything. Because she called me up and asked me if I would be a pallbearer. And I said yes. And then she called me up one time, told me that -- that Stephanie was accusing me of selling Jonathan drugs. And -- but that's the only --

MS. BRIDENSTINE: Does Nikki Angel have any mental health issues?

MR. PRITCHARD: They say she does. But I don't know. I never did, you know, diagnose her or anything. But they said that she pulled off all her clothes one time, and was walking down the road. Sheriff picked her up. But I -- I don't know, you know. And I know she went in for treatment right about the time that Jonathan's death.

MS. BRIDENSTINE: Treatment for what?

MR. PRITCHARD: For drugs.

MS. BRIDENSTINE: Was it just for drugs, or were there mental health issues involved?

MR. PRITCHARD: I'm not sure.

MS. BRIDENSTINE: Does Nikki Angel have any intellectual disabilities?

MR. PRITCHARD: I'm not sure about that either. I just know that she was -- she told me before that her -- that Nathan was abusive when she was growing up, and that he used to say things, you know, a father shouldn't say around his daughter. That was it.

MS. BRIDENSTINE: When is the last time you spoke to Nikki Angel?

MR. PRITCHARD: I think that was right -- right before trial. And she called me on the telephone when I was locked up. No, she didn't call me on the telephone. She came to visit. And in the visit, you

know, I seen her on the screen.

MS. BRIDENSTINE: What did you talk with her about at that visit?

MR. PRITCHARD: Just that I asked her if she would come to the trial and get her mother, too. Because Ann was having -- she said Ann was having cold feet and didn't want to -- didn't want to come into the courtroom. She couldn't stand to see Russell, which was, I guess, married to her at one time or another. I'm not sure. But --

MS. BRIDENSTINE: Did you ever tell Nathan Angel that you were afraid of being blamed in this case?

MR. PRITCHARD: Only time I think I might have said something like that when he went and told me that Stephanie had told the police that I was the one that gave him drugs and everything.

MS. BRIDENSTINE: When is the last time you spoke to Aaron Collins?

MR. PRITCHARD: It was -- he came back and stayed at my place and everything. So he -- we've seen each other more or less, off and on, you know, throughout the -- I think the next couple of weeks or something. Because I believe it was around in April or May that I told him that I needed him to leave, because -- you know, and told him that I was on probation, and I couldn't have

all that stuff around me. You know, couldn't be around. And he got upset about it. So I had to call the police. Well actually, I called my probation officer. And he come around and told him he was going to have to get out.

MS. BRIDENSTINE: Did you ever share your pills with Aaron Collins?

MR. PRITCHARD: No. Huh-uh. He might have stolen them. But he -- I didn't ever share them.

MS. BRIDENSTINE: Did you speak to Aaron Collins about this case?

MR. PRITCHARD: Not that I really -- no. He just said that -- something about the fact that when I went to get the tobacco for him, he said, why don't you tell them that I was with you. I said, you know, that I don't want to, you know, start lying about something. I said no, huh-uh.

MS. BRIDENSTINE: Was he with you?

MR. PRITCHARD: No, he wasn't. He was here, he was at the trailer. But he wasn't with me. And see, Robbie said something about that, too. She said, what did you have to go and get Aaron brought into all this. And I said, I ain't had Aaron brought into nothing.

MS. BRIDENSTINE: Did Aaron know that you were with Jonathan Whitson on March 5th, 2011?

MR. PRITCHARD: Afterwards he did.

MS. BRIDENSTINE: Okay. But on March 5th, 2011, was he aware that you had picked up Jonathan Whitson?

MR. PRITCHARD: I'm not sure if he did. No. I don't think so. Because he give me the money. He didn't say give the money to Jonathan. He just said for me to pick up the chewing tobacco. So no, he didn't say nothing about it.

MS. BRIDENSTINE: Did he ever provide drugs to Jonathan Whitson, Aaron Collins?

MR. PRITCHARD: They grew up together is what I know. You know, Robbie told me that. She said that they were junkies at an early age. They used drugs intravenously at a real early age.

MS. BRIDENSTINE: Did Aaron Collins shoot up Jonathan Whitson with drugs before he died?

MR. PRITCHARD: I don't know if he did or not. I couldn't say.

MS. BRIDENSTINE: Did you tell Aaron Collins that you were nervous that they were going to get you for murder after Jonathan Whitson died?

MR. PRITCHARD: I might have said something to him. Yeah. I mean, I was scared.

MS. BRIDENSTINE: When did you say that?

MR. PRITCHARD: I can't remember if it was

that night when he came back, or -- I'm pretty sure it was.

MS. BRIDENSTINE: What night?

MR. PRITCHARD: He left for a little bit, but then he came back that night on the 6th.

MS. BRIDENSTINE: Why did you tell him that?

MR. PRITCHARD: Why?

MS. BRIDENSTINE: Uh-huh.

MR. PRITCHARD: Because Nathan had told me, you know, what he told me about Stephanie.

MS. BRIDENSTINE: Did you tell Aaron Collins that you gave Jonathan Whitson morphine pills before he died?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you tell Aaron Collins that you gave Jonathan Whitson 10 morphine pills?

MR. PRITCHARD: No.

MS. BRIDENSTINE: When is the last time you spoke --

MR. PRITCHARD: I might have -- no. Wait a minute. I might have said something about the fact what Nathan had told me that I had given eight to Jonathan. I said that he had said that I had given him eight pills. So I think I might have said something about that, and that's why --

MS. BRIDENSTINE: Since there are people there, I'm going to speak a little louder. We're getting close to the end.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: When is the last time you spoke to Danny Edwards?

MR. PRITCHARD: In jail. When I was in Yancey County jail. Before he was -- I think he was sent up to go to prison in Marion. Him and his cousin, they were in there at the same time. And that's when I asked him, I said, listen, I'm going to have you subpoenaed, you know, to come testify at my trial about you seeing them that night at Nate's trailer.

MS. BRIDENSTINE: What did he say he saw at Nate's trailer?

MR. PRITCHARD: He said he seen Jonathan, William, and Nathan drinking and doing drugs. And they asked him if he wanted to buy some drugs.

MS. BRIDENSTINE: Did anyone else tell you what Jonathan Whitson was doing the night before he died?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Did you go to the Riverside gas station on March 5th, 2011?

MR. PRITCHARD: Riverside. Where's that at? Is that Riddle's?

MS. BRIDENSTINE: I don't know.

MR. PRITCHARD: Okay. That's the only one station I dropped of Jonathan at.

MS. BRIDENSTINE: Did you know of a Riverside gas station?

MR. PRITCHARD: No. I don't know -- it's called Riddle's is what, you know. It was right down --

MS. BRIDENSTINE: Is that a gas station?

MR. PRITCHARD: It's a gas station and a little grocery store. A little convenience store.

MS. BRIDENSTINE: Where is it located?

MR. PRITCHARD: It's right there across from the dump, up at the dump. Right across from Jacks Creek. Jacks Creek is right here. And then straight down this way, going towards Asheville.

MS. BRIDENSTINE: On March 5th, 2011, did you see Danny Edwards there?

MR. PRITCHARD: No. Huh-uh.

MS. BRIDENSTINE: Did you see Danny Edwards at all on March 5th, 2011?

MR. PRITCHARD: I didn't see -- the only time I seen Danny Edwards, and really didn't know who he was until we was in jail.

MS. BRIDENSTINE: What is Roxicet?

MR. PRITCHARD: I'm not sure. I think it's

Percocet. Is that what they call Roxies?

MS. BRIDENSTINE: Yes.

MR. PRITCHARD: I think so. I think that's Percocet.

MS. BRIDENSTINE: Did you ever give anyone Roxicet or Roxies?

MR. PRITCHARD: No. I've never had any. No. I take that back. Yeah, I did. When I had that accident, they took me to the emergency room in the Mission Memorial, they give me a Percocet.

MS. BRIDENSTINE: Was it a Roxicet?

MR. PRITCHARD: I don't know. It's just Percocet. That's what I know it as.

MS. BRIDENSTINE: I'm not sure if my understanding of Roxicet is completely accurate. But I believe it's Percocet mixed with acetaminophen.

MR. PRITCHARD: Oh, really?

MS. BRIDENSTINE: But it could be it's mixed with something else. But I think it's -- you know, Percocet along with something else.

MR. PRITCHARD: I'm not sure.

MR. ZIEGLER: Mr. Pritchard, I just want to clarify your answer.

MR. PRITCHARD: Yes, sir.

MR. ZIEGLER: Julie had asked you if you had

given anyone any Roxicet, Percocet. And you said no. And then you said no, you never had any. But then you wanted to back up and say that you did have it after your accident.

MR. PRITCHARD: Yes, sir.

MR. ZIEGLER: But regarding that first part of the question, did you ever give any to anyone.

MR. PRITCHARD: No, sir. No, sir. No.

MS. BRIDENSTINE: So you're saying you might have been given that for your accident?

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: To deal with the pain?

MR. PRITCHARD: Yes, ma'am. The nurse give it to me.

MS. BRIDENSTINE: Have you ever told anyone what to say in this case?

MR. PRITCHARD: No. The only thing I did was, I questioned Robbie about her statement that they had. That it wasn't signed. And for some reason or another, that statement and a few other documents that I had, that I wanted to give to my daughter, Lacey, I put it in the box that Randolph, C.O. Randolph gave them to Lacey. But I don't think she got them. Because when I asked her for them later on, she said, dad, I can't find them, they're not here.

MS. BRIDENSTINE: Did you give Jonathan Whitson any drugs after he got out of jail on March 4th, 2011?

MR. PRITCHARD: No, ma'am.

MR. ZIEGLER: That was a no?

MR. PRITCHARD: No.

MR. ZIEGLER: I just wanted to make sure the recorder picks it up with --

MS. BRIDENSTINE: Did you ask Danny Edwards to testify in your behalf?

MR. PRITCHARD: Yes, ma'am. I did. Or the part he told me about. That's the only thing I asked him to testify about.

MS. BRIDENSTINE: Did you ask Danny Edwards to lie for you?

MR. PRITCHARD: No.

MS. BRIDENSTINE: Is there anything significant that you think we should know that we haven't gone over yet?

MR. PRITCHARD: David Belser, he got my case in 2017. But yet, I didn't see him until 2019, and he still hadn't did anything on my case. And what I come to find out is that during that time, Sheriff Banks had retired.

MS. BRIDENSTINE: What does that mean to

you?

MR. PRITCHARD: What that means to me is that Sheriff Banks asked him to delay my MAR until he retired.

MS. BRIDENSTINE: Why would you think Sheriff Banks would want to delay your MAR until after he retired?

MR. PRITCHARD: Because it would be brought up the fact that it wasn't -- that Jonathan didn't die from an overdose.

MS. BRIDENSTINE: And why would Sheriff Banks care about that?

MR. PRITCHARD: Because he's the one that said that, you know, that's what happened.

MS. BRIDENSTINE: Have you told us everything you know about this case today?

MR. PRITCHARD: I believe I have. Yes, ma'am.

MS. BRIDENSTINE: Did you tell us the truth today?

MR. PRITCHARD: Yes, ma'am, I did.

MR. ZIEGLER: I just have a couple of really brief questions.

MR. PRITCHARD: Okay. Yes, sir.

MR. ZIEGLER: I just want to make sure we're

loud enough for the recorder.

MR. PRITCHARD: Yes, sir.

MR. ZIEGLER: You had mentioned the name William Angel a couple times.

MR. PRITCHARD: Uh-huh. Yes, sir.

MR. ZIEGLER: And I believe you said that was Nathan Angel's brother?

MR. PRITCHARD: Yes, sir. And I'm glad you brought that up. Because of the fact that Nathan -- William Angel used to get morphine from Tennessee, where he lived at. And it would be the -- the real good morphine, with a square box M, the original morphine sulfate. And I was getting generic. And that's why they --

MS. BRIDENSTINE: What did your morphine look like?

MR. PRITCHARD: It was purple, and it had a generic name to it. I can't think of the name now.

MS. BRIDENSTINE: Was it stamped with anything?

MR. PRITCHARD: Yes, ma'am. That's what I'm saying. It had a, like, a number on it.

MS. BRIDENSTINE: Who are you aware of who had morphine prescriptions that Jonathan Whitson might have gotten it from?

MR. PRITCHARD: William Angel.

MS. BRIDENSTINE: Is there anyone else?

MR. PRITCHARD: Oh, yeah. There's a guy in -- there's a guy in Riddle's Park, a man and his wife, they have prescription morphine, same kind as I do.

MS. BRIDENSTINE: What kind of drugs are you aware of that Jonathan Whitson would take?

MR. PRITCHARD: I knew he would take the -- I knew he would take the oxymorphone from Robbie.

MS. BRIDENSTINE: Oxymorphone from Robbie.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Anything else?

MR. PRITCHARD: You know, Aaron used to take -- say stories about they did this and that, something like that. And he would talk about they did the drugs and stuff like that. But that's all I ever heard.

MR. ZIEGLER: That actually brings up my second question.

MR. PRITCHARD: Okay.

MR. ZIEGLER: Did you ever see Aaron Collins and Jonathan Whitson together?

MR. PRITCHARD: Let me see. No, not really. Not together, together. No. Because Aaron was upset with Jonathan about having sex with his mom. So I think

they were on speaking terms, but not, you know, hanging out with each other.

MR. ZIEGLER: Okay. And going back to William Angel. I believe you said that he was approximately the same age as Nathan Angel.

MR. PRITCHARD: He's around -- he's close to him. He's his younger brother. He's Nathan Angel's younger brother.

MR. ZIEGLER: Okay. Are you aware of any other William Angels, perhaps a junior and a senior type situation?

MR. PRITCHARD: I'm not -- I think their father is called Wade. It's not -- I believe that their father's name is Wade.

MS. BRIDENSTINE: Okay. So --

MR. ZIEGLER: And Wade is Nathan's father, as well. Right?

MR. PRITCHARD: Yes.

MR. ZIEGLER: Okay.

MR. PRITCHARD: Uh-huh. Yes, sir. See, I find that pretty odd, because Christine -- Christine Angel said that Wade was in the house when Jonathan was there, that they were, you know in the bedroom, and Jonathan came by and said, I love you, grandma, I love you, grandma. That didn't happen. Danny Edwards said,

no, they didn't have that kind of a relationship.

MS. BRIDENSTINE: All right.

MR. ZIEGLER: Those are my only questions.

MS. BRIDENSTINE: I think that is it, Mr. Pritchard.

MR. PRITCHARD: Okay. Thank you.

MS. BRIDENSTINE: Unless you think that there's anything else that we should know.

MR. PRITCHARD: That's what I said. I've got some of them letters from Robbie and from Nikki, and I was going to mail them to you.

MS. BRIDENSTINE: You have letters from Robbie and Nikki?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: When did they send you the letters?

MR. PRITCHARD: It was in jail.

MS. BRIDENSTINE: You've had them this whole time?

MR. PRITCHARD: Ma'am?

MS. BRIDENSTINE: You've had them this whole time?

MR. PRITCHARD: Yes, ma'am. Uh-huh.

MS. BRIDENSTINE: Okay. Yeah. We would like those.

MR. PRITCHARD: Okay. All right. I'll get them and mail them to y'all.

MS. BRIDENSTINE: Okay. How many letters do you have?

MR. PRITCHARD: I know about two.

MS. BRIDENSTINE: Two from -- so one from Nikki and one from --

MR. PRITCHARD: One from Nikki, and two from Robbie.

MS. BRIDENSTINE: Did you ever get --

MR. PRITCHARD: There may be more from Robbie. I'm not sure.

MS. BRIDENSTINE: Okay.

MR. PRITCHARD: I've got to check my mail and everything.

MS. BRIDENSTINE: What happened to the letter that was talked about at trial, but not introduced?

MR. PRITCHARD: That was my statement that I wrote.

MS. BRIDENSTINE: No. No. The letter that came from Robbie to you.

MR. PRITCHARD: Okay. Yeah. Okay.

MS. BRIDENSTINE: Where is that letter?

MR. PRITCHARD: I think I have it.

MS. BRIDENSTINE: You still have it?

MR. PRITCHARD: Yes, ma'am. That's the one I think I have.

MS. BRIDENSTINE: Okay. Yes. We would like those.

MR. PRITCHARD: Yes, ma'am.

MS. BRIDENSTINE: Do you have anything else?

MR. PRITCHARD: Not pertaining to this case. No.

MR. ZIEGLER: I think you would know this, but the sooner, the better that we get those.

MR. PRITCHARD: Yeah. Get them mailed to you.

MR. ZIEGLER: Correct.

MS. BRIDENSTINE: Yes.

MR. PRITCHARD: Yeah. I sure will. As soon as I leave and go back to my dorm, I will start pulling it out.

MS. BRIDENSTINE: Yeah. I think that's it. All right. Thank you, Mr. Pritchard.

MR. ZIEGLER: Thank you, Mr. Pritchard.

MR. PRITCHARD: Oh. And also, I told you about Randall, C.O. Randall taking parts of the discovery away for my daughter, taking them out of the box.

MR. ZIEGLER: I'm sorry. Just explain that

really quickly.

MR. PRITCHARD: Yeah. C.O. Randall --

MR. ZIEGLER: This is somebody in the jail?

MR. PRITCHARD: Yes.

MR. ZIEGLER: Okay.

MR. PRITCHARD: Right before they shipped me out to Raleigh, Randall took the box of stuff that I had, which was my discovery and documents that I had gotten from Daniel Hockaday. And anyway, Randolph took them to my daughter. And my daughter said that the documents that I was asking for were not in that box. And I know that they were in that box.

MR. ZIEGLER: Okay.

MS. BRIDENSTINE: All right. Thank you.

MR. PRITCHARD: Okay. Thank you both for coming out.

[CONCLUSION OF INTERVIEW.]

STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
COUNTY OF YANCEY

STATE OF NORTH CAROLINA,
Petitioner,
-vs-
JOHN PRITCHARD,
Defendant.

File No. 11 CRS 304
File No. 11 CRS 305

INTERVIEW OF
JOHN PRITCHARD
August 5, 2021

I, June Robinson, having been assigned to transcribe the above-captioned interview from August 5, 2021, do hereby certify that said interview, pages 1 through 119, is a true, correct, and verbatim transcript of said proceeding to the best of my ability.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was heard; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, and am not financially or otherwise interested in the outcome of the action.

This 12th day of August, 2021.

June E. Robinson

June Robinson, transcriptionist
2304 Vail Avenue
Charlotte, North Carolina 28207
(704) 377-4372

Handout 2

Dr. Brent Hall Deposition Digest, Transcript, and Exhibits

July 30, 2021

Deposition of Dr. Brent Dwayne Hall by Julie Bridenstine

Page #	Description of Hall's Testimony	Exhibit
4-12	• Commission Staff Attorney Julie Bridenstine (JB) deposed Dr. Brent Hall (Hall) on July 30, 2021. JB explains the Commission process and asks Hall preliminary questions. Hall testifies about his prior experience with depositions and trial testimony. JB goes through preliminary matters.	
12-15	• Hall is not taking any medications or drugs and does not have any conditions that would interfere with his ability to testify. He lists the medications he is currently taking. Hall was in a car accident in February 2020 and sustained a concussion. He has some degree of memory lapse of varying frequency.	
16-18	• Prior to the deposition, Hall reviewed material from the Office of the Chief Medical Examiner (OCME) and photographs from the Watauga Medical Center. He kept copies of materials of cases he worked on, but they were destroyed in a flood. He did not meet with or talk to anyone prior to the deposition.	**Ex. 5 – Documents received from Dr. Hall**
18-19	• Hall was not aware the Commission was investigating this case until he received his subpoena. JB goes over Hall's demographic information.	**Ex. 1 – Subpoena for Dr. Hall**
19-22	• Hall is currently an independent pathologist. He stopped being a pathologist and medical director for several hospitals in August 2019. He had been at the Watauga Medical Center since 1993. The duration of his time at the other hospitals varied. He last worked as a medical examiner in 2013.	**Ex. 2 – Hall's CV from Court File**
22-27	• JB goes over Hall's educational background. Hall also explains pathology generally and what a forensic pathologist does. He was a medical examiner in North Carolina for approximately 20 years. He was responsible for Yancey, Mitchell, Avery, and Watauga Counties.	
27-29	• Hall's cases were always reviewed by another pathologist at OCME. He doesn't remember anyone disagreeing with his opinion. He does not recall having performance reviews. He reviewed cases himself during his fellowship, but not after.	
29	• After his fellowship, he would also consult with people who had questions about an autopsy. He felt free to give a different opinion from the original medical examiner when providing those services.	
29-31	• Hall recognizes **Ex. 3** and most of **Ex. 4**. JB clarifies that the only differences between what is contained in Ex. 3 and Ex. 4 and what Hall provided in **Ex. 5** are pictures he obtained from Brenda Rush Taylor (Taylor).	**Ex. 3 – Documents from Watauga Medical Center** **Ex. 4 – Documents from OCME**
31-34	• Hall became involved with this case at the request of the Yancey County Sheriff's Office (YCSO) or Yancey County EMS. He doesn't recall the specific information provided. **Ex. 6** does not refresh his memory as to what he was told. He did	**Ex. 6 – Police Report from YCSO**

	not go to the scene in this case, but he would routinely ask if he needed to go to a scene and relied on law enforcement or EMS to tell him if he was needed. He can't say how often he was actually asked to go to a scene.	
34-35	• Hall's trial testimony indicates that he had gone to a "few scenes" in the last 100 autopsies he had done. He cannot remember if this is true. He does not remember percentages.	**Ex. 7 – Hall's Trial Testimony**
36-37	• JB asks Hall to describe the autopsy process, from the external exam to the internal exam. Hall also clarifies that each autopsy may have a slight variation.	
38	• Hall took notes during the autopsy. These notes were destroyed by the flood. The hospital would have the photographs taken during the autopsy.	
38-39	• The autopsy took place on March 7, 2011 at 11:30 a.m. at the Watauga Medical Center. Hall cannot remember what information he had about the case before beginning the autopsy.	**Ex. 3 and Ex. 4**
39	• Hall states that notes taken by EMS and law enforcement may also have been destroyed by the flood. Those notes would be provided prior to the autopsy beginning.	
39-41	• Hall says he feels at a disadvantage not having time to read his trial testimony prior to the deposition. JB pauses the deposition to allow him to review it.	**Ex. 7**
41-43	• Hall describes the treatment he is receiving for his head injury and the effects from it. He is dealing with memory loss and tinnitus. He stopped taking medication he was prescribed for headaches. He is not currently having any symptoms other than a slight headache.	
43-44	• He cannot recall if he received information from YCSO about the case in written or oral form. Law enforcement would usually tell him a brief history of the decedent and the findings at the scene. He did not know if the Victim had taken drugs prior to his death, but notes that information would be helpful for a medical examiner (ME).	**Ex. 7**
44-46	• JB points Hall to pg. 3 of **Ex. 4** and has him explain what "livor" means. Hall explains it's the coloring of the body that comes from the settling or pooling of blood after death. Posterior/purple means that the livor was predominantly distributed on the Victim's back. This indicates to Hall that the Victim was lying on his back when the livor became fixed.	**Ex. 4**
46-47	• The date at the end of the "Report of Investigation" is March 7, 2011. He would typically fill this portion out after the autopsy. The "occurrence" box has information provided by both YCSO and by him.	**Ex. 4**
47-49	• JB directs him to the box filled out by the OCME reviewer. He cannot make out who reviewed the case. He does not know where the reviewer got the information from that section. JB asks if "morphine toxicity" documented from line 1 came from	**Ex. 4**

	reading Hall's report, and Hall says JB would need to ask the reviewer. Hall does not know what the checked box that says "AL" means. "Contributing Conditions" has "accident" marked off. "Contributing conditions" are other conditions related to death but not directly related to the cause of death. Hall agrees with JB that "accident" being marked is a mistake. The review was completed on July 6, 2011.	
49	• Hall finalized his autopsy report on May 31, 2011. He would then provide the documents to OCME for review. He cannot recall ever talking to a reviewer and doesn't recall speaking to one about this case.	**Ex. 4**
50	• Pg. 8 of **Ex. 4** has the "Toxic Agents Suspected" box checked under the "Means of Death" section. The "Others" box is also checked. The handwriting "MS04" is the medical abbreviation for morphine. Hall does not remember where he got the information for the "Means of Death" section but thinks it likely came from the investigating officers.	**Ex. 4**
50-51	• Typically, if an autopsy was performed, Hall would not fill out the body diagram portion of the "Report of Investigation" because it would have been redundant, and any discrepancy would have to be explained.	**Ex. 4**
51-53	• JB asks Hall to explain the handwritten notes on the body diagram on pg. 6 of **Ex. 4**. He noted tattoos on the right arm, a question mark that was noted on the left arm along with needle marks on the left arm, abrasions on the inguinal area and dorsal aspect of the right hand, and an ulcer on the left heal. He cannot remember what the abrasions in the groin area looked like or why the Victim had those abrasions. Hall agrees with JB that the abrasions appear to be symmetrical but does not know what would have caused them. At trial, he was asked if shoes rubbing could have caused the ulcer on the heel and he agreed it could. He does not remember if the ulcer looked infected. Hall stated the question mark "probably signifies some degree of ambiguity." He doesn't remember any other details. It is not unusual for drug users to have injection marks in those areas of the left arm.	**Ex. 4, Ex. 7**
54	• Hall cannot remember what the Victim's left arm looked like. JB asks about the left arm in comparison to the right and Hall indicates the left arm had needle marks and the right arm did not. He can't remember seeing any swelling on the left arm and did not note any in the autopsy report.	**Ex. 4**
54-55	• JB asks Hall to read the "Narrative Summary of Circumstances Surrounding Death" on pg. 10 of **Ex. 4**. Hall says it is likely the information from the narrative summary from the investigating officers but does not specifically remember. Hall repeats that he would typically fill this out after the autopsy, but on occasion did fill it out before.	**Ex. 4**
56	• Hall would normally note swelling if he saw it.	**Ex. 4**

56-57	• Hall cannot remember if he or pathology assistant, Irene Coffey (Coffey), took photographs during the autopsy. They would always take a facial identification shot. Hall describes the routine photos taken during a typical autopsy. **Ex. 3** appears to contain three photographs taken during the autopsy. Hall isn't aware of any other photos taken. All three are considered identification photos.	**Ex. 3**
57-58	• JB points out what appears to be discoloration to skin on the Victim's shoulders and face. Hall says that is livor. Hall is not sure what the brown substance coming out of the Victim's right nostril is but says it appears to be mucus. The mucus does not indicate anything to him.	**Ex. 3**
58-59	• Hall is not sure why he didn't photograph the needle marks on the Victim's left arm. Hall agrees those would be relevant in a death investigation involving a suspected drug overdose. Hall does not remember why no photographs of other areas of the body weren't taken. Hall doesn't remember why photographs of other injuries to the Victim's body weren't taken. It would be his practice to take photos of injuries. Hall offers that photographs could have been taken but not downloaded for some reason. Coffey would have been in charge of downloading the photos. He can't remember a case where Coffey didn't download all of the photos.	**Ex. 3**
59-60	• Pg. 3 of **Ex. 4** indicates that x-rays were taken and chemistry was performed on the fluid taken from the Victim's eyeball (vitreous). JB asks what the chemistry levels mean. Hall says it depends. None of the Victim's levels indicate anything abnormal.	**Ex. 4**
60-62	• Pg. 4 of **Ex. 4** details the cardiovascular system. Mild concentric ventricular hypertrophy in the heart means that the left ventricle was slightly enlarged. This can be caused by a number of things, whether congenital or non-congenital. It can contribute to death by leading to cardiac arrhythmias. You can determine this in the autopsy by looking at sections of the conduction system for abnormalities. He is not sure if this was available in 2011, but currently, you can also do DNA analysis for congenital anomalies. He did not look at the conduction system or do DNA analysis in this case. The only way to know for sure is to do an EKG strip. Hall agrees that the mild concentric left ventricular hypertrophy may have been a contributing factor in this case, but not the cause of death. The morphine in the Victim's system was the cause of death.	**Ex. 4**
62-64	• Marked edema and congestion in the lungs means there was water on the lungs. This can be caused by a drug overdose. It can also be caused by heart attacks or a "litany" of other things, including pneumonia.	**Ex. 4**
64-65	• Mild emphysematous change means that the alveolar spaces were somewhat dilated. This is most commonly caused by	**Ex. 4**

	smoking but can also be caused by pneumoconiosis or exposure to toxic chemicals. Seeing this in the autopsy indicated to Hall that the Victim was probably a smoker.	
65-66	• JB asks if there was anything he could have done during the internal examination that he did not do, and Hall gives a number of examples. He says he had no reason to do additional procedures. You can do cut-downs to look in someone's arms or legs. You can also do bacterial cultures if there is gross evidence of pneumonia or consolidation in the lungs. He did not do a bacterial culture in this case because he did not see any evidence of consolidation, which is indicated when the lungs get hard and look more red. He assumes he examined both lungs but can't remember.	**Ex. 4**
66-67	• He did not do viral cultures in this case because they are not typically done in cases where there is clinical evidence of viral pneumonia. Evidence would include a clinical history or seeing evidence of consolidation. He did not have any information that the Victim had been ill prior to his death. That's information that would usually be given to him by the attending physician, EMS, or the investigating agency.	**Ex. 4**
67-69	• He could have gotten blood cultures in this case. Blood cultures are typically for sepsis. Signs of sepsis include multi-organ failure. You may see "soft findings" of sepsis, but it is hard to determine on gross examination. The diagnosis has to be through microscopic examination of the organs. A blood culture will tell you the organism infecting the body.	
69	• Hall does not think it is possible that the Victim had sepsis in this case. The liver and kidneys appeared normal, and he saw no evidence of sepsis on microscopic examination. It would be unusual not to see evidence of sepsis if someone had not been treated with antibiotics. If they had been treated with antibiotics, you would not see signs of sepsis in the organs.	**Ex. 4**
69-70	• On pg. 4 of **Ex. 4**, Hall notes a typo regarding the slides of the heart. Myelocyte hypertrophy should be myocyte hypertrophy. Myocyte is the cell that makes up the heart. Myocyte hypertrophy is the microscopic equivalent of the concentric left ventricular hypertrophy.	**Ex. 4**
70	• The lung slides showed marked edema congestion, which is fluid within the alveolar spaces and dilated blood vessels. They also showed moderate acute bronchial pneumonia, which was indicated by neutrophils white blood cells in the alveolar spaces. Neutrophils are always an indication of pneumonia. Other indications of pneumonia are reactive pneumocytes. He cannot recall if he saw those during the autopsy.	**Ex. 4**
72-73	• The lung slides also showed that the perihilar lymph nodes contained granulomas with birefringent material. Birefringent material indicate talc, which a substance commonly used to cut illicit drugs. Talc is also present in pills and baby powder, but	**Ex. 4**

	Hall does not know if talc is usually present in pills. Birefringent materials can also be other crystal materials. You can occasionally see birefringent materials in cases that involve drug use and also in cases that don't involve drug use.	
74	• Hall cannot remember any pre-existing conditions the Victim had or his medical history. He thinks he was furnished some history of drug use by YCSO.	
74-75	• An abscess is an infection. It can spread to the lungs and cause bronchopneumonia. It can also cause a fever. He doesn't recall seeing an abscess on the Victim. None were noted in his report. It is possible to miss an abscess during an autopsy. You cannot tell if the decedent had a fever when they died unless you measured the temperature. He did not do that in this case, and it wouldn't be typical to do in an autopsy.	
75-76	• You can detect blood clots during autopsies by visual inspection of internal organs. You would not know if the blood clot was in someone's arm or leg unless there were other manifestations of the blood clot internally. No blood clots were noted in the Victim's autopsy.	**Ex. 4**
76-78	• Hall agrees that you can see signs of a blood clot on the histology slides. He explains how you can determine if a blood clot played a role in someone's death. It is possible that if there was no evidence of a blood clot on gross inspection of the lung and you took a random section of the lung, you could miss a blood clot. A blood clot in the arm or leg typically has to travel somewhere else in order to cause death. It could also get infected in the extremity and lead to an abscess, sepsis, and death.	
79	• Hall could have done other cultures in this case but in his opinion, these would have added little to no value to the autopsy because the Victim died of morphine toxicity. He saw no signs of death being caused by complications from the ulcer on the heel or from sepsis. It was not routine to take cultures of the areas around the suspected needle marks unless there were signs of an abscess.	
79-80	• Hall did not receive information prior to the autopsy, and did not note anything during the autopsy, to indicate that the Victim had an underlying bacterial or viral medical condition.	
80	• No indication of infection was noted around the needle marks.	
80-81	• Hall explains other samples he could have collected and what the reasoning behind collecting those would have been.	
81	• Hall took blood, urine, and vitreous samples for the toxicology screen due to the history, possible needle marks, and autopsy findings, and specifically due to the pulmonary edema congestion. The samples were sent to the toxicology lab via USPS.	

82-83	• Hall reviews **Ex. 4** and does not see the toxicology form. It would usually include patient demographics, a brief clinical history, and a list of samples submitted.	**Ex. 4**
83	• Hall does not recall what specific tests he requested. Given the history, he likely requested a morphine analysis. Blood alcohol analysis was done routinely.	
84	• JB asks Hall to walk through the list on pg. 11 of **Ex. 4**. The liver, exudate substrate for measuring drug levels, was not tested in this case. Hall says it is likely the toxicologist performing the assays decided not to test it.	**Ex. 4**
84-85	• The urine sample indicates that morphine was detected. Hall cannot recall if he specifically requested the urine be tested.	**Ex. 4**
85	• The typical routine is to test the aortic blood first, then the peripheral samples like femoral blood or a subclavian sample to quantitate the analyte. If femoral blood is inconclusive, different substrates like urine will be tested. If the urine doesn't give the answer, they would have tested the liver. Hall's understanding was that toxicologists determined what tests and what order.	
85-87	• Hall does not know what types of opiates, opioids, or organic bases were tested. Hall's understanding is that because morphine was present in the aorta, only morphine was tested in the femoral. Alcohol was present at 40 mg/deciliter. He does not know why alcohol wasn't tested in the femoral or urine samples. He thinks the urine sample was sufficient to test for both morphine and alcohol but is not sure.	**Ex. 4**
87	• Hall does not recall talking to the toxicologist, but believes it is likely because this was a marginal case. He would have documented the conversation with his papers that were destroyed. You would typically get results via email or mail.	
88	• **Ex. 8** is the toxicology report from OCME. It shows Hall received it via email on April 4, 2011.	**Ex. 8**
88	• JB asks if it is accurate to say the aorta portion of the test is the screening and the femoral portion is the confirmation and Hall agrees that is accurate.	
88-89	• The testing of the blood in this case was inconclusive for morphine so they tested the urine. 15 mg/L of morphine in the Victim's urine indicates a lethal level of morphine. Based on the textbooks, morphine becomes lethal in the urine at 14 mg/L. He does not know when that literature came out, but there are several editions.	**Ex. 8**
89	• Trace morphine from the femoral vessel indicates to Hall that there was not enough to quantitate. Hall does not know the minimum cutoff level for reporting morphine in the femoral vessel.	**Ex. 8**
89-90	• Hall did not look at the raw data for the toxicology report or see the toxicology file. He does not know the actual level of morphine detected in the femoral vessel.	**Ex. 8**

90	• Hall says the trace amount of morphine in the blood could have come from a couple of reasons: he ingested a low dose or the dose he ingested could have been metabolized out.	
90-91	• Alcohol in the blood indicates to Hall that the Victim had ingested alcohol. JB asks if it is possible the alcohol was a false positive and Hall says anything is possible. He is not aware of any issues with false positives in alcohol related to the shipment getting hot on its way to toxicology.	
91	• In Hall's opinion, it is not possible that alcohol caused the Victim's death because the concentration is too low. It could have been a contributing factor. Like morphine, alcohol is a nervous system depressant. The two substances could have worked in conjunction with each other.	**Ex. 8**
91-92	• JB asks if alcohol alone can lead to pneumonia. Hall says if a person aspirates it can cause pneumonia.	
92	• JB asks what would happen if crushed up blood-pressure medication was melted and injected, and Hall says that is a broad question he doesn't feel comfortable answering.	
92	• Toxicology screens usually show drugs that are being abused. Hall does not know what "Opana" is.	
92-93	• Hall says you cannot tell from the toxicology report what form of morphine was used or how the decedent ingested a drug. If you see needle marks during an autopsy, you can assume an IV ingestion. If you see pill fragments in the stomach, you can assume it was oral intake. Hall agrees it is possible that someone could take pills and the pills could not be present in the stomach during the autopsy.	**Ex. 8**
93	• Hall is not aware of any studies regarding the half-life of morphine when it is in pill form, melted, and injected, and cannot draw any conclusions as to the half-life if taken in that form. If a morphine tablet is marketed as slow release, the half-life is longer than liquid morphine injected by a doctor.	
93-94	• Hall determined the Victim's cause of death was morphine toxicity, which means an overdose. At autopsy, a morphine overdose will show pulmonary edema congestion. You can also see pneumonia. These are "soft findings" that may not necessarily be present. He arrived at the cause of death by doing the gross examination, looking at the slides, and getting the toxicology results. The ethanol could have contributed.	
94-95	• Hall is pretty confident that morphine toxicity was the cause of death. He found no other cause of death. He cannot say anything absolutely. You need to be fairly confident to list a cause of death on an autopsy, but he cannot give a percentage. Each case is different.	
95-96	• JB goes to pg. 2 of **Ex. 4**. Final anatomic diagnosis means all of the gross and microscopic anatomic findings are coalesced. It can include cause of death but did not in the Victim's case.	**Ex. 4**

96	• The report describes the acute bronchial pneumonia as moderate. This means a moderate number of neutrophils in the alveolar spaces of the lungs. "Moderate" is a subjective term and each pathologist has his own cutoff point.	
96-97	• "Pulmonary edema and congestion, severe" means there was proteinaceous fluid in the alveolar spaces and the vessels were dilated. In his opinion, this was caused by leakage of proteinaceous material from the alveolar capillaries into the alveolar spaces. The proteinaceous material is an excellent media for micro-bacterial growth.	
97	• If the body is not oxygenating well, the lungs try to compensate by opening up alveolar spaces as wide as they'll go. When they open, the connections between the endothelial cells stretch and allow fluid to leak from the vascular space into the pulmonary parenchyma cell.	
98	• Lack of oxygenation can be caused by a number of things, including infection.	
98-99	• Based on the findings at the autopsy, it is likely the pulmonary edema that resulted from the brainstem depression was a result of morphine and alcohol intoxication. Symptoms of this would include trouble breathing, cough, and fever. Acute bronchial pneumonia can be a cause of death. You may not always know what causes bronchial pneumonia.	**Ex. 4**
99-100	• Aspiration pneumonia results from aspiration of gastric material into the lungs. It can also cause death. How long it takes for someone to die depends on a number of factors. Death can occur in minutes, days, or months. Hall did not see any signs of aspiration bronchial pneumonia in this case.	
100-101	• Acute bronchial pneumonia can cause death within hours, days, or months. It would not cause death within minutes. The symptoms also include fever, cough, and gagging during aspiration.	
101	• The Victim being described as "hot to the touch" at the time of death would indicate a fever, but this could have been caused by the ambient temperature in the environment where he died.	
101	• Hall does not remember speaking to Chief Deputy Thomas Farmer (Farmer) about the case on March 7, 2011. **Ex. 9** is Farmer's report for this case. JB then directs Hall to pg. 39.	**Ex. 9**
101-103	• The report says Farmer and Hall spoke at 2 p.m. on March 7, 2011. The autopsy was started at 11:30 a.m. on March 7, 2011. Hall doesn't remember how long the autopsy took. Autopsies typically took a couple of hours for the gross dissection, 30 minutes to read the slides, and 10-15 minutes to interpret the toxicology results. At the time he spoke to Farmer, he probably did not have the toxicology or microscopic results.	**Ex. 9**
104	• Hall does not recall telling Farmer that it was his professional opinion that the Victim died of a drug overdose. JB asks why Hall was giving opinions about the cause of death before	**Ex. 9**

	getting the toxicology results. Hall says because of the needle marks, pulmonary edema congestion, and no other findings that would have caused his death.	
104-105	• Hall doesn't recall receiving information from sources other than law enforcement. There may have been an EMS report.	
105	• In Hall's opinion, it is not possible that something other than morphine caused the Victim's death. No other findings at autopsy would account for his demise.	
105	• Hall has ruled a death as being caused by a drug overdose hundreds or thousands of times throughout his career. It is a "too common" cause of death.	
105	• Hall cannot think of any other cases where a decedent presented as having a high level of a drug in the urine but a trace amount in the blood, but it is possible.	
105-106	• Hall was not surprised that there was only a trace amount of morphine in the blood. Hall agrees with JB that it would be typical in drug overdose cases to see a high amount of drug in the blood and less common to only see a trace amount.	
106-107	• Hall had a substance abuse issue with alcohol. Hall wondered when JB would get to this "because all attorneys who don't have the facts on their side try to diminish the character of the witnesses." JB reiterates that the Commission is just looking for the truth.	
107	• Hall is currently in recovery. He started abusing alcohol in his late 40s and is now 61. He thinks his alcohol abuse started around 2005.	
107-108	• JB asks Hall if he was charged with Driving While Intoxicated (DWI) on January 28, 2010. Hall says there is no record of that and will not answer whether he was charged.	
108	• JB asks if Hall had a pending DWI case from 2010 to April 2015 and Hall says there is no record of that. JB asks if he had an attorney and Hall says he's not aware of a record of that.	
108-110	• **Ex. 10** includes a news article indicating he was charged with DWI on January 28, 2010, convicted in district court in 2011, and appealed his case to Superior Court where it was postponed 20 times until April 2015. The article also indicates he had an attorney named Robert Speed (Speed). According to Speed, prosecutors did not want the case resolved due to concerns about defense attorneys using that information in cases where Hall testified as a ME. The charge was ultimately dismissed.	**Ex. 10**
111	• JB asks if Hall is representing the case never happened and Hall again says there is no record of this case. JB asks if that means he never had a pending DWI case from 2010-2015 and Hall says he's answered the question. He is not sure if prosecutors were worried about defense attorneys using this against him when he testified as a ME. He doesn't remember anyone expressing those concerns.	

111-113	• Hall continued working as a ME until he resigned in 2013. The autopsy in this case was performed in March of 2011. The trial was in April 2014, after he resigned.	
113	• Hall says he was being monitored for alcohol use through NC Physicians Health Program (PHP) between 2010 and April 2015 because he was deemed to have a problem with alcohol.	
113-114	• At one point, Hall received a private letter of concern from the state board. His license was revoked for 90 days and he was immediately reinstated thereafter.	
114-116	• **Ex. 11** is the Interim Non-Practice Agreement from the NC Medical Board. It was issued on February 21, 2018. It ordered a physical and mental examination. The treatment center through the PHP diagnosed him with alcohol dependence. PHP also ordered Hall to receive psychotherapy and a comprehensive assessment on June 16, 2011. He signed a medical non-practice agreement on August 5, 2011 through January 15, 2012.	**Ex. 11**
116	• Hall does not know why the medical board got involved.	
116-117	• JB clarifies that Hall was diagnosed with alcohol dependence after he performed the autopsy in this case.	
117	• As a result of the agreement, Hall also had to undergo treatment.	**Ex. 11**
117-118	• Hall does not remember if he was using alcohol when he performed the autopsy and death investigation in this case. He doesn't remember what his usual drinking habits were when he was using alcohol. He doesn't remember if he was using alcohol at the time he testified at this trial but doubts it. Hall states, "Because who would use alcohol and then testify in a trial? Some people think I'm dumb, but I'm not that dumb." He doesn't remember if he was using alcohol in the evenings or when he wasn't at work.	
118	• Hall last used alcohol on February 12, 2018. His medical license was only suspended once.	
118-119	• JB asks if Hall was charged with DWI on February 11, 2018 and Hall says there is no record of that. JB clarifies she is talking about 2018 and Hall says his license was suspended after that case. He took a plea for the 2018 charge. He thinks he got a year of probation and community service.	
119-121	• **Ex. 12** is a consent order from the NC Medical Board. It states he was diagnosed with alcohol use disorder and attended inpatient treatment starting on February 14, 2018. He entered into the interim non-practice agreement on February 21, 2018. He also signed a monitoring agreement with PHP on May 9, 2018. On May 31, 2018, the interim non-practice agreement was dissolved, and PHP determined he was safe to return to the practice of medicine.	**Ex. 12**
121	• The consent order suspended his license for 90 days but stayed the suspension on the condition that he adhere to NC laws and	

	abstain from alcohol use. Monitoring was part of the conditions. He is still subject to monitoring today. These conditions are still under effect.	
122	• **Ex. 13** is an order dissolving the interim non-practice agreement. He signed a five-year monitoring contract with PHP on May 9, 2018. Hall is still under this contract.	**Ex. 12**
122-124	• Hall resigned as a medical examiner in 2013 because he was "blackmailed" by OCME and DHHS. They told him that if he did not resign, the Secretary of DHHS would find a way to make him ineligible for Medicare payments from the state. At the time, his Medicare reimbursement was much larger than what he was making off of his ME work, so he resigned. Debbie Radisch (Radisch) from OCME relayed the message from DHHS. In exchange, they wouldn't say anything related to the hotel deaths. In reality, they had a press conference as soon as he resigned. This was all discussed in a deposition.	
125-126	• Hall was not sued in relation to the Boone Best Western Hotel cases from 2013 because he didn't do anything wrong. He did face a lot of criticism about those cases. The criticism is that he didn't order the toxicology stat, which Hall states there was no method for doing. He was also criticized for being negligent in performing the autopsies, which he denies. Hall was also criticized for not giving the toxicology to the fire marshal immediately, but he was on vacation when it came back and didn't have a way to check his email from his phone. Hall denies all of these accusations.	
126	• Radisch called him after the little boy died. The initial conversations were about issues with the system and solutions. He received another call from Radisch with a different tone and she was "coming down on me to resign."	
126-127	• No one ever expressed concerns to Hall about the other cases he performed autopsies in. Hall is not aware of any internal investigations related to the Best Western Hotel cases. He was asked to resign, and no one ever talked to him about it again.	
127	• Hall has never been accused of improper conduct in other cases.	
127	• JB asks if the Commission should speak to anyone else and Hall suggests the OCME reviewer and the toxicologist.	
127-128	• Morphine in the urine will not tell you when the morphine was ingested. It can stay in the urine for as many as 6 days. It also will not tell you how many times someone has used morphine.	
128	• JB explains the upcoming hearing.	
128-129	• Hall describes this case as a marginal case in that the level of morphine in the urine was in the low toxic range, but it was the only finding at autopsy that could account for the Victim's demise. By marginal, Hall means that he'd "… rather the morphine had been very high."	

129	• He does not have any concerns about the autopsy finding. His own feeling is that there was possible overreach by the District Attorney's office (DA) given the circumstances surrounding the case. The DA's office only asked him to get up and testify.	
129-130	• Hall has not talked to anyone about what he said during this deposition. No one has told him what to say or made any promises or threats. He has nothing else to add.	
130	• Deposition concludes.	

STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
COUNTY OF YANCEY

STATE OF NORTH CAROLINA,	)	
	)	File No. 11 CRS 304
	)	
Petitioner,	)	File No. 11 CRS 305
	)	
-vs-	)	
	)	
	)	
JOHN PRITCHARD,	)	
	)	
Defendant.	)	
	)	

VIDEOTAPED DEPOSITION

OF

DR. BRENT DWAYNE HALL

July 30, 2021

This is the transcript of the audio recording of the deposition of DR. BRENT DWAYNE HALL. The deposition was conducted by Julie Bridenstine, Staff Attorney for the North Carolina Innocence Inquiry Commission. The witness was affirmed by Brian Ziegler, Staff Attorney for the North Carolina Innocence Inquiry Commission. The deposition took place at Law Library of the Courthouse in Ashe County, North Carolina, on Friday, July 30, 2021, beginning at 12:04 p.m.

A P P E A R I N G

Ms. Julie Bridenstine
Staff Attorney
North Carolina Innocence Inquiry Commission
Raleigh, North Carolina

Mr. Brian Ziegler
Staff Attorney
North Carolina Innocence Inquiry Commission
Raleigh, North Carolina

Dr. Brent Dwayne Hall

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I N D E X

E X H I B I T S

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P R O C E E D I N G

MS. BRIDENSTINE: This is the deposition of Dr. Brent Hall by the North Carolina Innocence Inquiry Commission. Today's date is July 30, 2021, the time is 12:04 p.m. Present at the Law Library at the Courthouse in Ashe County are myself, Julie Bridenstine, and Brian Ziegler, both attorneys with the North Carolina Innocence Inquiry Commission, and Dr. Hall.

* * *

DR. BRENT DWAYNE HALL

HAVING first been duly affirmed, was examined and testified as follows:

EXAMINATION BY MS. BRIDENSTINE:

Q. Dr. Hall, could you please state your full name for the record.

A. Brent Dwayne Hall.

Q. Dr. Hall, my name is Julie Bridenstine, and I will be taking your deposition today.

A. Okay.

Q. As I said, I'm an attorney for the North Carolina Innocence Inquiry Commission. We are a neutral state agency that investigates post-conviction innocence claims. You are being deposed today in the matter of State of North Carolina versus John Pritchard, case number 11 CRS 304 and 11 CRS 305. These are related to

convictions out of Yancey County from April 2014.

This case involved the second-degree murder, delivery of Schedule II controlled substance, possession with intent to sell, manufacture or deliver Schedule II controlled substance, and maintaining a vehicle, dwelling, or place for controlled substances. All of these charges occurred on March 5th, 2011, to March 6th, 2011. And the victim in this case was Jonathan Whitson.

The North Carolina Innocence Inquiry Commission is a neutral and truth-seeking commission. We are not prosecutors. We do not represent the defendants who make innocence claims with our agency. I am only looking for the truth in this case.

Are you represented by counsel this morning?

A. No, ma'am.

Q. Have you ever been deposed before?

A. Yes, ma'am.

Q. How many times?

A. Dozens.

Q. What were the types of cases in -- what were the types of cases in which you were deposed?

A. Predominantly cases in which I had autopsied a person.

Q. Were these for civil matters?

A. Criminal. Predominantly criminal.

Q. Were the depositions taken during the course of the criminal case?

A. Prior to the criminal case.

Q. And who was deposing you in those cases?

A. It was primarily the defense attorney.

Q. And what areas, when you were deposed, did you typically cover?

A. Forensic and autopsy pathology.

Q. Have you ever testified at depositions that involved testimony beyond the scope of your work as a pathologist?

A. I don't think so.

Q. Have you ever testified at a deposition in which you were a party?

A. Yes, ma'am.

Q. And in what case was that?

A. That was a case in which a malpractice suit was brought against me, but was later dismissed.

Q. And when did that case occur?

A. A long time ago. Back in the '90s.

Q. What was the basis of the malpractice claim?

A. That I had missed a focus of squamous cell carcinoma in a consult.

Q. Can you say that first part again? I heard carcinoma.

A. A focus of squamous cell carcinoma in a consult.

Q. Was that for an autopsy?

A. No.

Q. No?

A. It was surgical pathology.

Q. And you said the case was dismissed?

A. Dismissed. And the attorney disbarred.

Q. Did you ever testify at any other depositions in which you were the party?

A. No.

Q. Is it fair to say that you are familiar with the deposition process?

A. Yes, ma'am.

Q. Outside of your testimony at your depositions, have you testified in other settings?

A. Yes, ma'am.

Q. How many times?

A. Dozens, if not hundreds.

Q. And in what kind of cases did you testify?

A. Predominantly autopsy-related cases.

Q. Were those in criminal matters, civil matters, both?

A. Both.

Q. All right. I just have a few things to go over

to begin with, including some ground rules, so that we all have the same understanding. Does that sound fair?

A. Sure.

Q. First, do you understand that you are testifying under affirmation today?

A. Yes, ma'am.

Q. Do you understand that your answers are subject to the penalty of perjury?

A. Yes, ma'am.

Q. Do you -- and could you speak up just a little bit? I'm a little bit -- I'm having a little bit of trouble hearing you. And I want to make sure the video and the tape recorders are picking your voice up and my voice up.

A. Okay.

Q. Do you understand that this is the same affirmation that you would make if you were testifying at trial?

A. Yes, ma'am.

Q. You are under affirmation today, and you are expected to answer completely and truthfully. Do you understand that?

A. I do.

Q. Do you understand that at today's deposition I will ask questions, you will answer, and everything that

I say and that you say will be taken down verbatim and later transcribed by a court reporter?

A. I understand that now that you've said it. Yeah. Uh-huh.

Q. And you will have the right to request to review the transcript and make any corrections before the deposition is completed. Do you understand that?

A. Yes, ma'am.

Q. Do you understand that when you review this transcript, you can make any changes of form or substance so that your testimony and the transcript is true, accurate and complete?

A. Yes, ma'am.

Q. Do you also understand that we want to find out everything you know about the facts and events in this case, and so we want your answers to be as full, accurate, and complete as possible?

A. Yes, ma'am.

Q. I understand you might want to answers questions before I have completed them. However, please wait until you hear my entire question before you answer. Will you do that?

A. I'll try.

Q. And also, because inaudible responses are sometimes difficult to record, and especially because we

are wearing masks right now, can you please provide audible responses to my questions?

A. I'll try. Yes, ma'am.

Q. If you do not understand a question, please just inform me that you do not understand, and ask me to clarify. Will you agree to ask me to clarify any question you don't understand?

A. I will.

Q. If you do not ask me to clarify a question, I will assume that you understood the question, and that you gave a complete response. Do you understand that?

A. Yes, ma'am.

Q. After you have given an answer, you may remember more information later on during the deposition that responds to an earlier question. If this happens, please stop me, tell me you remember more information that is responsive to that earlier question, and provide it. Will you do this?

A. Yes, ma'am.

Q. If I believe that I have a document that will help you respond to a question, I will label it as an exhibit and show it to you and ask you to review it. If you believe that I may have a document that will help refresh your memory, please ask to see it. And if I have it, I will provide it to you. Okay?

A. Yes, ma'am.

Q. Will you ask me for those records if you believe them to be available?

A. I'm sorry. Repeat the --

Q. Will you ask me for any records if you believe them to be available?

A. Yes, ma'am.

Q. If you need to take a break, I do ask that you answer any question that is pending before we take a break. Do you understand?

A. Yes, ma'am.

Q. And if you want to take a break, just let me know, and we'll stop and we'll talk about taking a break. My plan is to take a break at least every hour, hour and a half, if that sounds okay. But if you need an earlier break, just let me know.

A. Okay. Well, how long is this going to take?

Q. I don't know. I guess that depends on how much information we get through. But if you need to take a break, just let me know, and we'll stop. Okay?

A. Okay.

Q. All right. Is there any reason you can't give full and complete responses today?

A. No, ma'am.

Q. Are you taking any medication or drugs of any

kind that might interfere with your ability either to recall past events accurately or testify about them fully and completely today?

A. No, ma'am.

Q. Do you have any condition that might interfere with your ability to recall past events accurately?

A. No, ma'am.

Q. Do you have any conditions that might interfere with your ability to testify fully and completely today?

A. No, ma'am.

Q. Is there any reason why your ability to recall past events accurately and testify about them fully and completely is not -- is not as good today as it normally is?

A. Well, the only reason would be that this case is 10 years old.

Q. Are you feeling okay today?

A. Yes, ma'am.

Q. Are you currently under the influence of alcohol?

A. No, ma'am.

Q. Are you currently under the influence of drugs, either illegal or prescription?

A. Yes, ma'am.

Q. And what drugs are you -- or medications are

you taking?

A. I'll have to get my phone.

Q. Oh, okay.

[redacted]

Q. All right. Do any of the medications that you just listed impair your ability remember or to testify completely, truthfully, and accurately?

A. No, ma'am.

Q. And it sounds like you're taking some medications that are due to your need for ongoing treatment from a physician. Is that accurate?

A. That's accurate.

Q. Do any of those conditions prevent you from giving truthful, accurate, and complete testimony today?

A. No, ma'am.

Q. Are there any other circumstances or issues preventing you in any way from giving truthful, accurate,

and complete testimony today?

A. Well, the only thing that I can think of is that I was in a car accident fairly recently, in which the car overturned, and I sustained a concussion. And I do seem to have some degree of memory lapse from time to time because of that.

Q. When did the car accident happen?

A. February of last year.

Q. Would that be 2020?

A. 2020. Yes, ma'am.

Q. Are you being treated by a physician in relation to those issues?

A. Yes, ma'am.

Q. Are you taking any medication related to the car accident?

A. Well, one could say that the antianxiety and the sleep medication.

Q. Have you been diagnosed with anything related to memory lapse?

A. I've had a formal consultation by a psychologist down in Hickory. But I've yet to receive his report.

Q. And when you say you have memory lapses, what sort of memories are being affected?

A. Short term, medium term, some long term. But

it's mostly things like, for instance, I'll be looking through the microscope, and I'll see a tumor. And I know I know what that tumor is, but I can't recall the name of the tumor. It's things like that.

Q. How often are you claiming that you experience memory lapses?

A. Periodically.

Q. Is it a daily occurrence?

A. Depends on the day.

Q. Approximately how many times a week do you find yourself experiencing memory lapses?

A. It varies.

Q. What does it -- can you give me more detail about that? What do you mean by "varies"?

A. I mean, it'll be more frequent some weeks than others.

Q. What's an example of a week where it's not frequent? How many times per week?

A. I would feel uncomfortable putting a numerical value to that question.

Q. If you're experiencing a week where you are having frequent memory lapses, approximately how many times per week would that week look like?

A. I'm not going to give you an exact number.

Q. Have you done anything to prepare for your

deposition today?

A. Yes, ma'am.

Q. What have you done?

A. Actually, I had none of the material with me. All the material I had got destroyed in a flood/rain several years ago. So I had to obtain the material from the Office of the Chief Medical Examiner in Chapel Hill. Oh, and pictures from the -- the hospital.

Q. Okay. Did you bring all those documents with you?

A. Yes, ma'am.

Q. And you got everything from the Office of the Chief Medical Examiner?

A. Except the pictures.

Q. Except -- and where did you get the pictures?

A. From the hospital.

Q. From -- is that Watauga Medical Center?

A. Watauga Medical Center. Yes, ma'am.

Q. Where did this flood occur?

A. I'm sorry?

Q. Where did the flood occur?

A. At my office.

Q. Was it your practice to hold onto materials from your work as a medical examiner?

A. Yes, ma'am.

Q. Did you make a copy of -- of everything that you did in those cases?

A. Everything was in a brown manilla folder, and in a paper file folder.

Q. For each case? Did you have a paper file for each case?

A. Yes, ma'am.

Q. And were all of your documents destroyed in the flood?

A. Yes, ma'am.

Q. Have you met with anyone in order to prepare for your deposition?

A. No, ma'am.

Q. Did you talk to anyone in order to prepare for your deposition?

A. Nothing other than ordering the documents.

Q. Other than the documents that you obtained from the Office of the Chief Medical Examiner and Watauga Medical Center, did you examine or review anything else in preparation for the deposition today?

A. No, ma'am.

Q. I have documents, as well, from the Office of the Chief Medical Examiner and Watauga Medical Center. And so when we get to that point in the deposition, we can compare and just make sure that I have everything

that you have.

A. Okay.

Q. If you have anything that I don't have, then I will just ask to make a copy for us.

A. I will. Actually, I have copies, so these can be your copies.

Q. Okay. All right. Then actually, at this time, I'll just take that and make it an exhibit.

A. Okay.

MS. BRIDENSTINE: And yeah, the subpoena, I'll give back to you. So I'm going to make this Exhibit 5. And I'll keep it in this folder. We can look at it a little bit later and compare. So I've marked as Exhibit 5 the documents that you just handed to me that you got from Watauga Medical Center and the Office of the Chief Medical Examiner.

[Exhibit Number 5 identified]

Q. Have you been asked by anyone to withhold information or misrepresent any facts during the deposition today?

A. No, ma'am.

Q. When did you first learn that the North Carolina Innocence Inquiry Commission wanted to take your deposition in this case?

A. When I received the subpoena.

Q. From the time you first learned that, when you received the subpoena, until today, have you communicated with anyone about the facts of the case or about your deposition?

A. No, ma'am.

Q. I'm handing you what I have previously marked as Exhibit 1, which is a copy of the subpoena for this deposition.

[Exhibit Number 1 identified.]

Q. Dr. Hall, what is your date of birth?

A. 2/17/60.

Q. Where do you live?

A. 225 -- no, I'm sorry. Yeah. 225 Meat Camp Road, Todd, North Carolina, 28684.

Q. What is your phone number?

[redacted]

Q. Are you currently employed?

A. Yes, ma'am.

Q. What do you do?

A. I'm a pathologist.

Q. Do you have an employer?

A. My own company.

Q. So is it fair to say you're an independent pathologist now?

A. Yes, ma'am.

Q. What was your last employment before you were an independent pathologist?

A. I was a pathologist, laboratory medical director for several hospitals in the area.

Q. When did you stop being a pathologist and medical director for those hospitals?

A. In August of 2019.

Q. What was your employment before you were a pathologist and medical director for several hospitals?

A. I was in medical school, or doing my residency.

Q. And when you say several hospitals in the area, what hospitals?

A. Well, at one time I had Watauga Medical Center, Blowing Rock Hospital, Cannon Memorial Hospital, and Blue Ridge down in Spruce Pine.

Q. And how long have you been a pathologist and medical director at those hospitals?

A. It varies. But the longest is with Watauga. And that's since 1993.

Q. I'm showing you what has been previously marked as Exhibit 2. Do you recognize Exhibit 2?

[Exhibit Number 2 identified.]

A. So there's two copies. Are they the same thing?

Q. One copy is for me, actually. Yes, they are

the same thing.

A. I do.

Q. And what is Exhibit 2?

A. That is a copy of a curriculum vitae for me.

Q. Was this your CV back in 2011 to 2014, in that time period?

A. Possibly.

Q. And actually, I'll be more specific. Was this your CV back in 2014? I see that you have a position listed as medical examiner that ended in 2013 listed on Exhibit 2.

A. So what was the question?

Q. Was this your CV back in 2014?

A. Probably.

Q. I obtained this CV from the court file in this case. And the trial happened in 2014.

A. Okay.

Q. Okay. Do you think that this is the CV that you were using back in 2014?

A. In all likelihood.

Q. As I just noted, it says that you're a medical examiner from 1993 to 2013.

A. Yes, ma'am.

Q. Is that the last time you worked as a medical examiner was 2013?

A. Yes, ma'am.
Q. What is your educational background, generally?
A. Are you asking where I went to school?
Q. Yes.
A. Okay. So I went to undergrad at Western, Western Carolina over in Cullowhee. And I went to med school at East Carolina in Greenville, North Carolina. Then I did my internship and residency at Duke University in Durham. Then I did a fellowship in hem-path at Duke.
Q. In what?
A. Hematopathology. Then I did a fellowship in forensics over at NC Chapel Hill/Office of the Chief Medical Examiner.
Q. When you say you did internship in forensics, is that forensic pathology?
A. Not an internship, a fellowship. I did a fellowship.
Q. In forensic pathology?
A. Yes, ma'am.
Q. And what is hematopathology?
A. That's the study of predominantly leukemias, lymphomas, lymph nodes and bone marrows.
Q. What type of physician are you?
A. I'm a pathologist.
Q. What is pathology?

A. Pathology is the field of medicine that studies disease and the impact of that -- and I'm using disease in a very broad term -- and the impact of that disease on the human body.

Q. What is a forensic pathologist?

A. A forensic pathologist is a pathologist who attempts to determine the cause and manner of death.

Q. What does it mean to be a board certified physician?

A. It means you've taken a test and passed it.

Q. Who administers the test?

A. American Board of Pathology.

Q. American Board of what?

A. Pathology.

Q. Are you board certified in anything?

A. Yes, ma'am.

Q. What are you board certified in?

A. In anatomic, clinical pathology.

Q. Are there any educational requirements for being a medical examiner in North Carolina?

A. Well, I can't -- of course, I don't know about now. But when I was the ME, I can't remember any requirements. You know, there's requirements to be an MD. But not specifically to be a medical examiner, not that I'm aware of.

Q. Are you a forensic pathologist?
A. Yes, ma'am.
Q. What do you need to be considered a forensic pathologist?
A. I completed a fellowship in forensic pathology.
Q. How long was your fellowship?
A. A year.
Q. When did you complete that?
A. That would have been back '93. I can't remember the month.
Q. Are you board certified in forensic pathology?
A. No, ma'am.
Q. Are you a member of any professional associations for forensic pathologists?
A. Yes, ma'am.
Q. What are those?
A. The NAME, the National Association of Medical Examiners.
Q. Are you a current member of the National Association of Medical Examiners?
A. Yes, ma'am.
Q. When did you become a member?
A. Several years ago. I couldn't answer that with any degree of certainty.
Q. Other than a fellowship in forensic pathology,

are there any other kinds of training that a forensic pathologist can undergo?

A. Can undergo?

Q. Uh-huh.

A. Yes, ma'am.

Q. What are those?

A. Well, I mean, you can do fellowships in other aspects of forensic pathology, such as neuropathology. And of course, there's continuing education courses offered all the time.

Q. After you completed your fellowship in forensic pathology, did you do continuing education courses in forensic pathology?

A. Yes, ma'am.

Q. Is that something you would do every year?

A. Several times a year.

Q. How were you employed at the time of this case, which was March 2011?

A. Well, I was employed by another company I owned, Pathology Associates of Boone. And I had a contract for the state to do forensic cases for an area of northwestern North Carolina.

Q. When you say you had a contract with the state, was that your employment as a medical examiner?

A. Yes, ma'am. Medical examiner and what they

used to call regional forensic pathologist. I'm not sure what they call it now.

Q. When did you begin that contract with the state?

A. It was probably in '93.

Q. 1993?

A. When I came to Boone.

Q. And you ended in 2013?

A. Yes, ma'am.

Q. So approximately 20 years you were a medical examiner in North Carolina?

A. About 20 years. Yes, ma'am.

Q. What areas of the state were you a medical examiner?

A. I had responsibility for Yancey County, Mitchell County, Avery County, and Watauga County. Although, on occasion, I would do autopsies for surrounding counties, as well.

Q. What were your duties as a medical examiner?

A. Well, as a medical examiner, one is tasked with reviewing a death, making the determination as to whether or not an autopsy is needed, and ordering the autopsy.

Q. Now you said you were a contract employee. Is that right?

A. Yes, ma'am.

Q. So you were not considered a state employee?
A. No, ma'am. I don't think so. I don't know. I don't know about the intricacies of that.
Q. What was the length of your contract as medical examiner?
A. It varied. It varied over several years.
Q. Would the contract usually remain in place for a few years, and then it would have to be renewed?
A. To the best of my recollection.
Q. Did anyone review your work as a medical examiner?
A. Yes, ma'am.
Q. Who -- who did those reviews?
A. Cases were always reviewed by another pathologist down at the Office of the Chief Medical Examiner.
Q. And when you say cases were always reviewed, does that mean every time you worked on a case, someone at the Office of the Chief Medical Examiner reviewed it?
A. Yes, ma'am.
Q. When you say they reviewed a case, what was part of their review? What were they looking at?
A. I don't know. You would have to ask them.
Q. What information did you provide to them for them to review?

A. I provided what's called -- or what used to be called a report of investigation for all the cases. And then the cases that were autopsied, I provided an autopsy report.

Q. When you had cases who were reviewed by the Office of the Chief Medical Examiner, did you ever have anyone who disagreed with your opinion?

A. I can't remember any cases.

Q. Did you have performance reviews as a medical examiner?

A. Not as such. The only reviews that I'm aware of were the -- the report reviews.

Q. Did you have anything in your contract that prevented you from offering a different opinion in a case from another North Carolina medical examiner?

A. Honestly, I've not looked at that contract in a long time. But I can't remember anything.

Q. Did you ever review anyone else's work as a medical examiner in North Carolina?

A. When I was doing my fellowship, I did review cases.

Q. Was that considered part of the educational component of the fellowship?

A. I assume. Yes, ma'am.

Q. What about after your fellowship, did you ever

review anyone else's work as a medical examiner?

A. On occasion, I did provide consultation services to people if they had questions about the medical examiner's autopsy.

Q. Did anyone in the medical examiner system ask you to review another medical examiner? I guess what I'm trying to get at, was there ever a time where you were asked to help out or look at someone else's case in the state as a medical examiner?

A. Not after I completed my fellowship.

Q. Okay. So there was nothing set up that was like a peer review system or anything like that?

A. No, ma'am.

Q. When you did provide consultation services, did you feel that you were free to give a different opinion from what the original medical examiner had provided?

A. Yes, ma'am.

Q. All right. I want to now shift focus to this case. How did you become involved with this case?

A. I would have to refer to my -- the report of investigation.

Q. All right. Before we do that, I just want to show you -- this has been previously marked as Exhibit 3. This is information that I obtained from the Watauga Medical Center. And according to them, it's all the

information that they had. Do you recognize Exhibit 3.

[Exhibit Number 3 identified.]

A. [Witness reviews document.] Yes, ma'am. I do recognize Exhibit 3.

Q. I'm also going to show you Exhibit 4. Exhibit 4 is everything that I obtained from the Office of the Chief Medical Examiner. Can you take a minute to look through Exhibit 4?

[Exhibit Number 4 identified.]

A. [Witness reviews document.]

Q. Okay. Now looking at -- do you recognize Exhibit 4?

A. I recognize most of Exhibit 4. I don't recognize the cover page. And the death certificate is a very poor copy.

Q. Did you obtain, yourself, from either the Office of the Chief Medical Examiner or Watauga Medical Center anything in addition to what is in Exhibit 4 and 3?

A. No, ma'am.

Q. When I look at Exhibit 5, the only thing that I see that's additional is, it looks like you obtained the autopsy photos via e-mail from Brenda Rush Taylor.

A. Correct.

Q. Okay. And there is an e-mail at the top that

just says, here are the pics we have, it might help jog your memory.

A. Yes.

Q. Okay. So that's -- that's the only thing in addition to what I've shown you in Exhibit 3 and 4. Is that right?

A. Yes, ma'am.

Q. All right. I will also give you 5, if that will help. But I believe Exhibit 3 and 4 have all the information, as well.

So going back to that question, how did you become involved in this case?

A. I was contacted by the Yancey County sheriff's department.

Q. And what information did you learn from the Yancey County sheriff's department?

A. Well, let's go back to the previous question. I was contacted either by the Yancey County sheriff's department or Yancey County EMS. I can't remember.

Q. And why did they contact you?

A. Because they had a decedent.

Q. What information did they provide to you?

A. I can't remember specifically.

Q. Did anyone ask you to go to the scene?

A. Not to my recollection. However, I will say

that with all of my medical examiner cases, I ask if I'm needed at the scene. That was -- that was routine.

Q. Did you ask if you were needed at the scene in this case?

A. That was my routine. So I assume I did. Do I remember that specifically? No.

Q. I'm going to hand you what I am marking as Exhibit 6. This is a police report from the Yancey County Sheriff's Office. If you could review Exhibit 6, please.

[Exhibit Number 6 identified.]

A. [Witness reviews document.]

Q. Okay. On page 3 of Exhibit 6, there is a sentence that states, quote, Medical Examiner Brent Hall of Watauga Medical Center was contacted by telephone and made aware of the death, at which time he agreed to receive the body for autopsy, end quote. Is that right?

A. Yes, ma'am. That's what it says.

Q. Does this report refresh your memory about what information was provided to you?

A. No.

Q. Do you know what circumstances, or what inform -- let me start over. Do you know what information was provided to you about the death by the Yancey County sheriff's department?

A. I can't remember.

Q. You did not go to the scene in this case. Is that right?

A. I don't recall going to the scene. No, ma'am.

Q. I didn't -- in my review of this file, I have not seen anything to indicate that you went to the scene. And I'll represent to you that you testified that you didn't go to the scene. Why didn't you go to the scene in this case?

A. Well, as I said, it was my routine to ask if I was needed at the scene. And I depended on law enforcement and/or EMS to provide me that information.

Q. Why did you rely on them?

A. I always did.

Q. And what types of cases would law enforcement tell you it was necessary to come to the scene?

A. If there was, for instance, a gunshot wound, they routinely called me out to the scene for those type cases.

Q. In what types of cases would you typically go to the scene in?

A. Is that the same question you asked me before?

Q. Well, you just said gunshot cases.

A. Yes, ma'am.

Q. Are those the only types of cases you would go

to the scene for?

A. No. Any time that law enforcement or the EMS would ask me to come to the scene, I would go.

Q. How often would you go to the scene to investigate a death?

A. Whenever I was asked.

Q. And what kind of a percentage of cases was that, where you would go to the scene?

A. I can't give you a number for that.

Q. I'm handing you what I've previously -- what I'm marking as Exhibit 7. This is your trial testimony from this case. If you would turn to page 256, please. And if you read line 1 through 13.

[Exhibit Number 7 identified.]

A. [Witness complies.]

Q. So you testified at this trial that you did not go to the scene of this case. Is that right?

A. That's what the document says.

Q. And you testified that you went to a few scenes for the last 100 autopsies that you had done. Is that right?

A. That's what the document says.

Q. And the trial was back in 2014. So at least in 2014, for the 100 previous autopsies that you performed, you went to a few scenes. Is that right?

A. That's what the document says.
Q. Is that true?
A. I can't remember.
Q. Is it fair to say that based on your testimony at trial back in 2014, in this time frame, it was your practice to only go to a small percentage of the scenes for the deaths that you were investigating?
A. Repeat the question, please.
Q. Back in the time frame of this case -- so you went to trial in 2014, and testified that you went to a few scenes for the last 100 autopsies that you have performed. Correct?
A. That's what the document says.
Q. So is it fair to say that back in 2014, you were -- it was your practice to go to a small percentage of the scenes for the deaths that you were investigating?
A. I wouldn't agree with that statement.
Q. And why not?
A. Because those are broad terms, few and small percentage.
Q. What does few mean to you?
A. Few means a percentage of the total.
Q. Did you go to less than 50 percent of the scenes?
A. I don't remember that.

Q. Okay. Let's move on to the autopsy. Generally speaking, what does the autopsy process look like? Can you walk me through it?

A. Yes, ma'am. Well, the autopsy starts with an external exam in which you note the clothing that the decedent is wearing, and any abnormalities that can be identified. Then the clothing is removed. Well back up a second. Photographs are taken at that time. The clothing is removed. Additional photographs are taken.

The body is measured and weighed. A complete external examination noting external characteristics such as color of their hair, color of the irises, pupil size, that sort of thing. And also noting if there is any external wounds to the body.

Typically a vitreous sample is obtained, if possible.

Q. Can I stop you there. What is a vitreous sample?

A. It's the fluid in the eye.

Q. Okay. Proceed.

A. Okay. Then one proceeds -- oh, before doing that, typically a femoral blood sample is obtained. Then one proceeds with a Y-shaped incision of the chest and the abdomen in which the -- the neck, the thoracic, the abdominal, and the pelvic organs are exposed. Each organ

is removed and examined grossly. And sections of each organ are obtained for possible microscopic examination.

At that time, a central blood sample, typically from the heart or aorta, is also obtained. And of course, any abnormalities, deformities, wounds are noted at that time, as well.

Then one proceeds to examination of the cranium with a ear-to-ear incision across the top of the cranium. Pulling back of the scalp, exposing the skull. Removal of the skull cap. Then removal of the brain for examination.

Now, each autopsy may have slight variation. For instance, if the -- a patient had a possible brain infection, say, a cerebral spinal fluid sample would be obtained, as well.

Q. Okay. You mentioned earlier you take a femoral blood sample.

A. Yes, ma'am.

Q. Where is that located on the body?

A. That's in the inguinal region.

Q. In the what?

A. Inguinal region.

Q. Where is that?

A. At the top of the legs.

Q. All right. Looking at Exhibit 3 and 4 that I

provided to you which came from the Office of the Chief Medical Examiner and Watauga Medical Center, are you aware of any additional argument -- excuse me -- documents that were produced related to this case?

A. No.

Q. Did you take notes?

A. Yes, ma'am.

Q. When did you take notes?

A. During the autopsy.

Q. What happened to those notes?

A. They were destroyed by water.

Q. Were the notes the only thing additional that was produced in this case that was destroyed in your flood?

A. Well, obviously, I don't have that material in front of me, so I can't really be sure. That would most likely be all. Yes, ma'am.

Q. Would the hospital have all the photographs that were taken during the autopsy?

A. Yes, ma'am.

Q. When did you do the autopsy?

A. 3/7/2011.

Q. What time did the autopsy start?

A. 11:30.

Q. Where did the autopsy take place?

A. At Watauga Medical Center.

Q. When you began the autopsy, what information did you have about the case?

A. I can't remember.

Q. What kind of information would you typically have before you started an autopsy?

A. I would typi -- going back to the question about records that would be destroyed. I could have had EMS notes and sheriff's notes in there, as well. I'm not saying I did. But I could have.

Q. Would EMS and the sheriff provide those notes prior to the autopsy beginning?

A. Most of the time. Yes, ma'am.

Q. And if you look at Exhibit 7, which is your testimony from trial, on page 243. If you look down towards the bottom of the page, lines 21 through 25, please.

A. [Witness complies.]

Q. So during the trial you testified you did not talk to any of the family members of the decedent. Is that right?

A. That's what it says.

Q. And it's possible that you talked with Lieutenant Farmer. Is that right?

A. That's what the document says.

Q. But you were not sure.

A. If you're asking me if I remember, I don't remember.

Q. And based on your testimony at trial, you did not -- you weren't sure if you had had a conversation with Lieutenant Farmer or not about this case.

A. That's what the document says. And I might say that I feel disadvantaged by not having this document prior to this deposition to review.

Q. So what we can do is, we can take a break right now, and you can review the document, which is all of your testimony.

A. Well, I feel that that's not sufficient time. That I would need more time to review and digest this document than a quick review under pressure at a deposition.

Q. Well, I am giving you the opportunity now to review it. And if you remember something, then that's what you're here for is to let me know. If you don't remember, then that's your answer.

A. Well, and I understand that. Again, I just feel at a disadvantage because I did not have this prior to giving this deposition.

Q. All right. Well, let's -- let's take a break. We can take a break. Take a break, and I would like for

you to review Exhibit 7. So that may help you refresh your memory for today.

A. Okay. And again, I would like to say that I don't think that's adequate time to fully review and digest.

Q. Okay. All right. Let's take a break.

MS. BRIDENSTINE: We're going to go off the record. It is approximately 1:10 p.m. We will check in maybe in 15 minutes to see how you're doing. Okay?

THE WITNESS: Okay.

MS. BRIDENSTINE: All right.

[Recess from 1:10 p.m. to 1:36 p.m.]

MS. BRIDENSTINE: We are back on the record. It is approximately 1:36 p.m. Present in the room is myself, Julie Bridenstine, Brian Ziegler, and Dr. Hall.

Q. Dr. Hall, did you have enough time to review Exhibit 7 during the break?

A. I reviewed Exhibit 7 during the break. Yes, ma'am, I did. And also, one of your previous questions, I can't remember whether I told you or not that I am under treatment by a neurologist for the head trauma, as well.

Q. Okay. All right. And what kind of treatment are you receiving for that?

A. Well, he put me on some medication. And he is observing me periodically to -- to see if the symptoms get any better.

Q. What symptoms are you experiencing?

A. Memory loss.

Q. Is it -- is there anything in addition to the memory loss?

A. Well, I have -- I've heard it pronounced two ways. Ten-ne-tus [phonetic] and ten-i-tus [phonetic] from the car crash, as well. So he thinks that my auditory nerve was involved during the concussion, too. So --

Q. All right. Are you taking any medications prescribed by the neurologist?

A. I was. But I couldn't tolerate the medication.

Q. What was the medication supposed to do?

A. It was supposed to help with my headaches, which it did. But I'm -- I couldn't go to the bathroom a lot, so I had to stop.

Q. Are you experiencing any symptoms right now?

A. No.

Q. Do you have a headache right now?

A. Slight.

Q. Do you feel okay?

A. Yeah. That's -- I have a low-grade, constant

headache anymore.

Q. All right. Well, let me know if you need to take a break for any reason.

A. I will.

Q. When did you receive the documents in Exhibit 5 from the Office of the Chief Medical Examiner and Watauga Medical Center?

A. I would say either last week or earlier this week. I can't remember.

Q. And you have had a chance to review those documents prior to today?

A. Yes, ma'am.

Q. All right. Now that you've had a chance to review Exhibit 7, did it help refresh your memory regarding what information you had about this case when you began the autopsy?

A. It did.

Q. All right. What information was provided to you before the autopsy?

A. Well, according to the document, I received some information from the Yancey County sheriff's department.

Q. What information did you receive?

A. I can't remember whether it said or not. I'm not sure at that time if I received a written -- written

documentation of the scene investigation or it was just a oral transmission.

Q. What kind of information was usually provided to you by law enforcement prior to beginning an autopsy?

A. If they knew the decedent, a brief history of the decedent. And findings at the scene.

Q. Did you -- at the time you started the autopsy, did you know when Mr. Whitson, the decedent, allegedly took drugs prior to his death?

A. No.

Q. Is that type of information helpful for a medical examiner?

A. If he can get it. Yes, ma'am.

Q. When you began the autopsy, did you know what drugs Mr. Whitson was alleged to have taken prior to his death?

A. I can't remember.

Q. Did you know how Mr. Whitson allegedly took drugs prior to his death?

A. I can't remember.

Q. I want to move on now to your autopsy report. And so, if we could look at Exhibit 4. I'll be referencing this exhibit a lot.

A. Okay.

Q. All right. You told us a little bit earlier.

But what is the external description of the autopsy report? Again, what are you doing during that?

A. Just documenting the external features of the body. How the body was received. What clothing the body had. You know, things like weight, size, length, hair color, eye color, that sort of thing.

Q. If you turn to page 2 of your report, which is actually page 3 of Exhibit 4.

A. Okay.

Q. There is a descriptive part that says livor, colon, posterior/purple. What does that mean?

A. Where is that at?

Q. It's on page 3 of Exhibit 4, which is page 2 of your autopsy report, towards the top.

A. Liver?

Q. It says l-i-v-o-r.

A. Oh, livor.

Q. Livor. Okay. I said it wrong.

A. Oh, I'm sorry. That's the color of the body. It comes about from the settling or the pooling of the blood within the body.

Q. What does posterior/purple mean?

A. Well it means the color was purple, and that the livor had a posterior distribution.

Q. What does posterior distribution mean?

A. It means it was predominantly on his back.
Q. What does that indicate to you?
A. That the decedent was lying on his back with the livor became fixed.
Q. Is that something that happens after death?
A. Yes, ma'am.
Q. Does livor happen in all deaths?
A. Yes, ma'am.
Q. So is it fair to say that it shows you how the body was placed when a person dies?
A. Well, livor becomes fixed at a certain period after death. For instance, if a person died on his back, but was flipped over prior to livor fixation, then the livor would become fixed anteriorly, which would not indicate the position at the time of death. If that makes sense.
Q. It does. All right. If we could turn to page 7 of Exhibit 4, which is titled, Report of Investigation by Medical Examiner. It appears that this particular report goes from page 7 through 10 on Exhibit 4. Is that right?
A. Yes, ma'am.
Q. When did you fill out this Report of Investigation by Medical Examiner?
A. Well, at the bottom of the report it says

3/7/11.

Q. Is this something that you fill out prior to the autopsy or after?

A. Typically after.

Q. And where did you get the information about occurrence on page 7 of this report -- of this exhibit. Excuse me. Looks like it's the second box at the top.

A. Occurrence. Oh, oh. Information about occurrence. That -- well, the first two lines would have been provided by the -- in this case, the sheriff's department. And of course, the -- well, and then the last line, too. And then the third and fourth lines would have been provided by me.

Q. What is the box that is designated as OCME review on page 7?

A. That's where a pathologist from the Office of the Chief Medical Examiner reviews the case.

Q. Do you know who reviewed this case?

A. No, ma'am. I can't make it out.

Q. And where did they get the information for this section?

A. I'm not sure. You'd have to ask them.

Q. The line number 1 that says morphine toxicity, is that something they get from reading your report?

A. Well, again, you'd have to ask them.

Q. The box that's checked to the side that says AL, what does that mean?

A. I don't know.

Q. And the contributing conditions, they have accident marked off.

A. Yes, ma'am.

Q. What does that mean?

A. Well, that's the manner -- well, you're -- I think you're misreading the box there. You see it's got number 1, due to, number 2, due to, number 3, due to, number 4. And then down here at the bottom, it's got contributing conditions. And that would be other conditions related to the -- to the death. For instance, if he had congestive heart failure, that would be listed there. If he had a brain tumor, that would be listed there. Conditions that are not directly -- that the decedent has, but not directly related to the cause of death.

Q. Are listed in boxes 2 through 4?

A. No. See, that's the -- that would be a whole sequence. Box 2 through 4. Oh, yeah. That would be -- I mean, she could have -- she could have put in there -- or he -- you know, morphine toxicity due to ingestion of morphine tablets, or due to morphine injection. Does that make sense?

Q. Uh-huh. So the accident box, is it fair to say that that is indicating that the morphine toxicity was an accident?

A. Yes.

Q. It wasn't done intentionally?

A. That whole line there, natural acts, homicide, suicide, undetermined, is the manner of death.

Q. Okay. All right. And this reviewer, it looks like they reviewed your autopsy report on 7/6/2011.

A. That's what it says.

Q. So this was after you finalized your autopsy report? And if you look at page 2, your report is dated.

A. Yes, ma'am. It would have been.

Q. All right. So you finalized your autopsy report on May 31st, 2011?

A. Yes, ma'am.

Q. And it was your practice to then provide these documents to OCME for them to review?

A. Correct.

Q. Did you ever talk to the reviewers who reviewed your cases?

A. I can't remember ever talking to one.

Q. That would include in this case, as well?

A. I don't remember talking to anybody about this case.

Q. If you'd turn to page 8 on Exhibit 4, under means of death. The toxic agents suspected box is checked. Correct?

A. Yes, ma'am.

Q. And there's also a box that's checked, others.

A. Yes, ma'am.

Q. What is the handwriting next to others?

A. MS04.

Q. What does that mean?

A. That's just the medical abbreviation for morphine.

Q. And where did you get the information for the means of death section?

A. I don't remember for sure. But it was likely from the investigating officers.

Q. I notice on page 9 that the body diagram is blank with a handwritten note that says, see autopsy report. Is that right?

A. Yes, ma'am.

Q. Is that because you had already filled it out on the autopsy report on page 6?

A. Well, I can't remember for sure. But typically how I did it was, if an autopsy was being performed, I did not fill out the body diagram portion of the report of investigation because that would have been redundant,

for one. And if there was some sort of discrepancy between the two, then that would have to be explained.

Q. When did you do the body diagram?

A. When I did the autopsy.

Q. Can you tell me what the handwritten notes on the body diagram say on page 6 of Exhibit 4?

A. Yes, ma'am. Well, looking at the front, on the right arm, it says tattoo. And then if you'll go over on the left arm, it's got a question mark, needle marks. Then in the inguinal area, it's got abrasions up to 2.8 centimeters. On the dorsal aspect to the right hand, it's got 0.5 centimeter abrasion. Then on the left heel, it's got 2.6 -- 2.0 centimeter ulcer.

Q. What did the abrasions on Mr. Whitson's body on -- looks like they're close to his groin. What did those look like?

A. I can't remember.

Q. Do you know why Mr. Whitson had those abrasions there?

A. No, ma'am.

Q. Based on your body diagram, it looks like those abrasions are pretty symmetrical. Is that fair?

A. It appears such. Yes, ma'am.

Q. Do you have any idea what could have caused symmetrical abrasions like that?

A. No, ma'am.
Q. What did the ulcer on the left heel look like?
A. Must have looked like an ulcer. I can't remember any detail.
Q. What does ulcer mean?
A. Ulcer is an area that's damage to the skin and typically to the subcutis.
Q. Your trial testimony that you reviewed in Exhibit 7 described it as shoes rubbing, looking like that.
A. I think I was asked if that could cause it. And I replied in the affirmative.
Q. So is a blister an ulcer?
A. No. But if a blister becomes ruptured and gets infected, it could become an ulcer.
Q. Did this ulcer on his heel look infected?
A. I can't remember that.
Q. And you said that the needle marks location on this body diagram had a question mark in front of it.
A. Yes, ma'am.
Q. Why is there a question mark in front of it?
A. I'm not sure now. I can't remember why there's a question mark there.
Q. Does the question mark -- could it possibly mean that you weren't sure if they were needle marks or

not?

A. Probably signifies some degree of ambiguity.

Q. What did those marks look like on Mr. Whitson's arm?

A. I can't remember any detail.

Q. It looked to me on the body diagram that you had found multiple marks on his left arm. Because it looks like you have two lines going on each side of his arm. Is that accurate?

A. I would agree.

Q. So does that mean it -- I don't -- what is the area called on the inside of your elbow?

A. Antecubital fossa.

Q. Okay. So you indicated there were marks on that part of his left arm?

A. Yes, ma'am.

Q. And it also looks like you're indicating that there were marks on the other side of his arm, down towards his wrist?

A. The dorsal aspect of the forearm. Yes, ma'am.

Q. All right. And are both of those areas typically where people can inject drugs into their veins?

A. It's not unusual to have injections in both of those areas.

Q. How did Mr. Whitson's left arm appear to you?

A. How did his what appear?

Q. How did Mr. Whitson's left arm appear to you?

A. Well, I can't remember. The only reference I have is the autopsy background.

Q. How did Mr. Whitson's left arm appear to you in relation so his right arm?

A. Well, evidently his left arm had needle marks, and his right arm did not.

Q. Did you see any swelling in Mr. Whitson's left arm?

A. None was noted.

Q. Did you see any swelling in his left arm?

A. I can't remember. But none was noted in the autopsy report.

Q. Can you turn to page 10 of Exhibit 4. This looks like it's the last page of the Report of Investigation by Medical Examiner. Is that right?

A. Yes, ma'am.

Q. Then the title of this page is Narrative Summary of Circumstances Surrounding Death. Correct?

A. Yes, ma'am.

Q. Could you read what is written there?

A. Yes, ma'am. Oh, you want me to read it out loud?

Q. Yes. Sorry.

A. Okay. Mr. Whitson was a 29 year old released from jail in Madison County 3/4/11. On 3/5/11 he is alleged to have taken morphine with his girlfriend. The next morning he was found dead in bed. Autopsy was requested by the Yancey County Sheriff's Department.

Q. Where did you get this information?

A. Well again, I don't remember. But in all likelihood from the investigating officers.

Q. And when was this information provided to you?

A. I don't remember that.

Q. Was this information provided to you before you began the autopsy?

A. I can't say for certain, but in all likelihood.

Q. What was your practice about filling out this Report of Investigation by Medical Examiner? At what point would you typically fill it out when you were doing autopsies?

A. Well, as stated earlier, I would typically fill it out at some point after doing the autopsy. That's not to say that on occasion it was filled out before.

Q. And as we previously pointed out, this form is dated the same day that you did the autopsy.

A. It is.

Q. All right. So it was done on March 7, 2011?

A. Yes, ma'am.

Q. Going back to whether or not Mr. Whitson's left arm had any swelling. Would you normally note swelling if you saw that?

A. Yes, ma'am.

Q. Did you take photographs during the autopsy?

A. Yes, ma'am.

Q. Who took the photographs?

A. I don't remember whether it was myself or Ms. Coffey.

Q. Who is Ms. Coffey?

A. Irene Coffey is a pathology assistant.

Q. Why did you take the photographs that you took in this case?

A. Well, I said I'm not sure I took them. Irene may have taken them. But we always take a, quote, mug shot, end quote, in every case.

Q. What's a mug shot?

A. It's a facial identification shot.

Q. When did you take -- or when did either you or Ms. Coffey take the photographs in this case?

A. Well again, I don't remember. But the routine is to take the photographs either prior to unclothing the decedent, after unclothing the decedent, prior to starting the autopsy incisions, or both prior to taking the clothing off and after taking the clothing off.

Q. If you look at Exhibit 3, the last pages of this exhibit, are these the photographs that were taken during Mr. Whitson's autopsy?

A. They appear to be.

Q. Were any additional photographs taken of Mr. Whitson other than these three?

A. Not that I'm aware of.

Q. Are these three photos, are they considered identification photos?

A. Yes, ma'am.

Q. If you look at the photographs, it looks like Mr. Whitson has maybe some discoloration to the skin on his shoulders, on his face. It looks red. Are you seeing what I'm seeing?

A. Yes, ma'am.

Q. What is that?

A. That's livor.

Q. And that's something that you see in every decedent?

A. Yes, ma'am.

Q. What is the brown substance that appears to be coming of Mr. Whitson's right nostril?

A. I'm not sure at this point. But it appears to be mucous.

Q. Does that mucous indicate anything to you?

A. No, ma'am.
Q. Why didn't you take photographs of the needle marks that you noted on Mr. Whitson's left arm?
A. I'm not sure.
Q. Are needle marks relevant in a death investigation involving a suspected drug overdose?
A. They are.
Q. Why didn't you take any photographs of any other areas of Mr. Whitson's body other than his head and the top of his shoulders?
A. I don't remember.
Q. And why didn't you take photographs of the injuries that you noted on Mr. Whitson's body diagram?
A. I don't remember.
Q. Was it your practice to take photographs of injuries that you noted on a body during an autopsy?
A. Yes, ma'am.
Q. Moving back to your autopsy report in Exhibit 4, if you could turn to page --
A. And I could -- I might say that the photographs may have been taken, but for some reason they were not downloaded or -- I mean, who knows.
Q. Who was in charge of downloading the photographs?
A. That would have been Irene, Ms. Coffey.

Q. Did you ever have any cases in which Ms. Coffey did not download all the photographs that were taken during an autopsy?

A. I can't remember that.

Q. If you could please turn to page 4 on Exhibit 4. Or excuse me, page 3, before we go to 4. There is a section of your report entitled additional procedures. What is that section?

A. Well, just as listed there. That says x-rays were taken or cultures were taken or chemistry was performed.

Q. All right. So radiographs, that would be x-rays. Correct?

A. Yes, ma'am.

Q. Microbiology cultures. And then what is the chemistry section?

A. That is chemistries that were performed on the vitreous.

Q. What do those levels mean?

A. Well, it depends. The -- you know, you're measuring electrolytes and certain metabolites in the body. For instance, you know, the glucose level. If the patient had of been in diabetic ketoacidosis, and had died from that, then you would expect a really increased level of glucose. The electrolytes are primarily a

measurement of the hydration status. And the urea nitrogen is a measure of kidney function.

Q. Do the levels noted on Mr. Whitson's chemistry section indicate anything abnormal to you?

A. No, ma'am.

Q. And you said that was taken from the eye, the vitreous?

A. Yes, ma'am.

Q. All right. What is the internal examination section?

A. That is where you make the Y-incision and examine all the internal organs.

Q. All right. Regarding the cardiovascular system, which is on page 4 of Exhibit 4.

A. Yes, ma'am.

Q. You noted that quote, sections of the heart demonstrate mild concentric ventricular hypertrophy, end quote. What does that mean?

A. It means that his left ventricle was slightly enlarged.

Q. What causes that?

A. A number of things can cause it. You know, it just means there's -- one cause would be increased stress on the heart, either from hypertension or other processes. It could be congenital in nature. He could

have a hypertrophic cardiomyopathy.

Q. And what is that?

A. It's a congenital enlargement of the heart.

Q. Could that be related to cause of death?

A. In some cases. Yes, ma'am.

Q. How does it contribute to death?

A. It can lead to cardiac arrhythmias.

Q. How do you know if someone had cardiac arrhythmias when you are doing an autopsy?

A. Well, you know, the -- in most autopsies, the final mechanism for cause of death is some sort of cardiac arrhythmia. You know, if there's -- you can take sections of the conduction system and look for abnormalities in the conduction system. Or you can do -- I'm not sure this was available in 2011. But now you can do DNA analysis to look for congenital anomalies.

Q. Did you do that in this case? Did you look for conduction system?

A. No.

Q. Did you do DNA testing?

A. None is noted.

Q. Do you know if Mr. Whitson had a cardiac arrhythmia?

A. Well, as I said, in most cases, the actual final mechanism of death is a cardiac arrhythmia. So in

all likelihood he had one in the agonal stages.

Q. Okay. Is there a way to know for sure if someone had one or not?

A. Well, other than them having an EKG strip, no.

Q. So it is possible that his mild concentric left ventricular hypertrophy contributed to death in this case?

A. It may have been a contributing factor. Yes, ma'am.

Q. Could it have caused the death?

A. Not in my opinion.

Q. And why is that?

A. Because the morphine in his system, in my opinion, was the cause of death.

Q. You also note under this section under the respiratory tracts, lung section, quote, Sectioning demonstrates marked edema and congestion, mild emphysematous change is also identified in the lower trachea, and major bronchi are unremarkable, end quote. What is marked edema and congestion in the lungs?

A. Well, in layman's terms, it would be water on the lung.

Q. What causes that?

A. Well, for instance, in a drug overdose, the -- especially with morphine, the -- it's a respiratory

depressant. It acts on the primitive area of the brain. And so the body is not oxygenating well. And so the lungs do what they can do to help oxygenate the body. So the capillaries, the alveolar spaces in the lungs will open up, the capillaries in the lungs will open up as much as they can. And when the capillaries open up, the endothelial cells which line the capillaries get really stretched. And their connections to one another get really stretched. And plasma leaks from the bloodstream into the lung parenchyma. And that's what causes the edema. The congestion is blood vessels dilating really big to try to help with oxygenation.

Q. Can something other than drugs cause marked edema and congestion in the lungs?

A. Yes, ma'am.

Q. What other things can cause that condition?

A. Heart attack.

Q. Anything else?

A. Yes, ma'am. There's a litany of things.

Q. What are some examples?

A. Well, if a person is smothered or strangulated. Anything that's going to impair oxygenation of the body can cause this.

Q. Could an illness cause marked edema and congestion in the lungs?

A. Sure.
Q. So a virus can cause it?
A. Virus can cause it. Yes, ma'am.
Q. Can bacteria cause it?
A. Yes, ma'am.
Q. Is it something that you typically see in pneumonia?
A. You can see that in pneumonia. You can. Yes, ma'am.
Q. What is mild emphysematous change?
A. Emphysematous.
Q. Sorry. I'm going to pronounce all these medical terms wrong. And I apologize.
A. No. That's fine.
Q. So please correct me.
A. Okay. That just means that his alveolar spaces were somewhat dilated.
Q. What causes that?
A. Most commonly, smoking.
Q. Can anything other than smoking cause it?
A. Sure.
Q. What else?
A. Well, pneumoconiosis. Exposure to toxic chemicals, exposure to toxic metals, that sort of thing.
Q. And what did the mild emphysematous change

indicate to you?

A. That he was probably a smoker.

Q. What did you see when you looked at Mr. Whitson's lungs during the internal examination?

A. Well, just what was noted there in the autopsy report.

Q. Was there anything that you could have done during the internal examination in this autopsy that you did not do?

A. Well, I mean, there's lots of things you could have done.

Q. Can you give me some examples?

A. Well, I mean, could have taken injections for culture. And I could have examined his testicles. You know, I could have taken the spinal cord. But at the time of autopsy, I saw no reason to do those procedures.

Q. Can you look inside someone's arms or legs?

A. Well, you can do -- yes, ma'am. You can do cut-downs and look inside somebody's arms or legs.

Q. And when you said you could do cultures, what kind of cultures can you do?

A. Well, you could do bacterial cultures or bile cultures.

Q. Why would you do a bacterial culture in an autopsy?

A. Well, if there's gross evidence of pneumonia or consolidation of the lungs, then you could do one. Or if there is a clinical history of pneumonia.

Q. Why didn't you do a bacterial culture in this case?

A. I saw no evidence of consolidation.

Q. What is consolidation?

A. That's a change that you see in the lungs associated with bacterial pneumonia.

Q. What does it look like?

A. The lung gets hard, and typically more red in that area.

Q. Did you examine the entire lung?

A. Yes, ma'am.

Q. Both lungs?

A. I assume I did.

Q. Do you know if you did?

A. Well, I can't remember.

Q. Why didn't you do viral cultures in this case?

A. Well, cultures typically are not done in a -- in a case like this. Our cultures are expensive. And actually, they are very low yield.

Q. Why do pathologists do viral cultures during autopsies? What would be the reason to do them?

A. If they had clinical evidence of some sort of

viral pneumonia.

Q. What indicates that there could be viral pneumonia during an autopsy?

A. Well first, a clinical history. And then you may see areas of consolidation.

Q. What is a clinical history?

A. Clinical history is the doctor that was taking care of the patient says, I think he's got COVID-19 pneumonia.

Q. Do you have any information in this case that Mr. Whitson was ill prior to his death?

A. There's none documented.

Q. Is that something you would typically try to find out, if someone was ill before they died?

A. I'm usually furnished that information. Yes, ma'am.

Q. Who furnishes the information to you?

A. Well, either the attending physician, the EMS, or sometimes the investigating agency.

Q. Could you have gotten blood cultures in this case?

A. Could have.

Q. And what are blood cultures for?

A. Typically sepsis.

Q. What are the signs of sepsis?

A. That the patient usually experiences multi-organ failure.

Q. And what is sepsis?

A. Sepsis is the distribution of an infectious agent throughout the body.

Q. When you say there's multiple-organ failure, how do you determine that during an autopsy if that's going on?

A. Well, that would be hard to determine just on gross examination. You may see signs, again, of vascular congestion in the lungs. You may see signs of hepatic congestion. The kidneys may be large and edematous. They're all soft findings.

Q. What does that mean, soft findings?

A. They are not a bullet wound to the heart.

Q. What do you mean by that?

A. Well, they could be caused by other things. By things other than sepsis.

Q. Is it difficult to determine, just based on the internal examination, if a person had sepsis?

A. Well, you could get a suggestion that they may have sepsis. But actually, the diagnosis would be made on microscopic examination.

Q. And the microscopic examination of what?

A. The organs.

Q. And which organs?

A. All the organs.

Q. All of them. What is the blood culture for in relation to sepsis?

A. It'll tell you -- it will hopefully tell you the organism that's infecting the body.

Q. Is it possible that Mr. Whitson had sepsis in this case?

A. I don't think so.

Q. Why don't you think so?

A. Because the -- the liver and the kidneys appeared relatively normal. Then on microscopic examination I saw no evidence of sepsis.

Q. Do you always see evidence of sepsis on the microscope in cases in which people had sepsis?

A. Not always.

Q. So it's possible someone has sepsis and you don't see evidence of it in their organs?

A. That would be unusual if they have not been treated with antibiotics. If they've been treated with antibiotics, then you may not see signs of sepsis in the organs.

Q. Moving on to the microscopic section of the autopsy on page 4 of Exhibit 4, what did you see on the slides of the heart?

A. Well actually, I notice there's a typographical area -- error there.

Q. What's that?

A. Instead of myelocyte hypertrophy, that should be myocyte hypertrophy.

Q. What's the difference?

A. Well, myocyte is a cell that makes up the heart. And myelocyte is a white blood cell.

Q. Is there such a thing as mild myelocyte hypertrophy?

A. Well, I mean, if you had an increase in myelocytes in the white blood cell component of your blood, I guess some people could refer to that as hypertrophy. For instance, if you had a myelocytic leukemia of some sort.

Q. Is that mild myelocyte -- or you said it should be myocyte.

A. M-y-o. Yeah. Myocyte.

Q. Okay. Hypertrophy. Is that the same thing as what you noted in the internal examination of the mild concentric left ventricular hypertrophy?

A. That's the microscopic equivalent.

Q. Okay. What did you see on the slides for the lungs?

A. The lungs -- I'm just reading from the report

here. The lungs demonstrated marked edema congestion, moderate acute bronchial pneumonia present, perihilar lymph nodes contain granulomas with birefringent material.

Q. What do you see on those slides that show you that there's marked edema and congestion?

A. You see fluid within the alveolar spaces and dilated blood vessels.

Q. What is moderate acute bronchial pneumonia?

A. He had -- evidently he had some neutrophils, which is a type of white blood cell, in the alveolar spaces.

Q. Does that always indicate that there is acute bronchial pneumonia?

A. That's an indication of pneumonia. Yes, ma'am.

Q. Are there additional indications?

A. Well, you know, you have -- typically have the accompanying edema. You may have reactive pneumocytes, as well.

Q. Did he have those?

A. I can't remember that.

Q. What are perihilar lymph nodes?

A. Those are the lymph nodes of the hilum, which is the area at the base line, where the trachea splits and the -- into the bronchus, into the right and left

bronchus. There is soft tissue in that area which typically contains lymph nodes.

Q. So you indicated that they had granulomas --

A. Yes, ma'am.

Q. -- with birefringent material.

A. Yes, ma'am.

Q. What is that?

A. The granulomas are composed of another type of white blood cells. If they are circulating in the blood, they are called monocytes. If they are in the tissue, they're called histiocytes. And often in tissues, they will coalesce to form giant cells. And this coalescence of histiocytes is referred to in the pathology literature as granulomas.

Q. What does it mean that they had birefringent material? What is birefringent material?

A. Okay. Birefringent material is typically a crystalline material in the cytoplasm of a macrophage that under polarized light will emit birefringence. Which means it changes color under polarized light.

Q. What does that indicate?

A. Well, in this case it likely indicates talc. And talc is a substance that's commonly used to cut illicit drugs.

Q. Is it present in pills?

A. It can be present in pills. Yes, ma'am. Present in baby powder.

Q. But it's okay for people to swallow talc?

A. Well, it's an inert substance typically.

Q. So is it something that's usually present in pills?

A. That's beyond my field of expertise.

Q. Can the birefringent material be something other than talc?

A. Yes, ma'am.

Q. What other kinds of things?

A. Well, it could be other types of crystal material. You know, again, there's a litany of things that it could be. And the only way to know for sure that it's talc will be to do special studies on the birefringent material.

Q. Can you see birefringent material in cases that don't involve drug use?

A. Yes, ma'am.

Q. Do you typically see birefringent material in drug overdoses?

A. You occasionally see birefringent material.

Q. Are you aware of any preexisting conditions that Mr. Whitson might have had?

A. No, ma'am.

Q. At the time that you did this autopsy, were you aware of any preexisting conditions that Mr. Whitson might have had?

A. I don't remember.

Q. Are you aware of Mr. Whitson's medical history?

A. I can't remember. I think that I was furnished some history of drug use by the law enforcement agency. But I can't remember anything other than that.

Q. What is an abscess?

A. It's an infection.

Q. Can an abscess cause bronchial pneumonia?

A. Can an abscess cause -- well, if it had a type of -- yeah. I mean, it could spread to the lungs and cause bronchopneumonia. I mean, either by sepsis, or if it was a lung abscess, by direct extension.

Q. Can an abscess cause a fever?

A. Yes, ma'am.

Q. Did you see any abscesses on Mr. Whitson?

A. Not that I recollect. And none were noted in the autopsy report.

Q. Did you see any abscesses on his arms?

A. Not that I can remember. None were noted.

Q. Is an abscess something that you would have been able to see during an autopsy?

A. In all likelihood.

Q. Is it possible that someone has an abscess and you don't see it during the external examination?

A. Well, it could be an internal abscess.

Q. And is an internal abscess, does that mean it's located under the skin?

A. No. Well, I guess it could be located under the skin. But I'm thinking of a lung abscess, or a liver abscess, or an abscess of the colon. You know, for instance, you could have diverticula that get infected and can cause a diverticular abscess in the colon.

Q. Is it possible to miss an abscess during an autopsy?

A. Anything is possible.

Q. Is it possible to determine during an autopsy if the decedent had a fever when they died?

A. Not unless you measured the temperature.

Q. Did you measure the temperature in Mr. Whitson?

A. No, ma'am.

Q. Is that something you typically do in autopsies?

A. No, ma'am.

Q. Can you detect blood clots during autopsies?

A. Yes, ma'am.

Q. How do you do that?

A. By visual inspection.

Q. Is that during the external exam?

A. Well, I mean, there may be -- if somebody had varicose veins, for instance, there may be an indication of blood clot. But typically it's during examination of the internal organs.

Q. If somebody had a blood clot in their arm or their leg, is that something you would know during an autopsy?

A. Not unless there were other manifestations of the blood clot internally.

Q. What other manifestations can that be?

A. Like if they had a clot in the leg that went to the lungs, and I found a pulmonary embolus, for instance.

Q. Did Mr. Whitson have any blood clots?

A. None were noted.

Q. Did he have any blood clots in his arm?

A. None were noted.

Q. If you didn't open up his arm and look at it, would there be a way to know?

A. Not unless there was some external evidence.

Q. Is it possible that Mr. Whitson could have had a blood clot and you wouldn't know it?

A. Anything is possible.

Q. Would you see signs of a blood clot on the histology slides?

A. Possibly. Yes, ma'am.

Q. And when I say histology slide, that just means all of the -- that's your microscopic section. Right? Is that the correct way to refer to it?

A. Yes, ma'am. The microscopic section is prepared by looking at the histology slides. Yes, ma'am.

Q. How do you determine if a blood clot played a role in someone's death?

A. Well, for instance, if it's a blood clot to the lungs, you may have a saddle embolus which occupies the right and the left pulmonary arteries. And the person can't breathe because of that. Now, microscopically, especially in the age of COVID, you can see microscopic blood clots in the lungs, in the heart, in the brain, in the liver, any -- basically any organ.

Q. Do you always see if someone had a blood clot if you're looking at the lungs, if it's there?

A. Well, it depends on the section taken. I mean, there may be some gross indication of a blood clot when you're sectioning the lungs. But microscopic blood clots cannot be visualized on gross examination. If you happened to take a section of the lung in which there is a microscopic blood clot, then you would expect to see that on examination of the histology slides.

Q. Did you take histology -- or sections of all of

Mr. Whitson's lungs in this autopsy?

A. You never take sections of all the lungs. You take --

Q. Which section -- I'm sorry. You go ahead.

A. I'm sorry. You take -- if you see an abnormality in a lung, you typically take a section of that area. For instance, if you see a pulmonary nodule that could be a cancer, you take a section of that area. Otherwise, you take random sections.

Q. So if I'm understanding you correctly, and please correct me if I'm wrong. It's possible that somebody could have a blood clot in their lung, and you would miss that on the -- during the internal examination. And if you didn't take a section from that area where that blood clot is, you would miss it completely?

A. Yeah. If there was no evidence of blood clot on gross inspection of the lung, and you took random section, you could miss a blood clot. Yes, ma'am.

Q. Does a blood clot that's in an arm or a leg have to travel somewhere in order to cause death?

A. Typically, yes. I guess a blood clot could get infected in an extremity, which, you know, may lead to an abscess, sepsis, and death that way. But typically, they travel somewhere.

Q. We've talked about cultures in this case. But are there any cultures in this case that you could have done that you didn't, like a culture of the ulcer on Mr. Whitson's heel?

A. Sure. I could have cultured that. But it would have added, in my opinion, little to no value to the autopsy.

Q. Why is that?

A. Because he died of a -- of morphine toxicity. Again, I saw no signs for him to have died from complications of the ulcer on his heel. He would have had to have signs of sepsis, which I did not see.

Q. Could you have taken cultures of the areas around the suspected needle marks?

A. Sure.

Q. And why didn't you?

A. That's not routinely done.

Q. Why is it not routinely done?

A. Unless there's signs of an abscess, I have never heard of anybody doing that.

Q. How did you know that Mr. Whitson did not have a bacterial underlying medical condition?

A. Well, prior to the autopsy, I did not receive that information. And at autopsy, there was nothing to indicate that.

Q. How did you know that Mr. Whitson did not have a viral underlying medical condition?

A. Same answer.

Q. Is it possible that the area of Mr. Whitson's arm around the suspected needle marks, that his arm was infected?

A. There was no indication of infection noted.

Q. You took an aorta sample and a femoral vessel sample of blood. Is that correct?

A. Yes, ma'am.

Q. Could you have taken any other samples?

A. I could have taken numerous other samples.

Q. Like what?

A. Could have taken a simple spinal fluid sample. Could have taken a bile sample.

Q. Why would you take a spinal fluid sample?

A. Well, as I stated earlier in this deposition, if one suspected that he had a central nervous infection, or central nervous system infection, you could take a sample and do the culture on that.

Q. And you said bile sample. Why would you do that?

A. A bile sample?

Q. Uh-huh.

A. Sometimes bile samples are taken if other

samples cannot be obtained. For instance, blood samples. Bile is a material that is harder to analyze. And it's just of less quality.

Q. What samples did you take to provide for the toxicology screen?

A. I took the blood samples and a urine sample. I'm not sure if I took -- yeah. Well, I took vitreous, as well.

Q. How did you provide those samples to toxicology?

A. The samples are retrieved via syringe injected into the appropriate container. Placed in a mail container, and put in the U.S. Postal Service, mailed to the toxicology lab. Which, I think back then, was still at Chapel Hill.

Q. So did you ship it via the United States Postal Service or UPS?

A. United States Postal Service.

Q. And why did you request toxicology testing in this case?

A. Well, because of the history, because of the possible needle marks, and because of the autopsy findings. The -- specifically, the pulmonary edema congestion.

Q. How do you -- or how did you request a

toxicology test in this case?

A. Well, I don't remember specifically in this case. But it was routine that a toxicology form, which I fail to see in the records supplied by OCME.

Q. What -- you said a toxicology form?

A. Yes. Hold on one second, let me look.

Q. Sure. Sure.

A. Make sure I didn't overlook it. [Witness reviews document.] I miss sticking my fingers in my mouth to turn pages.

Q. Yeah.

A. You've got that part out. No. The toxicology request form is not in there.

Q. What information did you include on the toxicology request form?

A. Well, I can't say since it's not there. But typically, it's the patient demographics, and a brief clinical history, and a list of the sample submitted.

Q. And what is on the brief clinical history?

A. It's just a blank space that you can fill in.

Q. What kind of information would you include?

A. Typically, information received from outside agencies like the law enforcement guys, and autopsy findings.

Q. Is it fair to say it's a case narrative?

A. It's a short summary.

Q. Do you know where this toxicology request form is?

A. No, ma'am. As stated, I put it in the mailbox along with the samples, and mail it.

Q. Did you speak to anyone prior to submitting the samples for toxicology?

A. Not that I can recall.

Q. Where did the samples go?

A. To the Office of the Chief Medical Examiner. And again, I can't remember whether they had moved to Raleigh at that time or whether they were still in Chapel Hill.

Q. Did you request specific tests from toxicology?

A. Again, I don't know for sure. But in all likelihood, I did.

Q. What specific tests?

A. Well again, I don't know for sure. But given the history, I likely requested a morphine would be done. And in all cases, back then, an alcohol -- blood alcohol was done just routinely.

Q. Do you know what drugs toxicology tested for in this case?

A. Well, other than the list that was provided on the -- where is that -- on the toxicology report. I

assume that's a comprehensive list, but I don't know for sure.

Q. Are you talking about on -- are you on Exhibit 4?

A. Yes, ma'am.

Q. Okay. So page 11?

A. Yes, ma'am.

Q. Are you talking about the list of drugs under the aorta blood section?

A. Well, the whole report.

Q. So why don't you walk me through the report. What is the liver section at the bottom? Let's start there.

A. Liver is a exudate substrate for measuring drug levels. One, if no blood is available. For instance, if the deceased were too decomposed to get a blood sample. And also, to assess redistribution of a toxic agent.

Q. Was the liver tested in this case?

A. No, ma'am.

Q. Who made that decision not to test the liver?

A. I'm not sure. But in all likelihood, it's the toxicologist performing the assays.

Q. The urine sample, it listed that morphine was detected. Is that right?

A. Yes, ma'am.

Q. Who requested that the morphine be tested in the urine?

A. Well, I can't -- again, I can't remember whether I requested that specifically. But the typical routine is that the aortic blood is tested first. And if there's material in that, especially material that could undergo central circulation redistribution, then the peripheral samples, like the femoral blood or subclavian sample is tested next to quantitate that analyte.

Then, if the femoral blood is inconclusive for whatever reason, then different substrates will be tested, such as the urine. If the urine gives them an answer, then they stop -- typically stop testing there. If the urine had not given them the answer then, maybe they would have tested the liver.

Q. So your understanding is that the toxicologists are determining which tests and what order to do them in?

A. That's my understanding. Yes, ma'am.

Q. And the toxicologist is determining what to test for in each sample?

A. Well, as indicated previously, in all likelihood, I requested that morphine be tested. But when the test is performed, they do a broader array of screening tests.

Q. Do you know how many drugs are tested for in

the aorta test?

A. I assume just the ones listed here. But I don't -- I don't know for sure.

Q. Since it says other opiates, opioids, and there's a section that says other organic bases, do you know which particular opiates and opioids and organic bases were tested?

A. No, ma'am.

Q. Is it your understanding that because they detected that morphine was present in the aorta, that only morphine was tested in the femoral vessel. Did I understand you right?

A. That's my understanding. Yes, ma'am.

Q. Okay. If alcohol is detected in the aorta, because it looks like it was present at 40 milligrams per deciliter. Is that right?

A. Yes, ma'am. That's what it says.

Q. Do you know why it wasn't tested in the femoral vessel alcohol?

A. You'd have to ask Ms. Winecker.

Q. And do you know why the alcohol was not tested in the urine?

A. Again, you'd have to ask Ms. Winecker.

Q. Is it your understanding that providing 5 milliliters of urine would have been enough to test for

morphine and alcohol in the urine?

A. I think it would be, but I'm not sure. Again, the toxicologist would give you a better answer than I could.

Q. Did you ever speak to anyone in toxicology about the toxicology report in this case?

A. I don't remember speaking to anyone. But in a marginal case, like this case was, in all likelihood, I did.

Q. Would you have documented that you talked to someone in toxicology?

A. In all likelihood.

Q. Where would you have kept that documentation?

A. With the report. With the folder that was destroyed.

Q. Do you know if you talked to anyone in toxicology in this case?

A. Like I said, I can't remember.

Q. How did you receive the results of the toxicology screen?

A. I'm not sure in this case. But it was typical to receive a report via e-mail and snail mail.

Q. So you would receive it first by e-mail, and then you would get an official copy in the mail?

A. That's typically the way it worked. Yes,

ma'am.

Q. All right. I'm going to show you what I'm marking as Exhibit 8. Do you recognize Exhibit 8?

[Exhibit Number 8 identified.]

A. Well, Exhibit 8 is a toxicology report from the Office of the Chief Medical Examiner. And evidently, they were still at Chapel Hill at that time.

Q. Okay. And does Exhibit 8 show that you received it via e-mail on April 4, 2011?

A. Yes, ma'am. It does.

Q. All right. Is my understanding correct that what you're saying is the aorta portion of the test is the screening test, and the femoral vessel portion of the test is the confirmation?

A. You could look at it that way. Yes, ma'am.

Q. What are you testing for in the urine?

A. Well, like I said, it's on the report. Tested for morphine.

Q. Why do they test both the blood and the urine for morphine?

A. Well, in this case, the testing of the blood was inconclusive. So that's the reason they went to testing the urine. That would be my assumption.

Q. What was inconclusive?

A. The testing of the blood.

Q. What does the fact that Mr. Whitson had 15 milligrams per liter in his urine, what does that indicate to you?

A. That indicates a lethal level of morphine.

Q. Did you say lethal?

A. Lethal. Yes, ma'am.

Q. When does morphine become lethal in the urine?

A. Well, based on the literature, it's about 14 milligrams per liter.

Q. What literature are you relying on?

A. The -- primarily the textbooks that all pathologists have used. It's a textbook by Baselt that's called Distribution [sic] of Toxic Chemicals in Man, or something like that. Don't hold me exactly to that.

Q. Do you know when that came out?

A. Well, there's been several editions.

Q. What does trace morphine mean from the femoral vessel?

A. Well again, Ms. Winecker could probably answer that better than I. But to me, that indicates that there was not enough to quantitate.

Q. Do you know what the minimum cutoff level was for reporting morphine in the femoral vessel?

A. No, ma'am.

Q. Did you look at the raw data for the toxicology

report?

A. No, ma'am.

Q. Did you ever see the toxicology file?

A. No, ma'am.

Q. Do you know what the actual level was that was detected for morphine in the femoral vessel?

A. No, ma'am.

Q. What do you make of the fact that there was only a trace amount of morphine found in Mr. Whitson's body at the time of death?

A. That -- well, I mean, it could have come from a couple of reasons. One, that he ingested a low dose. Were you just talking about the blood? Were you talking about the blood and the urine?

Q. No. Just the blood.

A. Okay. He could have ingested a small dose. Or the dose ingested could have been metabolized out.

Q. How does a morphine level of 15 milligrams per liter in the urine show that it was a lethal amount?

A. Well again, according to literature, people have died with levels as low as 14.

Q. What did you make of the fact that Mr. Whitson had alcohol in his blood?

A. That in all likelihood, alcohol had been ingested.

Q. Is it possible that the alcohol was a false positive?

A. Anything is possible.

Q. Did you ever have any issues with alcohol being false positives related to the fact that the shipment got hot on its way to toxicology?

A. Not that I'm aware of.

MS. BRIDENSTINE: It's three o'clock. Do you want to take a quick break?

THE WITNESS: I'm fine. We can keep going. If y'all are okay.

MS. BRIDENSTINE: I'm okay.

MR. ZIEGLER: I'm good.

Q. Is it possible that alcohol caused Mr. Whitson's death?

A. Not in my opinion.

Q. Why is that?

A. Because it's too low. The concentration is too low. It could have been a contributing factor to his death.

Q. How can alcohol be a contributing factor?

A. Because like morphine, alcohol is a central nervous system depressant. And they could have worked in conjunction with each other.

Q. Can alcohol alone lead to pneumonia?

A. Well, I mean, if a person aspirates, of course, it can cause pneumonia.

Q. Is that called aspiration bronchial pneumonia?

A. I'm sorry?

Q. Is that called aspiration bronchial pneumonia?

A. It can be called that. Yes, ma'am.

Q. If someone took crushed-up blood pressure pills, melted them, and injected them, what would happen?

A. That's a very broad question that I just don't feel comfortable answering.

Q. Do you know if blood pressure pills show up on the drug screen done by toxicology in this case?

A. Typically it's drugs of abuse.

Q. It's what?

A. Drugs of abuse.

Q. What is Opana?

A. What is what?

Q. Opana, O-p-a-n-a.

A. I don't know.

Q. Is there a way to tell from the toxicology report what form of morphine was used?

A. Not from the toxicology report. No, ma'am.

Q. Is there a way to tell how the decedent ingested a drug on the toxicology report?

A. No, ma'am.

Q. Is there a way to tell how a decedent ingested a drug from the autopsy?

A. Well, if you see needle marks, you can assume that it was an IV injection. Or if you see pill fragments in the stomach, you could assume it was an oral injection -- or an oral intake.

Q. Is it possible that somebody took morphine pills, so swallowed them, and died. And then by the time you look at the autopsy, they are not present in the stomach?

A. Yes.

Q. Are you aware of any studies that show what the half-life of morphine is when you take morphine in pill form, melt it, and inject it in the vein?

A. No.

Q. Can you make -- can you draw any conclusions about what happens to that half-life if you take it from pill form, crush it, and inject it?

A. No.

Q. And is it -- is my understanding correct that a morphine tablet that is marketed as slow release, that the half-life is longer than liquid morphine that's injected by a doctor?

A. I would say it is.

Q. What did you determine was the cause of death

in this case?

A. Morphine toxicity.

Q. What does morphine toxicity mean?

A. Morphine overdose.

Q. What does a morphine overdose usually look like?

A. At autopsy?

Q. Yes.

A. Okay. Well, typically you see pulmonary edema congestion. And you may see some pneumonia. But those are, again, soft findings. There may not be any other findings at autopsy. You may not see the pulmonary edema congestion at autopsy.

Q. When did you determine cause of death in this case?

A. After getting all of the pieces of the puzzle together. You know, doing the gross, looking at the slides, getting the toxicology back. Put all of that together to determine the cause of death.

Q. Did anything else contribute to Mr. Whitson's death?

A. Well, as stated previously, the ethanol could have contributed. Yes, ma'am.

Q. How confident are you that morphine toxicity was the cause of death in this case?

A. I'm pretty confident.

Q. When you say pretty confident, what does that mean?

A. That means I'm pretty confident. I found no other cause of death.

Q. Does pretty confident mean more likely than not?

A. Yeah. I mean, am I absolutely confident? I can't say absolutely about anything really. Were there other entities discovered at autopsy that could have led to Mr. Whitson's death? I didn't find any.

Q. How confident do you need to be to list a cause of death on an autopsy?

A. Fairly confident.

Q. Do you assign a certain percentage to how confident you are?

A. No, ma'am.

Q. I mean, I guess what I'm saying, is it 51 percent certain, or is it 99 percent certain?

A. You can't -- I can't give you a number like that. Because each case is different.

Q. Looking at page 2 of Exhibit 4, which is the first page of your autopsy report.

A. Yes.

Q. What does final anatomic diagnosis mean?

A. It means everything anatomically, both the gross anatomic findings, and the microscopic anatomic findings are coalesced into the final anatomic diagnosis section.

Q. Is the final anatomic diagnosis, is that related to cause of death?

A. Sometimes it may include the cause of death.

Q. Does it include the cause of death in this case?

A. No.

Q. What does acute bronchial pneumonia, moderate mean?

A. That means he had a -- to me, a moderate number of neutrophils within the alveolar spaces, the lungs.

Q. And I guess I'm trying to understand, what is the quantity associated with moderate?

A. Well, I mean, there's -- that would be highly subjective. Each pathologist has his own cutoff point for mild, moderate and severe.

Q. What does acute mean?

A. Acute refers to neutrophils being there, which is a type of white blood cell, compared to lymphocytes, which are considered -- associated with chronic inflammation, and signs of macrophages.

Q. What does the diagnosis of pulmonary edema and

congestion, severe, mean?

A. Well again, that means that there was proteinaceous fluid in the alveolar spaces, and the vessels were dilated.

Q. What caused the acute bronchial pneumonia in this case?

A. Well, in my opinion, it was the leakage of the proteinaceous material from the alveolar capillaries into the alveolar spaces. The proteinaceous material is a excellent media for micro-bacterial growth.

Q. What causes that leakage?

A. Well, I explained it earlier. You want me to explain it again?

Q. Yes.

A. Okay. When the body is not oxygenating well, then the lungs try to compensate by opening up the vessels as wide as they'll go, open up the alveolar spaces as wide as they go. When they open up -- the vessels are lined by endothelial cells. When they open up those vessels, the connections between the endothelial cells gets stretched, and that allows fluid to leak from the vascular spaces into the pulmonary parenchyma cell.

Q. Going back to the start of your answer, you said when a person is not breathing well, that kicks off the process?

A. Not oxygenating well.

Q. Not oxygenating well. What causes that?

A. Well, it could be a number of things. It could be respiratory depressant in the brain, which either alcohol or morphine is. It could be choking, strangulation. It could be a big tumor in the neck. A number of things.

Q. Could it be an infection?

A. Infection could cause that. Yes, ma'am.

Q. Or an illness?

A. Yes, ma'am.

Q. Do you know what caused the acute bronchial pneumonia in this case?

A. Well again, based on the findings at the autopsy, it was likely the pulmonary edema that resulted from brainstem depression as a result of morphine, and alcohol intoxication.

Q. What are the symptoms of acute bronchial pneumonia? If someone is experiencing that, what does that -- what are their symptoms?

A. Well, they may have, you know, trouble breathing. May have a cough, may have a fever.

Q. Can acute bronchial pneumonia be a cause of death?

A. Sure.

Q. Do you always know what causes bronchial pneumonia?

A. Not always.

Q. And what's the difference between acute bronchial pneumonia and aspiration bronchial pneumonia?

A. Well, aspiration pneumonia results from the aspiration of gastric material into the lungs.

Q. Can aspiration bronchial pneumonia cause death?

A. Yes, ma'am.

Q. How long does it usually take for someone to die from aspiration bronchial pneumonia?

A. Well, there's a lot of factors there. You know, what's the patient's overall health to begin with. How much of the gastric fluid was aspirated. How did they respond to that aspiration. There's too -- was the patient treated with antibiotics. Were they on antibiotics when they aspirated. There's too many factors to give a confidential answer to that question.

Q. What's a short time period associated with aspiration? How quickly can it happen?

A. Well, it could happen fairly quickly if the -- the aspiration was, you know, voluminous, and there is a lot of gastric material that could -- you know, depending on what was in the stomach, it could potentially clog the bronchial tree, and death could be almost immediate.

Q. Okay. So, like minutes?

A. Yeah. Minutes.

Q. What's a -- what's a lengthier time frame for aspiration bronchial pneumonia?

A. Days, or months even.

Q. Did you see any signs of aspiration bronchial pneumonia in this case?

A. No, ma'am.

Q. And the acute bronchial pneumonia, a similar question. What's the typical length of time associated with that before someone dies? How long do people tend to have it when it's a cause of death?

A. Well again, there's too many variable to give a good answer to that. I mean, it --

Q. Can I --

A. I'm sorry.

Q. No, no. Go ahead. I didn't mean to interrupt you.

A. I mean, it could be fairly quick, or it could be days to months.

Q. And fairly quickly, could that be minutes?

A. I wouldn't say minutes. I would say more likely hours to days.

Q. And what are the symptoms of aspiration bronchial pneumonia?

A. The same. I mean, fever, cough, gagging when he aspirated.

Q. Would Mr. Whitson, being described as being hot to the touch at the time of death, would that mean anything to you?

A. Well, it could indicate a fever. I'm not sure what the ambient temperature was in the environment in which he expired. For instance, if he were laying in front of a heater, that could have -- you know, make him hot to touch.

Q. Do you remember speaking to Chief Deputy Thomas Farmer about this case on March 7th, 2011? Which was the day you did the autopsy.

A. I don't remember it.

Q. I am going to show you what I'm marking as Exhibit 9, which is Farmer's report in this case. And I'm going to direct you to a page in just a second.

[Exhibit Number 9 identified.]

Q. All right. Let's turn to page 39, at the bottom. And it's the last paragraph.

A. [Witness reviews document.] That little Freudian slip there?

Q. Which one?

A. With the id.

Q. Oh, yeah.

A. Double entendre.
Q. Did you read that whole paragraph?
A. No. The id stopped me.
Q. Yeah. Okay.
A. [Witness reviews document.] Okay.
Q. Chief Deputy Farmer's report indicates that he talked to you at 2:00 p.m. on March 7, 2011. Is that right?
A. That's what the report says.
Q. Do you remember speaking to him at that time?
A. No, ma'am.
Q. Is there any reason to doubt he had the wrong time of the phone call?
A. I have no reason.
Q. In your other autopsy, you testified that the autopsy started at 11:30 a.m. Which is the trial testimony in Exhibit --
A. Yes, ma'am.
Q. I can give you a page. Just a second. Page 237.
A. It's on the autopsy report, as well.
Q. Okay. So 11:30 is when it started?
A. Yes, ma'am.
Q. How long did the autopsy take you in this case?
A. I don't remember that.

Q. How long would autopsies typically take?

A. Usually, the gross dissection would take a couple of hours. Then reading the slides would take maybe 30 minutes. Interpreting the tox, you know, 10 or 15 minutes.

Q. Once you got the tox report back?

A. Yes, ma'am.

Q. Okay. So when you spoke to Chief Deputy Farmer on March 7th, you talked to him about two-and-a-half hours after you started the autopsy?

A. That's what this would indicate.

Q. So it sounds like you had a conversation with him pretty much immediately after you completed the autopsy.

A. Well, the gross part of the autopsy.

Q. So everything except for the results of the tox screen?

A. And the microscopic.

Q. Okay. So you think this is before you did the microscopic?

A. I'm sure it was.

Q. So you had done the external/internal examination, but not the microscopic examination?

A. I would assume that that would be correct. Yes, ma'am.

Q. Did you tell Chief Deputy Farmer that it was your professional opinion, after performing the autopsy, that Mr. Whitson died as a result of an overdose?

A. That's what the report says.

Q. Did you tell him that?

A. I don't remember.

Q. Why were you calling the cause of death overdose before you had the toxicology test, assuming that Chief Deputy Farmer is correct in his recitation of your conversation?

A. Well, in all likelihood because I found what appeared to be needle marks, and the pulmonary edema congestion. And really, no other findings that would have caused his death.

Q. So is it fair to say that the information that you had before you issued your autopsy report on May 31st, 2011, was you had -- you had performed the autopsy, you had spoken to law enforcement and learned some of the facts about what they discovered at the scene, and you had the toxicology report?

A. Before I completed the autopsy report?

Q. Yes.

A. Yes, ma'am.

Q. Did you get any other information from any other source?

A. Not that I can remember. Well, as stated before, there may have been an EMS report in that file. But I don't know.

Q. Is it possible that something other than morphine caused Mr. Whitson's death?

A. Not in my opinion.

Q. And why is that?

A. Because there were no other findings at autopsy which would account for his demise.

Q. In your career, approximately how many times have you ruled a death as caused by drug overdose?

A. Lots of times. Hundreds of times, if not thousands.

Q. Has it been a pretty common cause of death in the area of North Carolina where you practiced?

A. Too common.

Q. Did you ever have any cases similar to Mr. Whitson's case?

A. Did I ever have any other people that died of morphine toxicity?

Q. Well, who presented in a similar manner to Mr. Whitson. So a high level of drug in the urine, but a trace amount in the blood.

A. Possibly. But none come to mind right now.

Q. Were you surprised that there was only a trace

amount of morphine in the blood?

A. I wouldn't say I was surprised.

Q. Is it fair to say that in typical overdose cases, drug overdose cases, that there is a high amount of drug found in the blood?

A. Yes, ma'am.

Q. Is it less common to see a trace amount in the blood?

A. It is.

Q. Dr. Hall, do you have any substance abuse issues?

A. I do.

Q. And which substances?

A. I did. Alcohol.

Q. Are you in --

A. I was wondering when you were going to get to this.

Q. What makes you say that?

A. Because all attorneys who don't have the facts on their side try to diminish the character of the witnesses.

Q. And I just want to be clear that we are not prosecutors or defense attorneys. We're just looking for the truth in the case.

A. As do I. I mean, I side with neither the

defense or the prosecution in any of my cases.

Q. Okay. Are you an alcoholic?

A. I am an alcoholic.

Q. And you said this is a past problem. Right?

A. Well, I'm currently in recovery.

Q. When did you start abusing alcohol?

A. Probably in my -- I want to say late 40s.

Q. How old are you now?

A. 61.

Q. When were you in your late 40s?

A. When I was in my late 40s?

Q. Uh-huh. Like what years?

A. I was born in 1960, so it would have been, you know, in the -- I would have been 40 in 2000. So it would have been, like, in 2005, somewhere in there.

Q. Is that when your problems with alcohol began?

A. Well, I wouldn't say that it was -- it's never a problem in the beginning.

Q. Okay. When did it become a problem?

A. It became a problem later on in my career. I can't give you an exact date.

Q. You were charged with driving while impaired in Watauga County on January 28th, 2010. Is that right?

A. There is no record of that.

Q. Were you charged with driving while impaired on

that date?

A. There's no record of that.

Q. And why is there no record of that?

A. You would have to address the court to get that answer.

Q. Is your testimony that you were not charged with driving while impaired from a police encounter on January 28, 2010?

A. My testimony is, there's no record of that.

Q. I understand there may be no record of that. But were you charged with driving while impaired?

A. I've answered your question.

Q. Did you have a driving while impaired case dismissed in 2015?

A. There is no record of that.

Q. Did you have a pending driving while impaired case from 2010 until April of 2015?

A. Again, there's no record of that.

Q. Were you represented by an attorney named Robert Speed?

A. I'm not aware of any record of that.

Q. I'm handing you what I'm marking as Exhibit 10.

[Exhibit Number 10 identified.]

Q. Dr. Hall, these documents came to us with handwritten notes, and underlined, but we did not make

those notations. But if you'd turn to page 857, and read that page.

A. [Witness reviews document.] Okay.

Q. This article indicates that you were charged with driving while impaired on January 28, 2010. Is that right?

A. That's what it says.

Q. And that you were convicted in District Court in 2011. Is that correct? That's what this exhibit says?

A. That's what this exhibit says.

Q. That you appealed your case to Superior Court, where the case was postponed 20 times before being called for motions in April of 2015. Is that right?

A. That's what this exhibit says.

Q. This exhibit quotes an attorney named Robert Speed, who is -- states represented you in District Court. Is that right?

A. That's what this exhibit says.

Q. And according to this article and this exhibit, Mr. Speed was -- Mr. Speed gave information that it was former prosecutors who did not want the case resolved. Is that right?

A. If that's what the exhibit says.

Q. Does the exhibit say that?

A. What are you -- where are you referring to specifically?

Q. It is the start of the first -- third paragraph, the full --

A. Oh. Yes, ma'am. That's what it says.

Q. In that same paragraph, the article goes on to say that Robert Speed provided information that if Dr. Hall was convicted in Superior Court, he said that prosecutors were worried that defense attorneys would make sure the fact was known to jurors in criminal cases where Hall testified as a medical examiner. Is that right?

A. That's what the exhibit says.

Q. And that prosecutors were worried that jurors would discount Dr. Hall's testimony because of a DWI conviction. Is that right?

A. That's what the exhibit says.

Q. It also goes on to say that District Attorney Seth Banks tried to have the case heard earlier in the year, and at that point Mr. Speed was the one who fought for a continuance. Is that right?

A. That's what the exhibit says.

Q. And it ultimately says that the DWI charge was dismissed. Is that correct?

A. Yes, ma'am. That's what it says.

Q. I understand that there may not be a record of your case because your case has been dismissed. But are you representing that this case never happened right now?

A. I'm saying there's no record of this case.

Q. Does no record of the case mean that you never had a pending DWI case from 2010 until 2015?

A. I've answered your question.

Q. Is that what there's no record means?

A. Again, there's no record of this.

Q. Is it true that prosecutors were worried that defense attorneys would make jurors in criminal cases in which you testified as a medical examiner knew about your DWI case if you were convicted in Superior Court?

A. I'm not sure. You would have to ask the prosecuting attorneys.

Q. Did anyone ever express any concerns like that to you?

A. I don't remember.

Q. In this time period, from 2010 until 2015, the first part of that, you were still working as a medical examiner in North Carolina. Is that right?

A. 2010 to 2015. Yes. I resigned as a medical examiner 2013, I believe.

Q. And the autopsy that you performed occurred in March of 2011.

A. That I performed on Mr. --
Q. In this case. Mr. Whitson. Yes.
A. -- Whitson. Yes, ma'am.
Q. And the trial in this case, that happened in April of 2014. Is that right?
A. I assume. I can't give you the date. I don't think the date was on the -- the copy of my testimony. I'm not sure when the trial date was.
Q. In any event, when you reviewed Exhibit 7, you saw that you testified that you had resigned in 2013. Is that right?
A. I did resign in 2013.
Q. So you testified after you resigned?
A. Well, so you say what day I testified?
Q. You testified in 2014.
A. Okay.
Q. But I'm just trying to confirm for you that you know, based on that exhibit, that that testimony happened after you resigned.
A. I resigned in 2013. I can say that. I'm not sure -- you're telling me that -- that I gave this testimony in 2014. If that is the case -- if that was the circumstances, then, yeah, I gave the testimony after I resigned.
Q. That's what I'm representing to you. But what

I'm also saying to you is that you reviewed that entire exhibit. Correct?

A. I did.

Q. And you reviewed the portion where you talked about how you resigned in June of 2013.

A. Yes, I did.

Q. All right. So you are aware, just based on what you reviewed earlier today, that your testimony happened after you were no longer a medical examiner at the trial that was held in this case.

A. I agree with that.

Q. Were you being monitored for alcohol use by anyone from 2010 until April 2015?

A. Yes, ma'am.

Q. What did that alcohol monitoring look like?

A. It's through the PHP, NCPHP, North Carolina Physicians Health Program.

Q. Why were you being monitored by the North Carolina Physicians Health Program?

A. Because I was deemed to have a problem with alcohol.

Q. Has anything happened to your medical license as a result of your abuse of alcohol?

A. Yes, ma'am.

Q. What is that?

A. Well, at one point I received a -- a private letter of concern from the state board. And then, later on, my medical license was revoked for 90 days, but immediately reinstated.

Q. All right. I am handing you what I am marking as Exhibit 11. Take a look at that, please.

[Exhibit Number 11 identified.]

A. [Witness reviews document.]

Q. Do you recognize Exhibit 11?

A. Yes, ma'am. I do.

Q. What is it?

A. It's a interim non-practice agreement from the North Carolina Medical Board.

Q. And it was issued on February 21, 2018. Is that right?

A. Yes, ma'am.

Q. You've seen this document before?

A. Yes, ma'am. I have.

Q. Did the North Carolina Medical Board order that you have a physical examination by the North Carolina Physicians Health Program?

A. Physical and mental.

Q. What?

A. Physical and mental.

Q. Is that right?

A. Yes, ma'am.
Q. Did the North Carolina Physicians Health Program diagnose you with alcohol dependence?
A. No, they didn't.
Q. Who diagnosed you with that?
A. The treatment center.
Q. Was that the treatment center that you went to because of the North Carolina Physicians Health Program?
A. Yes, ma'am.
Q. Did the North Carolina Physicians Health Program recommend that you receive psychotherapy and a comprehensive assessment?
A. Yes, ma'am. They did.
Q. And that was on June 16th, 2011? If you look at page 2 of Exhibit 11.
A. Yes, ma'am. According to this, that was the date.
Q. And that was because earlier, on June 2nd, 2011, the medical board issued an order for examination ordering you to be assessed by the North Carolina Physicians Health Program?
A. Yes, ma'am.
Q. On August 5th, 2011, did you sign a medical non-practice agreement?
A. I did.

Q. And that medical non-practice agreement was dissolved on January 15th, 2010 [sic]?

A. Does it say that on here somewhere?

Q. At page 2.

A. Yes, ma'am. That's -- that would be about right.

Q. So from August 5th, 2011 to January 15, 2012, you entered into a voluntary agreement to not practice medicine. Is that right?

A. Correct. Yes, ma'am.

Q. You mentioned the letter of private concern that was issued on December 21st, 2011.

A. According to this document. Yes, ma'am.

Q. Is that when it happened?

A. I assume. It's what the document says. Do I remember that happening? No, I don't.

Q. Why did the medical board get involved with you in order that you be examined by the North Carolina Physicians Health Program on June 2nd, 2011?

A. You would have to ask the medical board.

Q. Did you return to the practice of medicine on January 15th, 2012?

A. Yes, ma'am. I did.

Q. So you were diagnosed with alcohol dependence after you performed the autopsy in this case?

A. Yes, ma'am.

Q. Did your warning letter that you received in December 2011, did it say, quote, Repeated arrests for such conduct could form the basis for the Board charging you with unprofessional conduct or the inability to practice medical acts safely, end quote?

A. I don't remember.

Q. Did you have to do anything as a result of that agreement not to practice medicine?

A. Had to undergo treatment.

Q. At the time that you performed the autopsy and death investigation in this case, were you using alcohol?

A. I don't remember.

Q. What were your usual drinking habits when you were using alcohol?

A. I don't remember.

Q. At the time that you testified at this trial, were you using alcohol, which is April 2014?

A. I don't remember. But I doubt it.

Q. Why do you doubt it?

A. Because who would use alcohol and then testify in a trial? Some people think I'm dumb, but I'm not that dumb.

Q. Were you possibly using alcohol in the evenings or when you weren't at work during that time period?

A. I don't remember.
Q. When was the last time you drank alcohol?
A. February 12th, 2018.
Q. Are you licensed to practice now?
A. Yes, ma'am.
Q. How many times has your medical license been suspended?
A. Once.
Q. What were the circumstances that led to that suspension?
A. Well, the possibility that I had trouble with alcohol, and that I would -- to undergo treatment.
Q. Was it related to the fact that you were charged with DWI on February 11, 2018?
A. There is no record of that.
Q. From 2018?
A. Oh, 2018. I am sorry. You snuck one in there on me. Yeah.
Q. Okay. So your medical license was suspended after that 2018 case. Is that right?
A. That's correct. Yes, ma'am.
Q. So you had -- do you have a DWI conviction on your record?
A. I do.
Q. And you entered an Alford plea to that case.

Correct?

A. I entered some sort of plea in that case. I can't remember the name of it.

Q. Was that on February 21st, 2019?

A. I couldn't tell you the date.

Q. What was your sentence for that conviction?

A. I was placed on -- I think it was a year of probation. And I had to do some community service.

Q. After you were arrested and charged with driving while impaired from February 11, 2018, did you meet with the North Carolina Physicians Health Program?

A. I did.

Q. Did they diagnose you with alcohol use disorder?

A. Well again, I think the actual diagnosis came from the treatment facility.

Q. I'm showing you what I'm marking as Exhibit 12. What is Exhibit 12?

[Exhibit Number 12 identified.]

A. That's a consent order from the North Carolina Medical Board.

Q. What is this?

A. I'm sorry?

Q. So what is this consent concerning?

A. This is concerning the DWI in 2018.

Q. And this consent order states that you were diagnosed with alcohol use disorder, and you attended inpatient treatment for this beginning on February 14th, 2018?

A. Yes, ma'am. That's what it says.

Q. All right. Is that true?

A. Well, sometime, yeah. I mean, that's what it says. So I have no reason to believe that it's false. I did do that.

Q. Did you enter into an interim non-practice agreement on February 21st, 2018?

A. Yes, ma'am. I did.

Q. Did you successfully complete inpatient treatment on May 8th, 2018?

A. Yes, ma'am. I did.

Q. Did you sign a monitoring agreement with North Carolina Physicians Health Program on May 9th, 2018?

A. Yes, ma'am.

Q. And then on May 31st, 2018, was your interim non-practice agreement dissolved?

A. Yes, ma'am.

Q. Were you -- did the North Carolina Physicians Health Program determine that you safe to return to the practice of medicine?

A. Yes, ma'am.

Q. And did this order then suspend your license for 90 days, but stay it?

A. Yes, ma'am.

Q. What were the conditions of the stay?

A. That I adhere to North Carolina laws and abstain from alcohol use. There may have been more conditions, but I can't remember.

Q. Okay. Is monitoring part of that?

A. Oh, monitoring was part of it, too.

Q. Are you still subject to monitoring today?

A. Yes, ma'am. I am.

Q. Is that stay still in effect?

A. No. Well, to tell you the truth, I'm not sure what that means. Is that stay still in effect. Can you explain that to me a little bit?

Q. Well, the consent order --

A. I mean, they said I could go back to practicing. So --

Q. The consent order indicates that the entire suspension is hereby immediately stayed upon the following terms and conditions. Which included maintaining your current contract with the North Carolina Physicians Health Program.

A. I am still under contract. So I would say it's still in effect.

Q. Okay. And I'm going to also show you Exhibit 13, which is an order dissolving interim non-practice agreement. Do you recognize Exhibit 13?

[Exhibit Number 13 identified.]

A. I do.

Q. And this order indicates that you signed a five-year monitoring contract with North Carolina Physicians Health Program on May 9th, 2018. Is that right?

A. Yes, ma'am.

Q. So you are still under that contract?

A. I am.

Q. When did you resign as a North Carolina medical examiner?

A. In 2013.

Q. Was that June 2013?

A. I can't remember the month.

Q. Why did you resign?

A. Because I was blackmailed by the Office of the Chief Medical Examiner and the Division of Health and Human Services.

Q. How did they blackmail you?

A. Because they told me if I did not resign, that -- and this is all in a deposition, by the way, which you might want to get your hands on. That the

secretary of Health and Human Services at that time would find a way that I would be ineligible for Medicare payments from the state. At that time, Medicare -- my Medicare reimbursement was much larger than what I was making off of ME work. So I resigned.

Q. Who told you that?

A. Well actually, it was Debbie Radisch from the Office of the Chief Medical Examiner. But she was relaying a message from the Department of Health and Human Services.

Q. And this was given to you before you resigned?

A. Yes, ma'am.

Q. Did anyone tell you how they were going to make sure that happened?

A. Well, the secretary of Health and Human Services not only oversees the Office of the Chief Medical Examiner, she over -- at that time anyway, she oversaw the distribution and payment of Medicaid services. And she was going to use my problem with alcohol as a reason for me to not be enrolled in the Medicare program.

Q. Did she say anything else to you?

A. Well, other than if I would resign, that would be all it would be said of this, which was not the case. And that we would move forward.

Q. Did she tell you how she was going to make sure you wouldn't received Medicare payments?

A. No. She was in control of all that. I figured she could find a way.

Q. And you said the exchange was that they wouldn't say anything about what?

A. About -- I assume you're going to get to the hotel deaths. But about me resigning from that. When, in reality, as soon as I resigned, they had a press conference.

Q. And what did they say during the press conference?

A. That I was a sorry sack of shit.

Q. Who said that?

A. Well, I'm paraphrasing.

Q. I understand. But who gave the press conference?

A. It was some spokesman for the Department of Health and Human Services. Some guy. I can't remember his name.

Q. You said that this was all talked about in a deposition?

A. Correct.

Q. What case?

A. It was when the -- the family's lawyers, the

decedent's family lawyers. And at the deposition, there were, like, 20 lawyers there. Had sued the hotel chains and a number of other entities. And I gave a deposition for that, which has never seen the light of day, as far as I know.

Q. Were you sued in relation to the Boone Best Western Hotel cases?

A. No. Because I didn't do anything wrong.

Q. No one ever filed a lawsuit against you?

A. No. No.

Q. You faced a lot of criticism for those cases. Is that right?

A. Sure did.

Q. And we're talking about the deaths of Daryl Jenkins, Shirley Mae Jenkins, and Jeffrey Williams?

A. Yes, ma'am.

Q. And that was at the Best Western in Boone, North Carolina?

A. That's correct.

Q. In 2013?

A. Yes, ma'am. Well, I don't know if they died in 2012 or 2013. I can't remember.

Q. What was the criticism that you received about what people believed you had done wrong in those cases?

A. Well, primarily it was that I didn't order the

toxicology stat, which there was no method for doing that. I had been doing this for 20 years, had never ordered the toxicology stat. That I was somehow negligent in the performance of the autopsies, which I was not. That when the tox was sent back to me, I didn't immediately make it available to the fire marshal, the investigating entities. Which I was on vacation when I got the tox back. And at that time, didn't have a way of checking my e-mail with my phone. There were just numerous accusations like that. None of which were true.

Q. Did anyone ever talk to you about your work as a medical examiner in those cases from the Office of the Chief Medical Examiner?

A. Well initially, after the little boy died, Debbie Radisch, who was the chief medical examiner at the time, called me. And the initial few conversations were like, yeah, there's problems with the system, we need to work on solutions for the system. Are you willing to help me do that. And of course, I was. And then, like it was on -- late on a Friday afternoon -- I can't remember the date. I get this call, again from Debbie. And me and Debbie were colleagues. In which her demeanor had totally changed. And she was coming down on me to resign.

Q. Did anyone ever express to you that they had

any concerns about other cases you had performed autopsies in?

A. No, ma'am.

Q. Was there ever any internal investigation associated with those Best Western Hotel cases?

A. Not that I'm aware of. Nobody -- nobody from the ME office. I was asked to resign. Nobody from the ME office ever talked to me again that I can recall.

Q. Did you feel like people were accusing you of improper conduct related to those death investigations of the Best Western Hotel cases?

A. I do.

Q. Have you ever been accused of any other improper conduct relating to other cases?

A. No, ma'am.

Q. Is there anyone else that you think that we should talk to who would have information on this case?

A. On the --

Q. Mr. Whitson's autopsy and death.

A. Just the person maybe from the ME office that reviewed the case, and the toxicologist, would be the only people I can think of. You're going to run out of little notepads down there.

Q. Does morphine in the urine, does it tell you about when morphine was ingested?

A. No.

Q. Does it tell you over what time period the morphine was ingested?

A. Well, morphine can stay in the urine for up to as many as six days.

Q. Does the level of morphine in the urine tell you how many times someone used morphine?

A. No.

Q. Is there anything else you would like us to know about this case?

A. I think y'all pretty well covered it.

Q. Okay. Is there anything else that you think would be helpful for us in our investigation of this case?

A. I can't think of anything right offhand. Other than talking to those other people.

Q. It's possible that our case may proceed to a Commission hearing. And we've issued a subpoena for your presence at that hearing. But if you are not called to testify at that hearing, is there anything that you think our Commissioners should know?

A. Well, I think that this is a marginal case in that the level of morphine in the urine was in the low toxic range. But that was the only thing -- the only finding at autopsy that could account for his demise.

Q. What do you mean by marginal?

A. Well, that I'd rather the morphine had been very high.

Q. Do you have concerns about this case?

A. Not about the autopsy finding. I have con -- well, this is my own -- just my own feeling is that I feel like there was possibly overreach by the DA's office.

Q. What makes you say that?

A. Just the circumstances surrounding the case.

Q. Did the district attorneys ever say anything to you about this case?

A. Nothing other than get up there and testify. But that's part of my liberal agenda, I guess.

Q. That's part of your what?

A. My liberal agenda.

Q. Liberal agenda. Has anyone talked to you about what you have testified to at this deposition?

A. No.

Q. Has anyone told you what to say today?

A. No.

Q. Has anyone made you any promises about your testimony today?

A. No.

Q. Has anyone threatened you regarding your

testimony today?

A. No.

Q. Has anyone put any pressure on you regarding your testimony today?

A. Slight pressure. But that's to be expected.

Q. Who put slight pressure on you?

A. Y'all.

Q. Were you completely truthful when answering my questions today?

A. Yes, ma'am.

Q. Do you remember any additional information about any of the questions that I asked during the deposition?

A. Nothing comes to mind.

Q. Is there any other topic that we have not explored that you think might be important to my understanding of this case?

A. I can't think of any.

MS. BRIDENSTINE: All right. I'm going to conclude and end the deposition at this time. Time is 4:10 p.m.

(WHEREUPON, the foregoing deposition was concluded at 4:10 p.m. on July 30, 2021.)

STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

COUNTY OF YANCEY

STATE OF NORTH CAROLINA,
Petitioner,
-vs-
JOHN PRITCHARD,
Defendant.

File No. 11 CRS 304

File No. 11 CRS 305

DEPOSITION OF

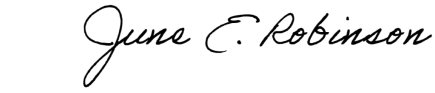
DR. BRENT DWAYNE HALL

July 30, 2021

I, June Robinson, having been assigned to transcribe the above-captioned deposition from July 30, 2021, do hereby certify that said deposition, pages 1 through 130, is a true, correct, and verbatim transcript of said proceeding to the best of my ability.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was heard; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, and am not financially or otherwise interested in the outcome of the action.

This 4th day of August, 2021.



June Robinson, transcriptionist
2304 Vail Avenue
Charlotte, North Carolina 28207
(704) 377-4372

STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

COUNTY OF YANCEY

STATE OF NORTH CAROLINA,
Petitioner,
-vs-
JOHN PRITCHARD,
Defendant.

File No. 11 CRS 304

File No. 11 CRS 305

DEPOSITION OF

DR. BRENT DWAYNE HALL

July 30, 2021

ERRATA SHEET

Page	Line	Correction

Date: Signature:

T R A N S C I P T C O R R E C T I O N S

CASE NAME: State v. John Pritchard

WITNESS NAME: Dr. Brent Hall

FILE NUMBER: 11 CRS 304, 305 (Yancey County)

DATE:

PAGE	LINE	READS	SHOULD READ

S I G N A T U R E

_____ I have read the foregoing pages which contain a true and accurate transcription of the answers provided to the questions herein recorded and I do not desire to make any changes.

_____ I have read the foregoing pages and wish to incorporate the changes that are delineated on the errata sheet to my deposition.

_____

I, _____, Notary Public for the County of _____, State of _____, do hereby certify that the hereinabove named personally appeared before me this the _____ day of _____, 2020, and that I personally witnessed the execution of this document for the intents and purposes hereinabove described.

_____
NOTARY PUBLIC

STATE OF _____

MY COMMISSION EXPIRES:_____

STATE OF NORTH CAROLINA

COUNTY OF YANCEY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
11 CRS 304
11 CRS 305

STATE OF NORTH CAROLINA)
)
v.) **CERTIFICATION**
)
JOHN PRITCHARD)
)
)
)

NOW COMES the undersigned, Brian Ziegler, and certifies pursuant to N.C.G.S. § 1A-1, Rule 30(f)(1) that on July 30, 2021, Dr. Brent Dwayne Hall appeared before him for the purpose of taking a deposition upon oral examination by the North Carolina Innocence Inquiry Commission (Commission). The deponent was duly sworn by the undersigned and the attached sound-and-video recording, together with all exhibits annexed thereto, constitutes a true and accurate record of the testimony given.

The undersigned further certifies that copies of the audio/video recordings of the deposition and the deposition transcript were submitted via electronic mail to the deponent for examination and review on August 23, 2021 with instruction to review all materials, make corrections, sign a deposition certificate, and return the deposition certificate to the Commission within 30 days. The Commission did not receive any request for changes or the signature page within 30 days.

This the 27th day of September, 2021.

Brian Ziegler

EXHIBIT 1

PENGAD 800-631-6989

21-CV02130

STATE OF NORTH CAROLINA

File No. 11 CRS 304

YANCEY County

In The General Court Of Justice
☐ District ☒ Superior Court Division

FILED
2021 JUL 23 11:11:06
YANCEY COUNTY, C.S.C.

State of North Carolina

Additional File Numbers
11 CRS 305

VERSUS

John Pritchard

SUBPOENA

G.S. 1A-1, Rule 45; 8-59, -61, -63; 15A-801, -802

Party Requesting Subpoena
☒ State/Plaintiff ☐ Defendant

NOTE TO PARTIES NOT REPRESENTED BY COUNSEL: *Subpoenas may be produced at your request, but must be signed and issued by the office of the Clerk of Superior Court, or by a magistrate or judge.*

TO

Name And Address Of Person Subpoenaed
Dr. Brent Hall
5525 Meat Camp Road
Todd, NC 28684

Telephone No.

Alternate Address
1201 Meat Camp Baptist Church Road
Boone, NC 28607

Telephone No.

YOU ARE COMMANDED TO: *(check all that apply)*

☐ appear and testify, in the above entitled action, before the court at the place, date and time indicated below.
☒ appear and testify, in the above entitled action, at a deposition at the place, date and time indicated below.
☒ produce and permit inspection and copying of the following items, at the place, date and time indicated below.
☐ See attached list. *(List here if space sufficient)*

PURSUANT TO N.C.G.S. 15A-1467(d), 15A-801, AND 1A-1, RULE 45, you are commanded to appear and testify in the above captioned manner. Pursuant to N.C.G.S. 1A-1, RULE 30(b)(4), testimony will be recorded by sound and visual means and a stenographer will not be present.

ALSO PURSUANT TO N.C.G.S. 15A-1467(d), 15A-802, and 1A-1, Rule 45, you are commanded to produce to the North Carolina Innocence Inquiry Commission at the deposition on July 14, 2021 at 12:00 p.m. any and all documents and records in your possession related to the autopsy of Jonathan Whitson and the prosecution of John Pritchard for the above-captioned case.

Name And Location Of Court/Place Of Deposition/Place To Produce
Law Library
Ashe County Courthouse
150 Government Circle
Jefferson, NC 28640

Date To Appear/Produce, Until Released
07/30/2021

Time To Appear/Produce, Until Released
12:00 ☐ AM ☒ PM

Date
07/14/2021

Name And Address Of Applicant Or Applicant's Attorney
Julie Bridenstine, Staff Attorney
North Carolina Innocence Inquiry Commission
Post Office Box 2448
Raleigh, NC 27602

Telephone No. Of Applicant Or Applicant's Attorney
(919) 890-1580

Signature
Julie Bridenstine

☐ Deputy CSC ☐ Assistant CSC ☐ Clerk Of Superior Court
☐ Magistrate ☒ Attorney/DA ☐ District Court Judge
☐ Superior Court Judge

RETURN OF SERVICE

I certify this subpoena was received and served on the person subpoenaed as follows:

By ☑ personal delivery. ☐ registered or certified mail, receipt requested and attached.
☐ telephone communication by Sheriff *(use only for a witness subpoenaed to appear and testify).*
☐ telephone communication by local law enforcement agency *(use only for a witness subpoenaed to appear and testify in a criminal case).*
NOTE TO COURT: *If the witness was served by telephone communication from a local law enforcement agency in a criminal case, the court may **not** issue a show cause order or order for arrest against the witness until the witness has been served personally with the written subpoena.*
☐ I was unable to serve this subpoena. Reason unable to serve: _____.

Service Fee	Date Served	Name Of Authorized Server (type or print)	Signature Of Authorized Server	Title/Agency
$ — ☐ Paid ☐ Due	7-15-21	Gerald Townsend	Gerald Townsend	Deputy

NOTE TO PERSON REQUESTING SUBPOENA: *A copy of this subpoena must be delivered, mailed or faxed to the attorney for each party in this case. If a party is not represented by an attorney, the copy must be mailed or delivered to the party. This does not apply in criminal cases.*

(Please see reverse side)

REC'D 07/15/2021

NOTE: Rule 45, North Carolina Rules of Civil Procedure, Subsections (c) and (d).

(c) Protection of Persons Subject to Subpoena

(1) Avoid undue burden or expense. - A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing an undue burden or expense on a person subject to the subpoena. The court shall enforce this subdivision and impose upon the party or attorney in violation of this requirement an appropriate sanction that may include compensating the person unduly burdened for lost earnings and for reasonable attorney's fees.

(2) For production of public records or hospital medical records. - Where the subpoena commands any custodian of public records or any custodian of hospital medical records, as defined in G.S. 8-44.1, to appear for the sole purpose of producing certain records in the custodian's custody, the custodian subpoenaed may, in lieu of personal appearance, tender to the court in which the action is pending by registered or certified mail or by personal delivery, on or before the time specified in the subpoena, certified copies of the records requested together with a copy of the subpoena and an affidavit by the custodian testifying that the copies are true and correct copies and that the records were made and kept in the regular course of business, or if no such records are in the custodian's custody, an affidavit to that effect. When the copies of records are personally delivered under this subdivision, a receipt shall be obtained from the person receiving the records. Any original or certified copy of records or an affidavit delivered according to the provisions of this subdivision, unless otherwise objectionable, shall be admissible in any action or proceeding without further certification or authentication. Copies of hospital medical records tendered under this subdivision shall not be open to inspection or copied by any person, except to the parties to the case or proceedings and their attorneys in depositions, until ordered published by the judge at the time of the hearing or trial. Nothing contained herein shall be construed to waive the physician-patient privilege or to require any privileged communication under law to be disclosed.

(3) Written objection to subpoenas. - Subject to subsection (d) of this rule, a person commanded to appear at a deposition or to produce and permit the inspection and copying of records, books, papers, documents, electronically stored information, or tangible things may, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, serve upon the party or the attorney designated in the subpoena written objection to the subpoena, setting forth the specific grounds for the objection. The written objection shall comply with the requirements of Rule 11. Each of the following grounds may be sufficient for objecting to a subpoena:

a. The subpoena fails to allow reasonable time for compliance.
b. The subpoena requires disclosure of privileged or other protected matter and no exception or waiver applies to the privilege or protection.
c. The subpoena subjects a person to an undue burden or expense.
d. The subpoena is otherwise unreasonable or oppressive.
e. The subpoena is procedurally defective.

(4) Order of court required to override objection. - If objection is made under subdivision (3) of this subsection, the party serving the subpoena shall not be entitled to compel the subpoenaed person's appearance at a deposition or to inspect and copy materials to which an objection has been made except pursuant to an order of the court. If objection is made, the party serving the subpoena may, upon notice to the subpoenaed person, move at any time for an order to compel the subpoenaed person's appearance at the deposition or the production of the materials designated in the subpoena. The motion shall be filed in the court in the county in which the deposition or production of materials is to occur.

(5) Motion to quash or modify subpoena. - A person commanded to appear at a trial, hearing, deposition, or to produce and permit the inspection and copying of records, books, papers, documents, electronically stored information, or other tangible things, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, may file a motion to quash or modify the subpoena. The court shall quash or modify the subpoena if the subpoenaed person demonstrates the existence of any of the reasons set forth in subdivision (3) of this subsection. The motion shall be filed in the court in the county in which the trial, hearing, deposition, or production of materials is to occur.

(6) Order to compel; expenses to comply with subpoena. - When a court enters an order compelling a deposition or the production of records, books, papers, documents, electronically stored information, or other tangible things, the order shall protect any person who is not a party or an agent of a party from significant expense resulting from complying with the subpoena. The court may order that the person to whom the subpoena is addressed will be reasonably compensated for the cost of producing the records, books, papers, documents, electronically stored information, or tangible things specified in the subpoena.

(7) Trade secrets; confidential information. - When a subpoena requires disclosure of a trade secret or other confidential research, development, or commercial information, a court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena, or when the party on whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot otherwise be met without undue hardship, the court may order a person to make an appearance or produce the materials only on specified conditions stated in the order.

(8) Order to quash; expenses. - When a court enters an order quashing or modifying the subpoena, the court may order the party on whose behalf the subpoena is issued to pay all or part of the subpoenaed person's reasonable expenses including attorney's fees.

(d) Duties in Responding to Subpoena

(1) Form of response. - A person responding to a subpoena to produce records, books, documents, electronically stored information, or tangible things shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the request.

(2) Form of producing electronically stored information not specified. - If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it ordinarily is maintained or in a reasonably useable form or forms.

(3) Electronically stored information in only one form. - The person responding need not produce the same electronically stored information in more than one form.

(4) Inaccessible electronically stored information. - The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, after considering the limitations of Rule 26(b)(1a).The court may specify conditions for discovery, including requiring the party that seeks discovery from a nonparty to bear the costs of locating, preserving, collecting, and producing the electronically stored information involved.

(5) Specificity of objection. - When information subject to a subpoena is withheld on the objection that it is subject to protection as trial preparation materials, or that it is otherwise privileged, the objection shall be made with specificity and shall be supported by a description of the nature of the communications, records, books, papers, documents, electronically stored information, or other tangible things not produced, sufficient for the requesting party to contest the objection.

INFORMATION FOR WITNESS

NOTE: *If you have any questions about being subpoenaed as a witness, you should contact the person named on Page One of this Subpoena in the box labeled "Name And Address Of Applicant Or Applicant's Attorney."*

DUTIES OF A WITNESS

- Unless otherwise directed by the presiding judge, you must answer all questions asked when you are on the stand giving testimony.
- In answering questions, speak clearly and loudly enough to be heard.
- Your answers to questions must be truthful.
- If you are commanded to produce any items, you must bring them with you to court or to the deposition.
- You must continue to attend court until released by the court. You must continue to attend a deposition until the deposition is completed.

BRIBING OR THREATENING A WITNESS

It is a violation of State law for anyone to attempt to bribe, threaten, harass, or intimidate a witness. If anyone attempts to do any of these things concerning your involvement as a witness in a case, you should promptly report that to the district attorney or the presiding judge.

WITNESS FEE

A witness under subpoena and that appears in court to testify, is entitled to a small daily fee, and to travel expense reimbursement, if it is necessary to travel outside the county in order to testify. (The fee for an "expert witness" will be set by the presiding judge.) After you have been discharged as a witness, if you desire to collect the statutory fee, you should immediately contact the Clerk's office and certify your attendance as a witness so that you will be paid any amount due you.

CURRICULUM VITAE

BRENT DWAYNE HALL, M.D.

Personal Data: Home - 1201 Meat Camp Baptist Church Road
Boone, NC 28607
(828) 264-1252

Work - Pathology Associates of Boone
P.O. Box 1818
833 State Farm Road
Boone, NC 28607
(828) 262-4106
bhall@paboone.com

Date and Place of Birth – February 17, 1960; Spruce Pine, NC

Martial Status – Married, Tricia; two children, Addie and Will

Current Positions: Pathologist, Watauga Medical Center, Boone, NC, 1993

Pathologist, Blue Ridge Regional Hospital, Spruce Pine, NC, 1999

Pathologist, Cannon Memorial Hospital, Linville, NC, 1999

Laboratory Inspector, College of American Pathologists, Chicago, IL, 1995

President, Pathology Associates of Boone, P.C., Boone, NC, 1997

Previous Positions: Medical Examiner/Regional Forensic Pathologist for Watauga, Ashe, Avery, Mitchell and Yancey Counties, Boone, NC, 1993-2013

Laboratory Medical Director, Watauga Medical Center, Boone, NC, 1993-2011

Medical Review Officer, Watauga Medical Center, Boone, NC, 1995-2010

Medical Review Officer, Cannon Memorial Hospital, Linville, NC, 2000-2010

Medical Review Officer, Blowing Rock Hospital, Blowing Rock, NC, 2007-2010

Laboratory Medical Director, Blowing Rock Hospital, Blowing Rock, NC, 2007-2009

Laboratory Medical Director, Cannon Memorial Hospital, Linville, NC, 1999-2009

Laboratory Medical Director, Yancey Medical Center, Burnsville, NC, 1999-2009

Laboratory Medical Director, Blue Ridge Regional Hospital, Spruce Pine, NC, 1999-2009

President, Progressive Pathology, Boone, NC, 2003-2009

President, High Country Pathology, Boone, NC, 2004-2008

Adjunct Assistant Professor/Guest Lecturer, Department of Anthropology, Appalachian State University, Boone, NC, 1999-2008

Laboratory Medical Director, Brookcare Lab, Inc., Clemmons, NC, 1995-1996

Laboratory Medical Director, Precision Medical Laboratory, Inc., Pineville, NC, 1995

Adjunct Clinical Professor, Department of Nursing, North Carolina Central University, Durham, NC, 1992

Laboratory Instructor, Duke University Medical Center, Durham, NC, 1990-1992

Durham County Medical Examiner, Duke University Medical Center, Durham, NC, 1989-1992

Laboratory Instructor, East Carolina University School of Medicine, Greenville, NC, 1987-1988

Medical Technologist, Pitt County Memorial Hospital, Greenville, NC, 1985-1986
Medical Technologist, C. J. Harris Community Hospital, Sylva, NC, 1982-1984

Education:

Western Carolina University, Cullowhee, NC, 1978-1982; Bachelor of Science in Medical Technology

East Carolina University, Greenville, NC, 1984-1988; Doctor of Medicine

Duke University Medical Center, Durham, NC, 1988-1991; Resident in Anatomic and Clinical Pathology

Duke University Medical Center, Durham, NC, 1991-1992; Fellow in Hematopathology

University of North Carolina School of Medicine/Office of the Chief Medical Examiner, Chapel Hill, NC, 1992-1993; Fellow in Forensic Pathology

Certification/ Licensure:

North Carolina Medical License #34026, 1988
American Board of Pathology, Anatomic and Clinical, 1994
Medical Review Officer Certification, 1995

Associations:

American Medical Association, 1984
North Carolina Medical Society, 1984
Watauga County Medical Society, 1994
American Society of Clinical Pathologists, 1994
College of American Pathologists, 1994
International Academy of Pathology, 1996
American Association of Blood Banks, 1999
American Pathology Foundation, 2004
American Association for Clinical Chemistry, 2005
North Carolina Society of Pathologists, 2009

Publications/ Presentations:

Will be furnished upon request

References:

Will be furnished upon request

PATHOLOGY ASSOCIATES OF BOONE

Phone: 828-262-4106
Fax: 828-265-2554

833 State Farm Road
Boone, North Carolina 28607

Name:	**WHITSON, JONATHAN RUSSELL**	**Autopsy #:**	**AP-11-5**
Age/Sex:	29 Y M	Race:	White
Date of Autopsy	03/07/2011	Time:	11:30
Date of Death	03/06/2011	Received From:	Yancey County
Authorized By:	Brent Hall, M.D.	Body Identified By:	Accompanying papers
Persons Present At Autopsy:	Irene Coffey, Catlin Mack		

REPORT OF AUTOPSY EXAMINATION

FINAL ANATOMIC DIAGNOSIS:

Pulmonary edema and congestion, severe
Acute bronchial pneumonia, moderate
Pulmonary emphysema, mild
Cardiomegaly, mild, with left ventricular hypertrophy

CAUSE OF DEATH: Morphine toxicity

BRENT D. HALL, MD
Electronically Signed: 05/31/2011 20:32

EXTERNAL DESCRIPTION:

Body condition: Intact

Length: 71.0 inches

Weight: 150.0 pounds

Body heat: Cold

Rigor: Complete

Livor: Posterior/purple

Hair: Brown

Eyes: Brown

Teeth: natural

Facial hair: Mustache and goatee

The body is that of a thin adult white male wrapped in a blue/green blanket. A black and white pillow case is present within the blanket. The decedent is wearing blue jeans and white briefs. Within the right rear pocket of the pants is a black wallet with an identification card, various papers and various cards. No money is present in the wallet. A tattoo of the right arm of a Rebel flag with lightening is identified.

EVIDENCE OF INJURY:

Abrasions of both upper legs measuring up to 2.8 cm in greatest diameter are present. There is a 0.5 cm abrasion of the right thumb. A 2.0 cm ulcer of the left heel is also identified. Needle marks are present in the left antecubital fossa and left forearm.

ADDITIONAL PROCEDURES:

Radiographs: None

Microbiology: None

Chemistry:

Glucose-	<20.0 mg/dL
Chloride-	114.0 mmol/L
Potassium-	12.2 mmol/L
Sodium-	158.0 mmol/L
UREA nitrogen	16.0 mg/dL
Calcium-	6.6 mg/dL

Evidence collected: None

Personal Effects Disposition: Clothing, pocket contents, blanket and pillowcase released with the body to the funeral home.

INTERNAL EXAMINATION:

Body Cavities: Unremarkable

Cardiovascular system: Heart weight-420 grams. The coronary arteries display normal anatomic distribution and are free of significant atherosclerotic change. Sections of the heart demonstrate mild concentric left ventricular hypertrophy. The cardiac valves, cardiac chambers and myocardium are otherwise unremarkable. The aorta is unremarkable.

Neck: The thyroid is of the usual size and configuration. The hyoid bone and thyroid cartilage are intact. The larynx and trachea are unremarkable.

Respiratory tract: Lungs: Right weight-1040 grams; left weight-900 grams. Sectioning demonstrates marked edema and congestion. Mild emphysematous change is also identified. The lower trachea and major bronchi are unremarkable. . .

Gastrointestinal tract: The gastrointestinal tract is intact throughout its length. The stomach contains about 200 cc of partially digested food among which are recognizable bits of white meat. Unusual odor is not detected. The appendix is present. The large bowel contains a small amount of semisolid stool.

Liver: 1760 grams. Glisson's capsule is intact. Sectioning demonstrates unremarkable hepatic parenchyma. The extrahepatic biliary system is patent. The gallbladder contains liquid bile.

Pancreas: Unremarkable.

Spleen: 210 grams. Unremarkable.

Adrenals: Unremarkable.

Urinary tract: Kidneys: Right weight-180 grams; left weight-160 grams. The capsules strip with ease to reveal smooth cortical surfaces. Sectioning shows good corticomedullary differentiation. Bladder: The bladder contains about 10 cc of straw colored urine. The bladder mucosa is unremarkable.

Reproductive tract: Unremarkable

Musculoskeletal system: Unremarkable.

Immunologic system: Unremarkable.

Head: Scalp: Intact. Skull: Intact. Brain: Weight-1260 grams. The meninges are thin, delicate and without evidence of hemorrhage or exudate. Sectioning demonstrates unremarkable parenchyma. The blood vessels at the base of the brain are unremarkable.

MICROSCOPIC:

Heart: Sections of the heart show mild myelocyte hypertrophy.

Lungs: The lungs demonstrate marked edema and congestion. Moderate acute bronchial pneumonia is present. Perihilar lymph nodes contain granulomas with birefringent material.

Liver: No pathologic diagnosis.

Kidneys: No pathologic diagnosis.

Brain: No pathologic diagnosis.

SUMMARY AND INTERPRETATION:

Mr. Whitson was a 29 year old found dead in bed 3-6-11. Autopsy was requested by the Yancey County Sheriff's Department.

Autopsy demonstrated marked pulmonary edema and congestion with a moderate degree of acute bronchial pneumonia. Mild pulmonary emphysema was also present. The heart was mildly enlarged with left ventricular hypertrophy. An ethanol level performed on aortic blood obtained at the time of autopsy was 40.0 mg/dL (0.04% of Breathalyzer scale). Additional toxicology performed on aortic blood demonstrated the following: Benzodiazepines, none detected; cocaine, none

detected; morphine, present; nicotine, present; other opiates/opioids, none detected; other organic bases, none detected. A trace of morphine was present in the femoral blood. Morphine was present in the urine at concentration of 15.0 mg/L.

The case of death in this case was morphine toxicity.

WATAUGA MEDICAL CENTER
Member of Appalachian Regional Healthcare System

Medical Examiner Release of Body

I certify that I received the body of Whitson, Jonathan

and following personal belongings blue/green blanket, blk/wt pillow case, jeans, briefs, ~~rt pocket~~ black wallet & ID card

Signed: [signature]

Funeral Home: Yancey Funeral Service

Address: 378 Charlie Br Rd
Burnsville NC 28714

Phone Number: (828) 678-9962

Witness: D. Walker

Date: 3-7-11

This document was obtained during the Commission's investigation of State v. John Pritchard – 11 CRS 304-305. Due to the sensitive nature of this document the Commission Chair has ordered that it not appear on our website.

If you wish to review this document, you may contact the Yancey County Clerk's Office or you may make a Public Records Request through the North Carolina Administrative Office of the Courts.

This document was obtained during the Commission's investigation of State v. John Pritchard – 11 CRS 304-305. Due to the sensitive nature of this document the Commission Chair has ordered that it not appear on our website.

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EXHIBIT
4

PENGAD 800-631-6989

Mandy Cohen
Secretary

Mark T. Benton
Assistant Secretary, Division of Public Health

Dr. Cardra Burns, DBA, MPA, CLC
Senior Deputy Director, Division of Public Health

Michelle Aurelius, M.D.
Chief Medical Examiner

April 7, 2021

CERTIFICATE

I certify that I am Custodian of Records at the Office of the Chief Medical Examiner in Raleigh, North Carolina.

I further certify that the attached document(s) pertaining to ***Jonathan Russell Whitson***, consisting of thirteen pages (13), are true and accurate copies of the document(s) which are on file at the Office of the Chief Medical Examiner.

I further certify that the original records were made and kept in the regular course of the investigation of this death as required by N.C.G.S. 130A-385(a) and 130A-389(a), and that they were made by persons having knowledge of the information set forth.

LaDeita Lindsey
PATHOLOGIST/CUSTODIAN OF RECORDS

State of North Carolina, County of Durham

I, Mary L Harrell Yedi, a Notary Public for said County & State, do hereby certify that LaDeita Lindsey personally appeared before me this day & acknowledged the due execution of the foregoing instrument. Witness my hand and official seal, this the 7 day of April, 2021.

Mary L Harrell Yedi, Notary Public

My Commission expires: July 15, 2024

4504

A2011-03448

NC OCME
NC Office of the Chief Medical Examiner
JUN 29 2011

PATHOLOGY ASSOCIATES OF BOONE

Phone: 828-262-4106
Fax: 828-265-2554

833 State Farm Road
Boone, North Carolina 28607

Name:	**WHITSON, JONATHAN RUSSELL**	**Autopsy #:**	**AP-11-5**
Age/Sex:	29 Y M	Race:	White
Date of Autopsy	03/07/2011	Time:	11:30
Date of Death	03/06/2011	Received From:	Yancey County
Authorized By:	Brent Hall, M.D.	Body Identified By:	Accompanying papers
Persons Present At Autopsy:	Irene Coffey, Catlin Mack		

REPORT OF AUTOPSY EXAMINATION

FINAL ANATOMIC DIAGNOSIS:

Pulmonary edema and congestion, severe
Acute bronchial pneumonia, moderate
Pulmonary emphysema, mild
Cardiomegaly, mild, with left ventricular hypertrophy

OCME DATE

CAUSE OF DEATH: Morphine toxicity

BRENT D. HALL, MD
Electronically Signed: 05/31/2011 20:32

EXTERNAL DESCRIPTION:

Body condition: Intact

Length: 71.0 inches

Weight: 150.0 pounds

Body heat: Cold

Rigor: Complete

Livor: Posterior/purple

Hair: Brown

Eyes: Brown

Teeth: natural

Facial hair: Mustache and goatee

The body is that of a thin adult white male wrapped in a blue/green blanket. A black and white pillow case is present within the blanket. The decedent is wearing blue jeans and white briefs. Within the right rear pocket of the pants is a black wallet with an identification card, various papers and various cards. No money is present in the wallet. A tattoo of the right arm of a Rebel flag with lightening is identified.

EVIDENCE OF INJURY:

Abrasions of both upper legs measuring up to 2.8 cm in greatest diameter are present. There is a 0.5 cm abrasion of the right thumb. A 2.0 cm ulcer of the left heel is also identified. Needle marks are present in the left antecubital fossa and left forearm.

ADDITIONAL PROCEDURES:

Radiographs: None

Microbiology: None

Chemistry:

Glucose-	<20.0 mg/dL
Chloride-	114.0 mmol/L
Potassium-	12.2 mmol/L
Sodium-	158.0 mmol/L
UREA nitrogen	16.0 mg/dL
Calcium-	6.6 mg/dL

Evidence collected: None

Personal Effects Disposition: Clothing, pocket contents, blanket and pillowcase released with the body to the funeral home.

INTERNAL EXAMINATION:

Body Cavities: Unremarkable

Cardiovascular system: Heart weight-420 grams. The coronary arteries display normal anatomic distribution and are free of significant atherosclerotic change. Sections of the heart demonstrate mild concentric left ventricular hypertrophy. The cardiac valves, cardiac chambers and myocardium are otherwise unremarkable. The aorta is unremarkable.

Neck: The thyroid is of the usual size and configuration. The hyoid bone and thyroid cartilage are intact. The larynx and trachea are unremarkable.

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Pancreas: Unremarkable.

Spleen: 210 grams. Unremarkable.

Adrenals: Unremarkable.

Urinary tract: Kidneys: Right weight-180 grams; left weight-160 grams. The capsules strip with ease to reveal smooth cortical surfaces. Sectioning shows good corticomedullary differentiation. Bladder: The bladder contains about 10 cc of straw colored urine. The bladder mucosa is unremarkable.

Reproductive tract: Unremarkable

Musculoskeletal system: Unremarkable.

Immunologic system: Unremarkable.

Head: Scalp: Intact. Skull: Intact. Brain: Weight-1260 grams. The meninges are thin, delicate and without evidence of hemorrhage or exudate. Sectioning demonstrates unremarkable parenchyma. The blood vessels at the base of the brain are unremarkable.

MICROSCOPIC:

Heart: Sections of the heart show mild myelocyte hypertrophy.

Lungs: The lungs demonstrate marked edema and congestion. Moderate acute bronchial pneumonia is present. Perihilar lymph nodes contain granulomas with birefringent material.

Liver: No pathologic diagnosis.

Kidneys: No pathologic diagnosis.

Brain: No pathologic diagnosis.

SUMMARY AND INTERPRETATION:

Mr. Whitson was a 29 year old found dead in bed 3-6-11. Autopsy was requested by the Yancey County Sheriff's Department.

Autopsy demonstrated marked pulmonary edema and congestion with a moderate degree of acute bronchial pneumonia. Mild pulmonary emphysema was also present. The heart was mildly enlarged with left ventricular hypertrophy. An ethanol level performed on aortic blood obtained at the time of autopsy was 40.0 mg/dL (0.04% of Breathalyzer scale). Additional toxicology performed on aortic blood demonstrated the following: Benzodiazepines, none detected; cocaine, none

detected; morphine, present; nicotine, present; other opiates/opioids, none detected; other organic bases, none detected. A trace of morphine was present in the femoral blood. Morphine was present in the urine at concentration of 15.0 mg/L.

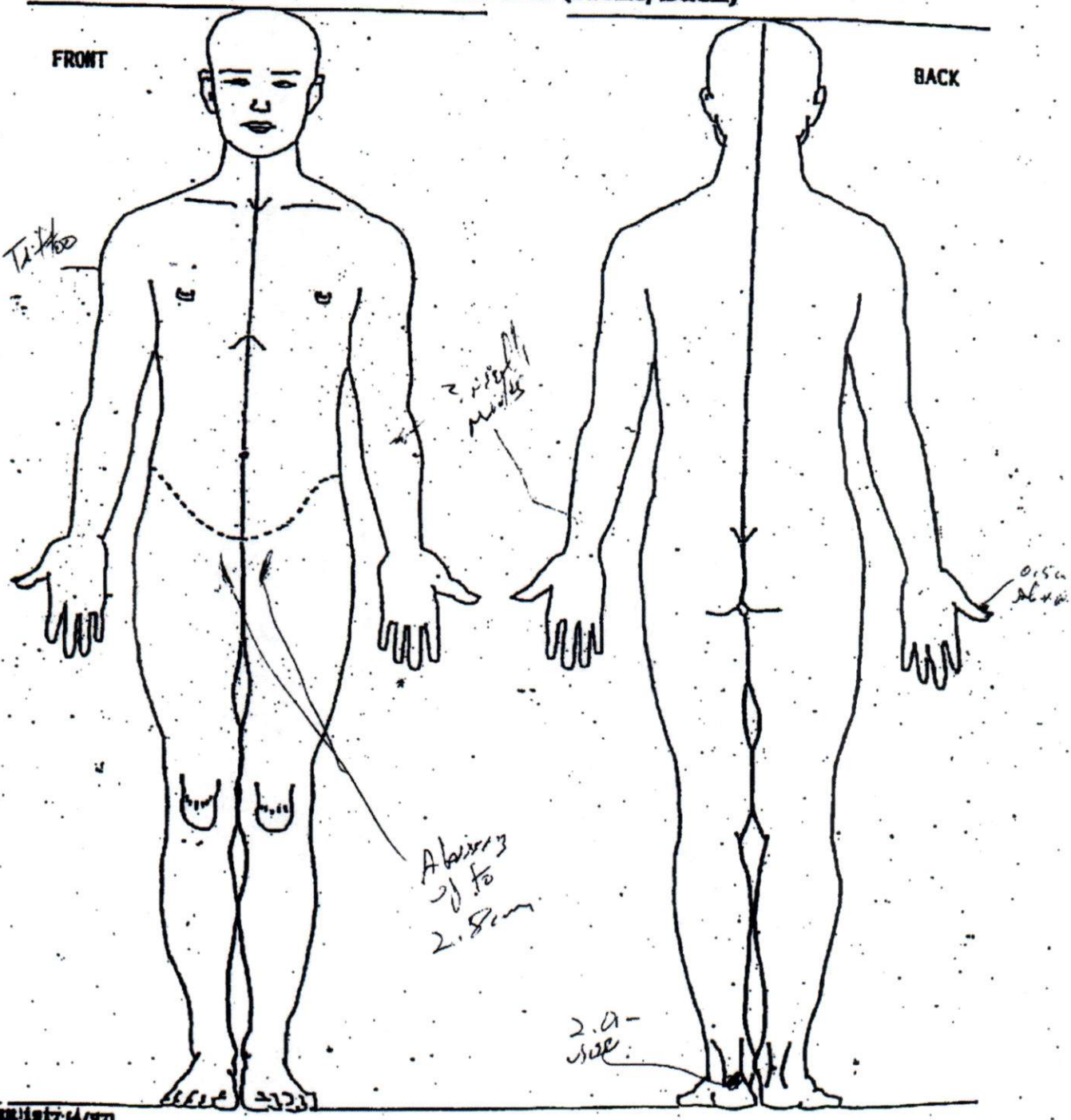
The case of death in this case was morphine toxicity.

5

State of North Carolina
Office of the Chief Medical Examiner
Chapel Hill, North Carolina 27599-7580

Name of Decedent: Jonathan Whitson
Autopsy # APM-5
Examined By: [illegible] Date: 3/7/11

BODY DIAGRAM: ADULT (Front/Back)



DCHME 1317 (4/97)
Medical Examiner

This form may be photocopied.

12011-02420

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE CHIEF MEDICAL EXAMINER
Chapel Hill, North Carolina 27599-7580

REPORT OF INVESTIGATION BY MEDICAL EXAMINER

OCME USE ONLY
11-0509
Case number
MAR 09 2011
Date received
☐ Res ☐ NR

DECEDENT: Jonathan Russell Whitson
First Middle Last Suffix

RESIDENCE: 12681 St. Hwy. 1975 Bakersville, NC Yancey
Number and Street City, State County

AGE: 29 SEX: ☑ Male ☐ Female ☐ Unknown

RACE: ☐ Black ☐ Native American ☐ Oriental ☑ White ☐ Unknown

HISPANIC ORIGIN: ☐ Yes ☑ No ☐ Unknown

INFORMATION ABOUT OCCURRENCE

	DATE	TIME	ADDRESS OR FACILITY	COUNTY
ONSET OF INJURY OR ILLNESS	3/6/11	AM	Home	Yancey
DEATH	"	"	"	"
VIEW OF BODY	3/7/11	11:30	☐ Scene of death ☑ Hospital ☐ Funeral home ☐ Other _____ ☐ Not viewed	
M.E. NOTIFIED	3/7/11	12:30		
LAST KNOWN TO BE ALIVE	3/6/11	AM		

LAW ENFORCEMENT AGENCY: Yancey Co. Sheriff
OFFICER: Cpt. Brian Higgins TELEPHONE: —
Death occurred while in custody: ☐ Yes ☑ No ☐ Unknown

AUTOPSY: ☐ None ☑ M.E. Authorized ☐ Non-M.E. Autopsy facility: Watauga
BLOOD SAMPLE: ☐ Mailed ☑ Obtained by pathologist ☐ Reason not obtained: _____
IF CLINICAL ALCOHOL DONE, RESULT: _____ By whom: _____

PROBABLE CAUSE OF DEATH: ☑ Pending

1. Pending
DUE TO
2. _____
DUE TO
3. _____
DUE TO
4. _____

CONTRIBUTING CONDITIONS

MANNER OF DEATH:
☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☑ Pending

OCME REVIEW

1. Morphine toxicity
DUE TO
2. _____
DUE TO
3. _____
DUE TO
4. _____

CONTRIBUTING CONDITIONS

SDC
☐ None
☑ AL
☐ Dictated
☐ COG

☐ Natural ☑ Accident ☐ Homicide ☐ Suicide ☐ Undetermined
Reviewer: _____ Date: 7/6/11
Information in this block supersedes that contained in space at left.

I hereby certify that after receiving notice of the death described herein I took charge of the body and made inquiries regarding the cause of death in accordance with Article 16 of Chapter 130A of the N.C. General Statutes and the information contained herein regarding such death is true and correct to the best of my knowledge and belief.

DHHS 1114 (Revised 10/00)
Medical Examiner (Review 10/02)

(Hall)
Signature of Medical Examiner

3/7/11
Date

Yancey
County of Appointment

E9501D
M.E. Number

MEDICAL HISTORY

☐ Alcoholism ☐ Diabetes ☐ IV drug abuse ☐ Ischemic heart disease ☐ Smoking
☐ Seizure disorder ☐ Cancer ☐ Hypertension ☐ Depression ☐ HIV/ AIDS
☑ Other Any above Attending Physician _____ City _____

MEANS OF DEATH

☐ VEHICLE: Type of vehicle associated with this decedent:
☐ Passenger car ☐ Pickup truck ☐ Truck--more than 2 axles ☐ Motorcycle
☐ Bicycle ☐ Farm vehicle ☐ ATV ☐ Moped ☐ Other _____
Position: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Unknown
Devices: ☐ Seat restraints ☐ Air bag ☐ Helmet ☐ Child restraint ☐ None ☐ Unknown
Number of vehicles involved _____

☐ GUN: ☐ Rifle--Caliber _____ ☐ Handgun--Caliber _____ ☐ Shotgun--Gauge _____
☐ Other _____ ☐ Unknown

☐ INSTRUMENT: ☐ Blunt ☐ Sharp Description: _____
☑ TOXIC AGENT(S) SUSPECTED: ☐ Alcohol ☑ Others MSO4
☐ DROWNING: ☐ Pond ☐ Lake or river ☐ Ocean ☐ Pool ☐ Bathtub ☐ Other _____
Life preserver: ☐ Yes ☐ No ☐ Unknown Able to swim: ☐ Yes ☐ No ☐ Unknown
Activity _____

☐ FIRE: Suspected cause _____ Smoke detector: ☐ Yes ☐ No ☐ Unknown
☐ FALL: From _____ to _____ Approximate distance _____ feet

ACTIVITY OF DECEDENT AND PREMISES

FATAL INJURY OR ILLNESS: Activity Sleeping
Type of place Home Specific location bed

Fatal injury or illness occurred on a job: ☐ Yes ☑ No ☐ Unknown
If yes, was employment: ☐ Primary job ☐ Secondary ☐ Volunteer work ☐ Unknown
Name of this employing firm or agency _____
Type of business or industry _____ Decedent's occupation _____

DEATH: Type of place Same Specific location same

Examples:
Activity: Running, lifting hay bales, eating, typing letter, driving commercial truck, sleeping, bathing, watching television, fighting, *etc.*
Type of place: House, apartment, trailer, school, jail, bar or tavern, hotel, restaurant, store, street, hospital, farm, highway, factory, *etc.*
Specific location: Bathroom, assembly line, kitchen, front yard, office, parking lot, emergency room, roadside, ambulance, car, *etc.*
On a job: Any activity that is income generating regardless of age of decedent including farming or part time work; also include non-income generating volunteer or charity work.

DESCRIPTION OF BODY

CONDITION: ☐ Intact ☐ Decomposition ☐ Skeletonized
☐ Embalmed ☐ Charred ☐ Prolonged immersion ☐ Exhumed

RIGOR: ☐ None ☐ 1+ ☐ 2+ ☐ 3+ LIVOR: ☐ None ☐ Anterior ☐ Posterior ☐ Lateral

HEIGHT: _____ inches ☐ Estimate WEIGHT: _____ pounds ☐ Estimate

BODY TEMPERATURE: ☐ Warm ☐ Cool ☐ Cold HAIR: Color _____ ☐ Beard ☐ Mustache

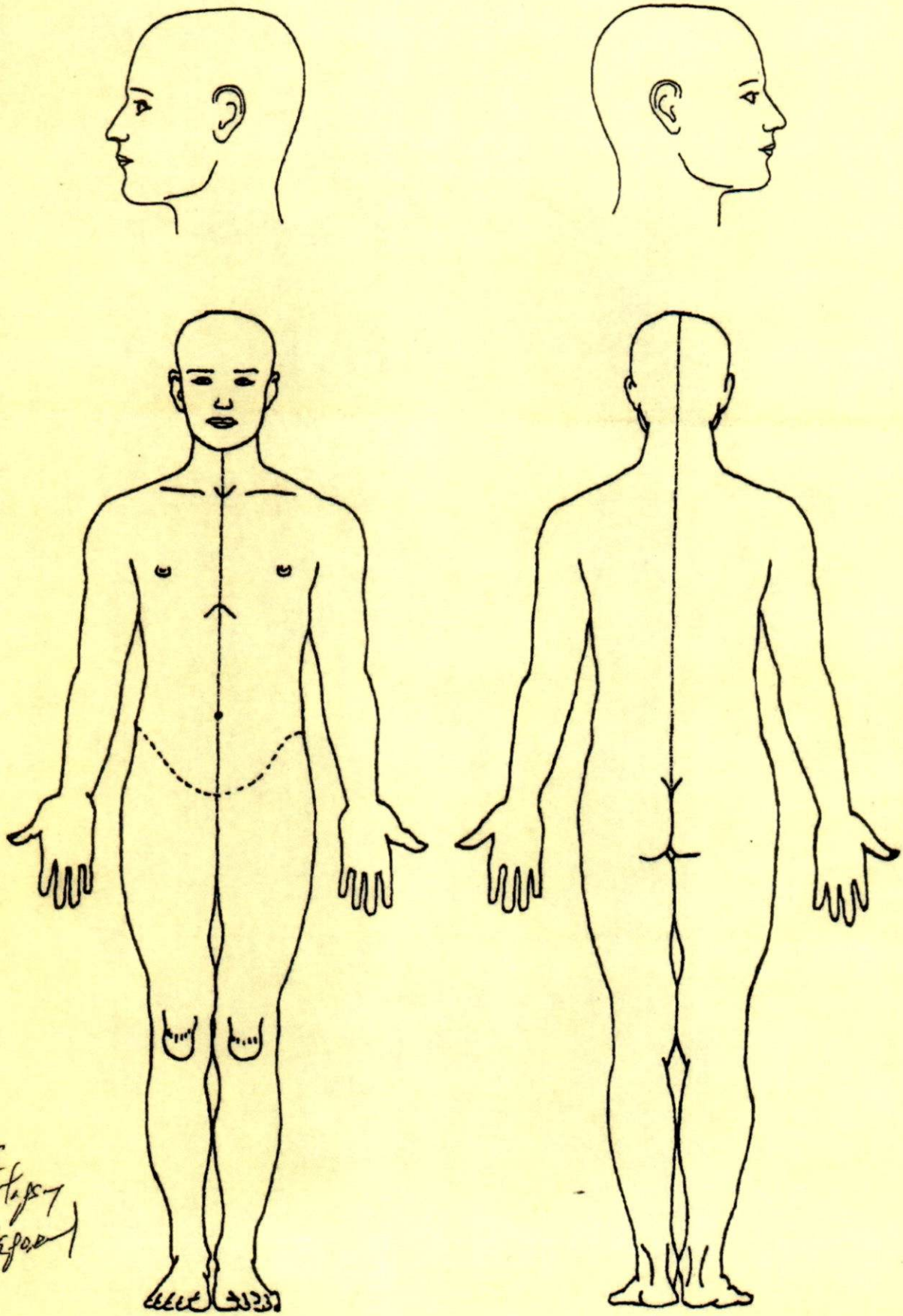
EYES: Color _____ Abnormalities _____

TEETH: Upper ☐ Natural ☐ Dentures ☐ Abnormalities _____
Lower ☐ Natural ☐ Dentures ☐ Abnormalities _____

CLOTHING: _____ ☐ Not clothed

VALUABLES: _____ ☐ No valuables

BODY DIAGRAMS



SEE Autopsy Report

Indicate nature and location of wounds and other lesions (scars, tattoos, medical therapy, *etc.*) on these diagrams.

NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH

Mr. Collinson was a 29 yo released from jail in Madison Co. 3/4/11. On 3/5/11 he is alleged to have taken morphine and his girlfriend. The next am he was found dead in bed. Autopsy was Requested by the YCSD.

PURPOSE: To document the findings of a medical examiner investigation. When completed, this form constitutes a report to the Chief Medical Examiner as required by G.S. 130A-385(a).
PREPARATION: The investigating medical examiner completes all appropriate information, and signs the certification statement on the front of the form.
DISTRIBUTION: Mail *original* copy to the Office of the Chief Medical Examiner, Chapel Hill, NC 27599-7580.
DISPOSITION: This form is maintained by the Chief Medical Examiner in accordance with the current records disposition schedule published by the N.C. Division of Archives and History.
COPIES: Additional copies may be ordered from the Office of the Chief Medical Examiner, Chapel Hill, NC 27599-7580.

T O X I C O L O G Y R E P O R T

Office of the Chief Medical Examiner
Raleigh,NC 27699-3025

Toxicology Folder: T201101851
Case Folder: F201102509
Date of Report: 04-apr-2011
DOD: 06-mar-2011

DECEDENT: Jonathan Russell Junior Whitson
Status of Report: Approved
Report Electronically Approved By: Ruth Winecker, Ph.D.

* * *

SPECIMENS received from Brent D. Hall on 09-mar-2011

S110004482: 6.0 ml Blood — CONDITION: Postmortem
SOURCE: Femoral Vessel — OBTAINED: 07-mar-2011

Morphine	Trace			04/04/2011

S110004483: 16.0 ml Blood — CONDITION: Postmortem
SOURCE: Aorta — OBTAINED: 07-mar-2011

Benzodiazepines	None Detected	LCMS		04/04/2011
Cocaine	None Detected	LCMS		04/04/2011
Ethanol	40		mg/dL	04/04/2011
Morphine	Present	LCMS		04/04/2011
Nicotine	Present			04/04/2011
Other Opiates/Opioids	None Detected	LCMS		04/04/2011
Other Organic Bases	None Detected			04/04/2011

S110004484: 5.0 ml Urine — CONDITION: Postmortem
SOURCE: Urinary Bladder — OBTAINED: 07-mar-2011

Morphine	15		mg/L	04/04/2011

S110004485: Liver — CONDITION: Postmortem
SOURCE: — OBTAINED: 07-mar-2011

T O X I C O L O G Y R E P O R T

Office of the Chief Medical Examiner
Raleigh, NC 27699-3025

Toxicology Folder: T201101851
Case Folder: F201102509
Date of Report: 04-apr-2011
DOD: 06-mar-2011

Decedent: Jonathan Russell Junior Whitson

* * *

032421 15:22 * * * E N D O F R E P O R T * * *

D2011 – 02962

2509

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NC VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MAR 29 2011

100-00 Local No.

1. Decedent's Name (First, Middle, Last): Jonathan Russell Junior Whitson	2. Sex: M	3. Date of Death (Month, Day, Year): Mar 6, 2011
4. Social Security Number: 238-37-1364	5a. Age—Last Birthday (Years): 29	6. Date of Birth (Month, Day, Year): Jan 20, 1982
7. Birthplace (County and State or Foreign Country): Mitchell, NC	8. Was decedent ever in U.S. Armed Forces? (Yes or No): NO	

9a. Place of Death (Check only one; see instructions on other side): Hospital ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

9b. Facility Name (If not institution, give street and number): 630 English Branch Rd
9c. City, Town, or Location of Death: Burnsville
9d. Inside City Limits: NO
9e. County of Death: Yancey

10. Marital Status: [illegible]
11. Surviving Spouse: [illegible]
12a. Decedent's Usual Occupation: [illegible]
12b. Kind of Business/Industry: Construction

13a. Residence—State: [illegible]
13b. County: Yancey
13c. City, Town, or Location: Burnsville
13d. Street and Number: 630 English Branch Rd
13e. Inside City Limits (Yes or No): NO
13f. Zip Code: 28714
14. Was decedent of Hispanic Origin? ☐ Yes ☒ No
15. Race: White
16. Decedent's Education: 12

17. Father's Name (First, Middle, Last): Ward Russell Wilson
18. Mother's Name (First, Middle, Maiden Surname): Annette Ann Whitson

19a. Informant's Name (Type/Print): Annette Ann Greene
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 435 N. Mitchell Ave, Bakersville, NC 28705
Date Amended:

Cause of Death

Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. If appropriate, enter tobacco, alcohol, or drug use. List only one cause on each line. (PRINT or TYPE)

Immediate cause (Final disease or condition resulting in death): a. Pending

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, such as tobacco, alcohol, or drug use, diabetes, etc.

21a. Was an autopsy performed? (Yes or No): YES
21b. Were autopsy findings available prior to completion of death certificate? (Yes or No): NO

22a. Manner of Death: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☒ Pending ☐ Not Determined
Date of Injury:
Time of Injury:
Injury at Work (Yes or No):
Describe how injury occurred:

Place of Injury:
Location:
Time of Death:

24a. Name and address of person who completed cause of death: Brent Hall, MD, 330 [illegible] Rd, [illegible], NC 28[illegible]

25a. Method of Disposition: ☐ Burial ☐ Cremation ☐ Donation ☐ Other (Specify)
25b. Place of Disposition: [illegible] Cemetery
25c. Location: [illegible]

26a. Name of Facility: [illegible] Funeral Service, Inc. 28714, 378 Charlie Brown Rd, Burnsville, NC
26b. Name of Funeral Director: Mark K. Grindstaff
26c. License Number: FS2171

27. Registrar's Signature: Deputy Registrar
28. Date Filed (Month, Day, Year): 03/25/2011
26d. Name of Embalmer: Jack Richard Gassaway
26e. License Number: FS2154

DHHS 2164 (Revised 9/05) VITAL RECORDS

020524

NORTH CAROLINA DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES
DIVISION OF EPIDEMIOLOGY - VITAL RECORDS SECTION

F201102509

SUPPLEMENTAL REPORT OF CAUSE OF DEATH

JUL 20 2011

NAME OF DECEASED
Jonathan Russell Junior Whitson

DATE OF DEATH	COUNTY OF DEATH	SEX	RACE
03/06/11	Yancey	M	White

PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death)
a. Morphine toxicity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST.
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):

20a. d:

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1
20b.

WAS AN AUTOPSY PERFORMED (YES OR NO) 21a. Yes

Were Autopsy Findings Available Prior to Completion of Death Certificate? 21b. (Yes or No) Yes

MANNER OF DEATH
☐ Natural ☒ Accident ☐ Suicide
21c. ☐ Homicide ☐ Pending ☐ Not Determined

DATE OF INJURY (Month, Day, Year) 22a.

TIME OF INJURY 22b.

INJURY AT WORK? (YES OR NO) 22c.

DESCRIBE HOW INJURY OCCURRED 22d.

PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) 22e.

LOCATION (Street and Number or Rural Route Number, City or Town, State) 22f.

TIME OF DEATH 22g. AM

To the best of my knowledge, death occurred at the time, date and place stated. (Signature and Title of Certifier)
23a. [signature], M.D.

DATE SIGNED (Month, Day, Year) 23b. 7/15/11

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type or Print)
24a. Brent D. Hall , MD Boone, NC 28607-0000

DATE PRONOUNCED DEAD (Month, Day, Year) 24b.

Note: All entries in the medical and cause-of-death section supersede the corresponding entries on the original certificate.

This document was obtained during the Commission's investigation of State v. John Pritchard – 11 CRS 304-305. Due to the sensitive nature of this document the Commission Chair has ordered that it not appear on our website.

If you wish to review this document, you may contact the Yancey County Clerk's Office or you may make a Public Records Request through the North Carolina Administrative Office of the Courts.

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12011-02420

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE CHIEF MEDICAL EXAMINER
Chapel Hill, North Carolina 27599-7580

REPORT OF INVESTIGATION BY MEDICAL EXAMINER

OCME USE ONLY
11-0509
Case number
MAR 09 2011
Date received
☐ Res ☐ NR

DECEDENT: Jonathan Russell Whitson
First Middle Last Suffix

RESIDENCE: 12681 St. Hwy. 1975 Bakersville, NC Yancey
Number and Street City, State County

AGE: 29 SEX: ☑ Male ☐ Female ☐ Unknown

RACE: ☐ Black ☐ Native American ☐ Oriental ☑ White ☐ Unknown

HISPANIC ORIGIN: ☐ Yes ☑ No ☐ Unknown

INFORMATION ABOUT OCCURRENCE

	DATE	TIME	ADDRESS OR FACILITY	COUNTY
ONSET OF INJURY OR ILLNESS	3/6/11	AM	Home	Yancey
DEATH	"	"	"	"
VIEW OF BODY	3/7/11	11:30	☐ Scene of death ☑ Hospital ☐ Funeral home ☐ Other ☐ Not viewed	
M.E. NOTIFIED	3/2/11	12:30	LAW ENFORCEMENT AGENCY: Yancey Co. Sheriff	
LAST KNOWN TO BE ALIVE	3/6/11	AM	OFFICER: Cpt. Donny Higgins TELEPHONE: —	
			Death occurred while in custody: ☐ Yes ☑ No ☐ Unknown	

AUTOPSY: ☐ None ☑ M.E. Authorized ☐ Non-M.E. Autopsy facility: Winston-Salem
BLOOD SAMPLE: ☐ Mailed ☑ Obtained by pathologist ☐ Reason not obtained:
IF CLINICAL ALCOHOL DONE, RESULT: By whom:

PROBABLE CAUSE OF DEATH: ☑ Pending

1. Pending
DUE TO
2.
DUE TO
3.
DUE TO
4.

CONTRIBUTING CONDITIONS

MANNER OF DEATH:
☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☑ Pending

OCME REVIEW

1. Morphine toxicity
DUE TO
2.
DUE TO
3.
DUE TO
4.

CONTRIBUTING CONDITIONS

SDC
☐ None
☑ AL
☐ Dictated
☐ COG

☐ Natural ☑ Accident ☐ Homicide ☐ Suicide ☐ Undetermined
Reviewer: Date: 7/6/11
Information in this block supersedes that contained in space at left.

I hereby certify that after receiving notice of the death described herein I took charge of the body and made inquiries regarding the cause of death in accordance with Article 16 of Chapter 130A of the N.C. General Statutes and the information contained herein regarding such death is true and correct to the best of my knowledge and belief.

(Hall) 3/7/11 Yancey ME9501D
Signature of Medical Examiner Date County of Appointment M.E. Number

DHHS 1114 (Revised 10/00)
Medical Examiner (Review 10/02)

MEDICAL HISTORY

☐ Alcoholism ☐ Diabetes ☐ IV drug abuse ☐ Ischemic heart disease ☐ Smoking
☐ Seizure disorder ☐ Cancer ☐ Hypertension ☐ Depression ☐ HIV/ AIDS
☑ Other Alcohol abuse Attending Physician _____ City _____

MEANS OF DEATH

☐ VEHICLE: Type of vehicle associated with this decedent:
☐ Passenger car ☐ Pickup truck ☐ Truck--more than 2 axles ☐ Motorcycle
☐ Bicycle ☐ Farm vehicle ☐ ATV ☐ Moped ☐ Other _____
Position: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Unknown
Devices: ☐ Seat restraints ☐ Air bag ☐ Helmet ☐ Child restraint ☐ None ☐ Unknown
Number of vehicles involved _____

☐ GUN: ☐ Rifle--Caliber _____ ☐ Handgun--Caliber _____ ☐ Shotgun--Gauge _____
☐ Other _____ ☐ Unknown

☐ INSTRUMENT: ☐ Blunt ☐ Sharp Description: _____
☑ TOXIC AGENT(S) SUSPECTED: ☐ Alcohol ☑ Others MSO4

☐ DROWNING: ☐ Pond ☐ Lake or river ☐ Ocean ☐ Pool ☐ Bathtub ☐ Other _____
Life preserver: ☐ Yes ☐ No ☐ Unknown Able to swim: ☐ Yes ☐ No ☐ Unknown
Activity _____

☐ FIRE: Suspected cause _____ Smoke detector: ☐ Yes ☐ No ☐ Unknown

☐ FALL: From _____ to _____ Approximate distance _____ feet

ACTIVITY OF DECEDENT AND PREMISES

FATAL INJURY OR ILLNESS: Activity Sleeping
Type of place Home Specific location bed

Fatal injury or illness occurred on a job: ☐ Yes ☑ No ☐ Unknown
If yes, was employment: ☐ Primary job ☐ Secondary ☐ Volunteer work ☐ Unknown
Name of this employing firm or agency _____
Type of business or industry _____ Decedent's occupation _____

DEATH: Type of place Same Specific location Same

Examples:
Activity: Running, lifting hay bales, eating, typing letter, driving commercial truck, sleeping, bathing, watching television, fighting, *etc.*
Type of place: House, apartment, trailer, school, jail, bar or tavern, hotel, restaurant, store, street, hospital, farm, highway, factory, *etc.*
Specific location: Bathroom, assembly line, kitchen, front yard, office, parking lot, emergency room, roadside, ambulance, car, *etc.*
On a job: Any activity that is income generating regardless of age of decedent including farming or part time work; also include non-income generating volunteer or charity work.

DESCRIPTION OF BODY

CONDITION: ☐ Intact ☐ Decomposition ☐ Skeletonized
☐ Embalmed ☐ Charred ☐ Prolonged immersion ☐ Exhumed

RIGOR: ☐ None ☐ 1+ ☐ 2+ ☐ 3+ LIVOR: ☐ None ☐ Anterior ☐ Posterior ☐ Lateral

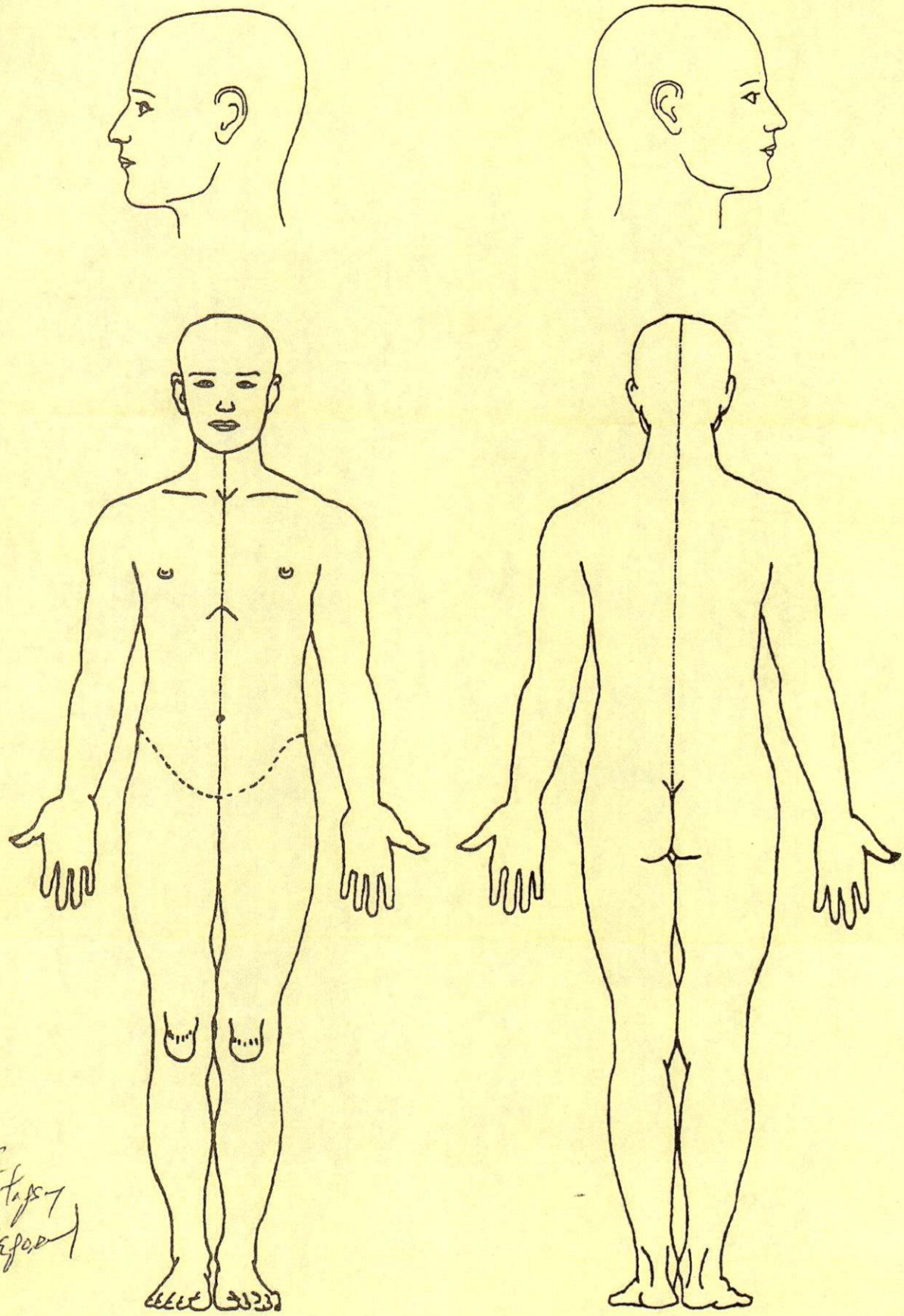
HEIGHT: _____ inches ☐ Estimate WEIGHT: _____ pounds ☐ Estimate

BODY TEMPERATURE: ☐ Warm ☐ Cool ☐ Cold HAIR: Color _____ ☐ Beard ☐ Mustache
EYES: Color _____ Abnormalities _____

TEETH: Upper ☐ Natural ☐ Dentures ☐ Abnormalities _____
Lower ☐ Natural ☐ Dentures ☐ Abnormalities _____

CLOTHING: _____ ☐ Not clothed
VALUABLES: _____ ☐ No valuables

BODY DIAGRAMS



Indicate nature and location of wounds and other lesions (scars, tattoos, medical therapy, *etc.*) on these diagrams.

NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH

Mr. Collinson was a 29 yo released from jail in Madison Co. 3/4/11. On 3/5/11 he is alleged to have taken morphine and his girlfriend. The next am he was found dead in bed. Autopsy was Requested by the YCSD.

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From: noreply@dhhs.nc.gov
Subject: No Reply: OCME Toxicology F201102509
Date: July 27, 2021 at 5:00 PM
To: bhall@paboone.com

TOXICOLOGY REPORT

Office of the Chief Medical Examiner Toxicology Folder: T201101851
Raleigh,NC 27699-3025 Case Folder: F201102509
Date of Report: 04-apr-2011
DOD: 06-mar-2011
Page: 1

Brent Hall
115 Doctor's Drive
Boone, NC 28607

DECEDENT: Jonathan Russell Junior Whitson
Status of Report: Approved
Report Electronically Approved By: Ruth Winecker, Ph.D.

* * *

SPECIMENS received from Brent D. Hall on 09-mar-2011

S110004482: 6.0 ml Blood CONDITION: Postmortem
SOURCE: Femoral Vessel OBTAINED: 07-mar-2011

Morphine	Trace	04/04/2011

S110004483: 16.0 ml Blood CONDITION: Postmortem
SOURCE: Aorta OBTAINED: 07-mar-2011

Benzodiazepines	None Detected LCMS	04/04/2011
Cocaine	None Detected LCMS	04/04/2011
Ethanol	40 mg/dL	04/04/2011
Morphine	Present LCMS	04/04/2011
Nicotine	Present	04/04/2011
Other Opiates/Opioids	None Detected LCMS	04/04/2011
Other Organic Bases	None Detected	04/04/2011

S110004484: 5.0 ml Urine CONDITION: Postmortem
SOURCE: Urinary Bladder OBTAINED: 07-mar-2011

Morphine	15 mg/L	04/04/2011

S110004485: Liver CONDITION: Postmortem
SOURCE: OBTAINED: 07-mar-2011

TOXICOLOGY REPORT

Office of the Chief Medical Examiner Toxicology Folder: T201101851
Raleigh, NC 27699-3025 Case Folder: F201102509
Date of Report: 04-apr-2011
DOD: 06-mar-2011

Decedent: Jonathan Russell Junior Whitson
* * *

072721 17:03 *** END OF REPORT ***

2509

A2011 – 03448

NC OCME
NC Office of the Chief Medical Examiner
JUN 29 2011

PATHOLOGY ASSOCIATES OF BOONE

Phone: 828-262-4106
Fax: 828-265-2554

833 State Farm Road
Boone, North Carolina 28607

Name:	**WHITSON, JONATHAN RUSSELL**	**Autopsy #:**	**AP-11-5**
Age/Sex:	29 Y M	Race:	White
Date of Autopsy	03/07/2011	Time:	11:30
Date of Death	03/06/2011	Received From:	Yancey County
Authorized By:	Brent Hall, M.D.	Body Identified By:	Accompanying papers
Persons Present At Autopsy:	Irene Coffey, Catlin Mack		

REPORT OF AUTOPSY EXAMINATION

FINAL ANATOMIC DIAGNOSIS:

Pulmonary edema and congestion, severe
Acute bronchial pneumonia, moderate
Pulmonary emphysema, mild
Cardiomegaly, mild, with left ventricular hypertrophy

dl 7/6/11
OCME DATE

CAUSE OF DEATH: Morphine toxicity

BRENT D. HALL, MD
Electronically Signed: 05/31/2011 20:32

EXTERNAL DESCRIPTION:

Body condition: Intact

Length: 71.0 inches

Weight: 150.0 pounds

Body heat: Cold

Rigor: Complete

Livor: Posterior/purple

Hair: Brown

Eyes: Brown

Teeth: natural

Facial hair: Mustache and goatee

The body is that of a thin adult white male wrapped in a blue/green blanket. A black and white pillow case is present within the blanket. The decedent is wearing blue jeans and white briefs. Within the right rear pocket of the pants is a black wallet with an identification card, various papers and various cards. No money is present in the wallet. A tattoo of the right arm of a Rebel flag with lightening is identified.

EVIDENCE OF INJURY:

Abrasions of both upper legs measuring up to 2.8 cm in greatest diameter are present. There is a 0.5 cm abrasion of the right thumb. A 2.0 cm ulcer of the left heel is also identified. Needle marks are present in the left antecubital fossa and left forearm.

ADDITIONAL PROCEDURES:

Radiographs: None

Microbiology: None

Chemistry:

Glucose-	<20.0 mg/dL
Chloride-	114.0 mmol/L
Potassium-	12.2 mmol/L
Sodium-	158.0 mmol/L
UREA nitrogen	16.0 mg/dL
Calcium-	6.6 mg/dL

Evidence collected: None

Personal Effects Disposition: Clothing, pocket contents, blanket and pillowcase released with the body to the funeral home.

INTERNAL EXAMINATION:

Body Cavities: Unremarkable

Cardiovascular system: Heart weight-420 grams. The coronary arteries display normal anatomic distribution and are free of significant atherosclerotic change. Sections of the heart demonstrate mild concentric left ventricular hypertrophy. The cardiac valves, cardiac chambers and myocardium are otherwise unremarkable. The aorta is unremarkable.

Neck: The thyroid is of the usual size and configuration. The hyoid bone and thyroid cartilage are intact. The larynx and trachea are unremarkable.

Respiratory tract: Lungs: Right weight-1040 grams; left weight-900 grams. Sectioning demonstrates marked edema and congestion. Mild emphysematous change is also identified. The lower trachea and major bronchi are unremarkable.

Gastrointestinal tract: The gastrointestinal tract is intact throughout its length. The stomach contains about 200 cc of partially digested food among which are recognizable bits of white meat. Unusual odor is not detected. The appendix is present. The large bowel contains a small amount of semisolid stool.

Liver: 1760 grams. Glisson's capsule is intact. Sectioning demonstrates unremarkable hepatic parenchyma. The extrahepatic biliary system is patent. The gallbladder contains liquid bile.

Pancreas: Unremarkable.

Spleen: 210 grams. Unremarkable.

Adrenals: Unremarkable.

Urinary tract: Kidneys: Right weight-180 grams; left weight-160 grams. The capsules strip with ease to reveal smooth cortical surfaces. Sectioning shows good corticomedullary differentiation. Bladder: The bladder contains about 10 cc of straw colored urine. The bladder mucosa is unremarkable.

Reproductive tract: Unremarkable

Musculoskeletal system: Unremarkable.

Immunologic system: Unremarkable.

Head: Scalp: Intact. Skull: Intact. Brain: Weight-1260 grams. The meninges are thin, delicate and without evidence of hemorrhage or exudate. Sectioning demonstrates unremarkable parenchyma. The blood vessels at the base of the brain are unremarkable.

MICROSCOPIC:

Heart: Sections of the heart show mild myelocyte hypertrophy.

Lungs: The lungs demonstrate marked edema and congestion. Moderate acute bronchial pneumonia is present. Perihilar lymph nodes contain granulomas with birefringent material.

Liver: No pathologic diagnosis.

Kidneys: No pathologic diagnosis.

Brain: No pathologic diagnosis.

SUMMARY AND INTERPRETATION:

Mr. Whitson was a 29 year old found dead in bed 3-6-11. Autopsy was requested by the Yancey County Sheriff's Department.

Autopsy demonstrated marked pulmonary edema and congestion with a moderate degree of acute bronchial pneumonia. Mild pulmonary emphysema was also present. The heart was mildly enlarged with left ventricular hypertrophy. An ethanol level performed on aortic blood obtained at the time of autopsy was 40.0 mg/dL (0.04% of Breathalyzer scale). Additional toxicology performed on aortic blood demonstrated the following: Benzodiazepines, none detected; cocaine, none

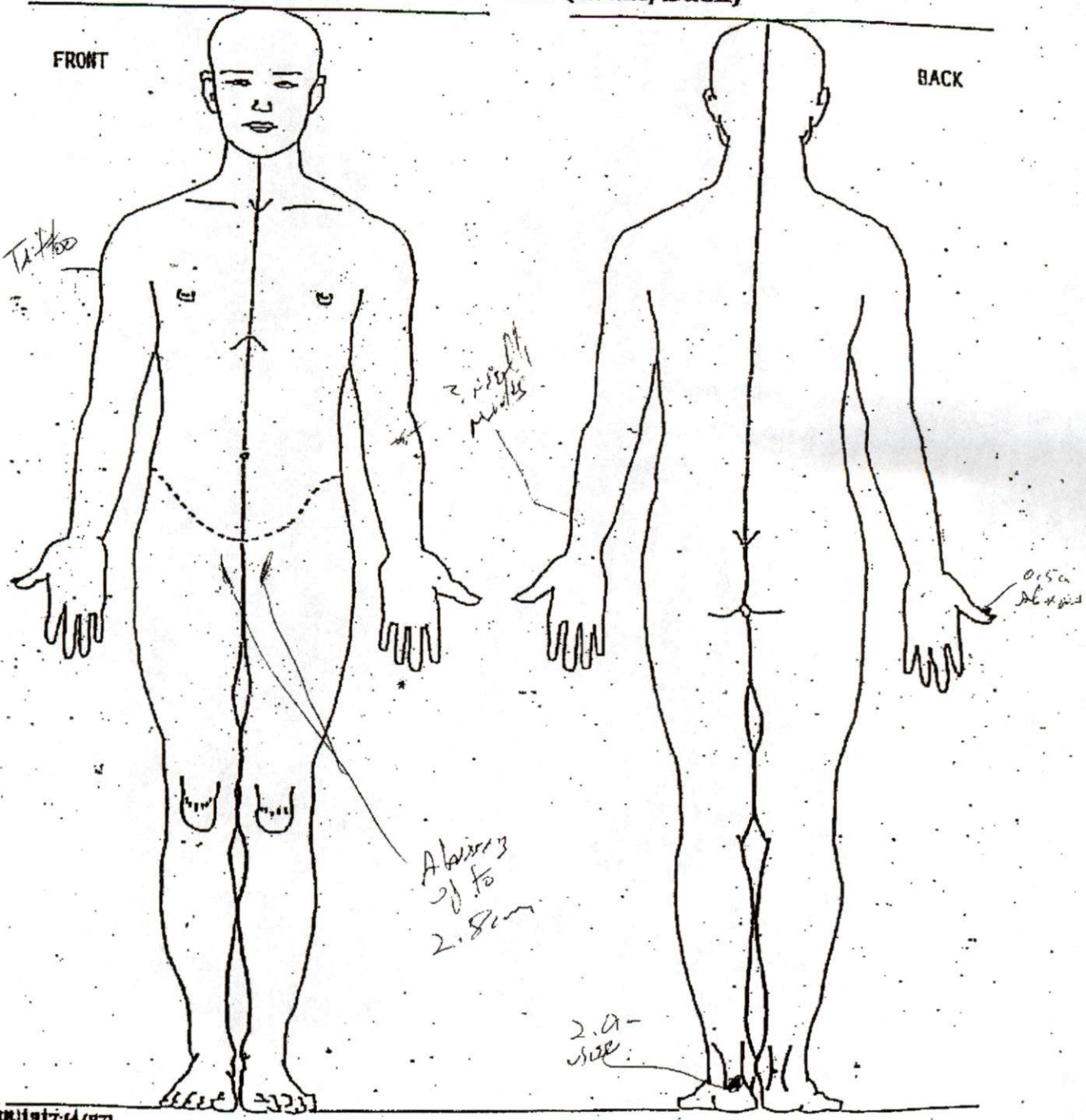
detected; morphine, present; nicotine, present; other opiates/opioids, none detected; other organic bases, none detected. A trace of morphine was present in the femoral blood. Morphine was present in the urine at concentration of 15.0 mg/L.

The case of death in this case was morphine toxicity.

State of North Carolina
Office of the Chief Medical Examiner
Chapel Hill, North Carolina 27599-7580

Name of Decedent: Jonathan White
Autopsy # APM-5
Examined By: [illegible] Date: 3/7/07

BODY DIAGRAM: ADULT (Front/Back)



DCHHR 1917 (4/97)
Medical Examiner

This form may be photocopied.

EXHIBIT 6

PENGAD 800-631-6989

INCIDENT/INVESTIGATION REPORT

INCIDENT DATA

Agency Name: Yancey County Sheriff's Office
ORI: NC1000000
OCA: 11-0151
Date / Time Reported: (S) M T W T F S — Month 03 | Day 06 | Yr 2011 | Time 11:33 Hrs.

	Crime / Incident(s)	Attempt / Complete	At Found (S M T W T F S) Month Day Yr Time	Last Known Secure (S M T W T F S) Month Day Yr Time	Location of Incident	Offense Tract
#1	9910 - Unattended Death	☐ Attempt ☐ Complete	03 | 06 | 2011 | 11:30 Hrs.	03 | 06 | 2011 | 10:30 Hrs.	410 English Branch Rd., Burnsville, NC 28714	06
#2	Crime Incident	☐ Attempt ☐ Complete				
#3	Crime Incident	☐ Attempt ☐ Complete	Premise Type: 01 - Home of Victim - Single Family Dwelling		Victim Residence Type: ☐ Single Family ☐ Multi Family	

MO

How Attacked or Committed: By the victim being found deceased at 410 English Branch Road.
Forcible: ☐ Yes ☐ No ■ N/A
Weapon / Tools: 97 - Not Applicable/None

VICTIM

# of Victims: 1
Type: ■ Person ☐ Business ☐ Society ☐ Government ☐ Financial Institute ☐ Religious ☐ L.E. Officer Line of Duty ☐ Other/Unk
Injury: ☐ None ☐ Minor ☐ Loss of Teeth ☐ Broken Bones ☐ Severe Lacerations ☐ Internal ☐ Unconscious ■ Other Major
Drug/Alcohol Use: ■ Yes ☐ Unknown ☐ No ☐ N/A

	Victim/Business Name (Last, First, Middle)	Victim of Crime #	DOB / Age	Race	Sex	Relationship To Offender	Resident Status
V1	WHITSON JR., JONATHAN RUSSELL	1	01/20/1982 | 29	W	M	NA	■ Resident ☐ Non-Resident ☐ Unknown

Home Address: 410 ENGLISH BRANCH ROAD, BURNSVILLE, NC 28714
Home Phone: (828) 682-9383
Employer Name/Address:
Business Phone:

VYR	Make	Model	Style	Color	Lic/Lis	Vin

OTHERS INVOLVED

CODES: V = Victim (Denote V2, V3) O = Owner (if other than victim) R = Reporting Person (if other than victim)
Type: ☐ Person ☐ Business ☐ Society ☐ Government ☐ Financial Institute ☐ Religious ☐ L.E. Officer Line of Duty ☐ Other/Unknown

Code	Name (Last, First, Middle)	Victim of Crime #	DOB / Age	Race	Sex
R	Angel, Christine Higgins		02/17/1945 | 66	W	F

Home Address: 410 English Branch Rd, Burnsville, NC 28714
Home Phone: (828) 682-9383
Employer Name/Address:
Business Phone:

Type: ☐ Person ☐ Business ☐ Society ☐ Government ☐ Financial Institute ☐ Religious ☐ L.E. Officer Line of Duty ☐ Other/Unknown

Code	Name (Last, First, Middle)	Victim of Crime #	DOB / Age	Race	Sex

Home Address:
Home Phone:
Employer Name/Address:
Business Phone:

PROPERTY

Status Codes: L = Lost S = Stolen R = Recovered D = Damaged Z = Seized B = Burned C = Counterfeit / Forged F = Found
(Check "OJ" column if recovered for other jurisdiction)

Victim #	DCI	Status	Value	OJ	QTY	Property Description	Make/Model	Serial Number

Number of Vehicles Stolen: Number of Vehicles Recovered:

ID

Officer Name: Sgt. L. R. Higgins ID#: 8873
Officer Signature:
Supervisor Signature:

STATUS

Complainant Signature:

Case Status: ■ Further Investigation ☐ Inactive ☐ Closed/Cleared ☐ Closed/Leads Exhausted

Case Disposition: ☐ Unfounded ☐ Juvenile/No Custody ☐ Extradition Declined ☐ Cleared by Arrest ☐ Refuse to Cooperate ☐ Located ☐ Cleared by Arrest by Another Agency ☐ Death of Offender ☐ Prosecution Declined

DCI-600F Rev. 3/92

000001

NCIIC - Yancey Co SFF

INCIDENT/INVESTIGATION REPORT

OCA
11-0151

Status Codes: L = Lost S = Stolen R = Recovered D = Damaged Z = Seized B = Burned C = Counterfeit / Forged F = Found

DRUGS

DCI	Status	Quantity	Type Measure	Suspected Type	Check up to 3 types of activity for each: Possess	Buy	Sale	Mfg.	Importing	Operating

OFFENDER

Offender Used Alcohol/Drugs ☐ Yes ☐ No ☐ Unk ☐ N/A
Computer ☐ Yes ☐ No ☐ Unk ☐ N/A

Age: Race: Sex:	Age: Race: Sex:	Age: Race: Sex:
Age: Race: Sex:	Age: Race: Sex:	Age: Race: Sex:

Primary Offender Resident Status ☐ Resident ☐ Non-Resident ☐ Unknown

SUSPECT

Name (Last, First, Middle)	Alias or Nickname	Home Address
Occupation	Business Address	

DOB / Age	Race	Sex	Height	Weight	Build	Hair Color	Hair Style	Hair Length	Eye Color	Glasses

Scars, Marks, Tatoos, or other distinguishing features (i.e. limp, foreign accent, voice characteristics)

Hat	Jacket	Shirt/Blouse	Tie/Scarf	Coat/Suit	Pants/Dress/Skirt	Socks	Shoes

Was Suspect Armed?	Type of Weapon	Direction of Travel	Mode of Travel

VYR	Make	Model	Style	Color	Lic/Lis	Vin

WITNESS

Name (last, first, middle)	DOB / Age	Race	Sex	OCA

Home Address	Home Phone	Employer	Phone

Suspect Hate / Bias Motivated: Yes ☐ No ☐

NARRATIVE

Narrative

Incident/Investigation Report Narrative

On 03/06/2011 at approximately 11:33 a call was received by the Yancey County Emergency Operations Center. The Emergency.Operations Center then relayed the call information to the Yancey County Sheriffs Office, which consisted of a white male being found deceased at 410 English Branch Road. Upon arrival to the scene at approximately 11:40 the residence was entered and the deceased,who was observed to be Jonathan Russell Whitson Junior was found to be lying on the living room couch. The deceased who was twenty nine years of age was observed to be lying flat on his back with his legs straight out covered by a blue blanket. The reporting person and an occupant of the residence Christine Angel was then contacted. Christine Angel along with her husband Wade Angel,son Nathan Angel, and grandsons Christian and James Angel were all noted as being present at the residence during the time in which the death occurred. Christine Angel who was a step-grandmother to the deceased stated that Whitson had been incarcerated and just recently released. Angel also stated that Whitson had arrived to her residence on 03/05/2011 at approximately 01 :00. Angel stated that Whitson's girlfriend Stephanie Whitson had came to the residence on 03/05/2011 at approximately 14:30. Angel stated that the two had left the residence together returning approximately an hour and a half later. Angel stated that upon returning to her residence that Stephanie Whitson stayed until approximately 21 :30 before leaving. Angel stated that the deceased then prepared to go to sleep on the living room couch.

CONTINUATION PAGE

1. AGENCY	2. ORI	3. CONTINUATION TO:	4. OCA FILE NO.
Yancey County Sheriff's Office	NC1000000	■ INVESTIGATION ☐ ARREST ☐ SUPPLEMENTARY INV.	11-0151

Narrative

Angel stated that she woke on 03/06/2011 at approximately 09:00 and Jonathan was still asleep on the couch snoring loudly. Angel stated that she and her husband Wade left the residence traveling to Burnsville to Sav-Mor supermarket returning at approximately 10:30. Angel stated that upon their return Jonathan was still asleep on the couch and still snoring. Angel stated that she then cooked and that everyone but Jonathan ate. Angel stated that her son Nathan, who was the deceased's stepfather, then told his son Christian to wake Jonathan up. Angel stated that it was then that they discovered Jonathan was deceased. Upon completion of the statement obtained from Christian Angel the body of the deceased was photographed. Medical Examiner Brent Hall of Watauga Medical Center was contacted by telephone and made aware of the death at which time he agreed to receive the body for autopsy. The deceased's mother Ann Annette Green, who had arrived to the residence, requested to use Yancey Funeral Services for burial. Yancey Funeral Services was then contacted-and requested to be en-route to the residence to transport the body. Yancey Funeral Service assistants John Paul Kirk and Scottie Mathis arrived to the residence at approximately 13:18. Christine Angel then revealed that she had discovered items in Jonathan's coat pocket. Upon observing the inside coat pocket a syringe was located and upon a search of the contents of the pocket an additional syringe was located as well. The items were then photographed and seized as evidence. Yancey Funeral Services then took custody of the body and transported the deceased to Watauga Medical Center.

Officer Name / ID	Officer Signature	Date / Time Submitted	Page 3 of 3
Sgt. L. R. Higgins - 8873			

Q. I think you said when you read the rest of it, take one tablet by mouth every eight hours for pain?

A. That is right.

Q. So that is the medication that one would take, is that your understanding, that is the medication that one would take and it would provide a slow release to address the pain, and one certainly wouldn't take a number of them at one time?

A. I am not a medical professional.

Q. That is your understanding of what a slow release tab is.

A. I understand it as a layman.

Q. And as time went on and released the effects of the medication to assist in the pain one would have, right?

A. I would accept that.

Q. The specific instructions for this medications were to take one by mouth every eight hours, right?

A. Yes.

Q. In no way was the use recommended to be take four at a time crush them, melt them, and inject them in ones arm, was there?

A. No.

MR. HOCKADAY: Those would be my questions.

MR. HOLMES: Nothing further.

THE COURT: You may step down. Are you ready to call your next witness?

MR. HOLMES: Yes sir, call Doctor Brent Hall.

THE COURT: Brent or Brent?

MR. HOLMES: Brent.

BRENT DWAIN HALL, being first duly sworn testified as follows during DIRECT EXAMINATION BY MR. HOLMES:

Q. Please state your name sir?

A. Brent Dwain Hall.

Q. Where do you work?

A. I am employed by the Pathology Associates of Boone.

Q. How long have you worked there?

A. Since 1993.

Q. What do you do there?

A. I am a pathologist, forensic pathology, meaning that I look at tissue that is removed from a patient in the operating room, or a doctor's office and attempt to render a diagnosis as to what pathological process has taken place in that tissue. I also oversee the day to day running of the local labs at Watauga, Blowing Rock, Linville, Cannon Memorial Hospital in Linville, Blue Ridge in Spruce Pine and Clinic Care in Burnsville.

Q. Are you a physician duly licensed to practice medicine in North Carolina?

A. Yes sir.

Q. When were you so licensed?

A. 1988.

Q. And can you briefly describe your educational background?

A. I went to medical school at East Carolina, did my internship and residency at Duke. While at Duke I did a Fellowship in Humana Pathology, which is a study of ------ and I did a fellowship in Forensic Pathology at UNC Chapel Hill.

Q. Is there a medical board in North Carolina?

A. Yes sir.

Q. Are you board certified?

A. I am board certified, yes sir.

Q. Are all doctors board certified, what is the significance in that?

A. Not all doctors are board certified, board certification requires taking and passing a test.

Q. How long have you had that certification?

A. Since '93.

Q. Have you ever testified in court before?

A. Yes sir.

Q. How many times, approximately?

A. In excess of 50 times.

Q. And were you tendered as an expert witness in those times you previously testified?

A. Yes sir.

Q. And what areas of expertise were you qualified as an expert in?

A. In the areas of pathology and forensic pathology.

MR. HOLMES: Your Honor I would tender Doctor Hall as an expert at this time.

MR. HOCKADAY: I would object, don't wish to be heard.

THE COURT: Members of the Jury I am going to excuse you while I deal with this objection. I think we will have you come back at 1:30 let this be your lunch recess, come back at 1:30 rather than having you come back and then be recessed immediately.

Before you do that I want to go back and instruct you that evidence has been received by the Court that the Defendant was involved with a criminal activity back in January of 2010, as you have heard testimony of that. And I want to instruct you that this evidence was received solely for the purpose of showing evidence that the defendant was maintaining a vehicle for the sale and delivery of controlled substances. That it was part of

a common scheme or plan and for the purposes of showing his state of mind and for no other purposes. If you believe that evidence you may consider it, but only for the limited purpose for which it was received. Anything further on that?

MR. HOCKADAY: No.

MR. HOLMES: No.

THE COURT: That was for state of mind. For second degree murder one element that you will hear about this is malice. And it was offered for the purpose of showing that state of mind. Again, if you believe the evidence you are to consider it for those limited purposes only and for no other purpose.

You will be excused for lunch. Please remember, don't talk to anybody else about this case. Don't do any internet research about this case. Don't goggle anybody or anything in this case. Don't allow anybody to talk to you about this case or talk about the case in your presence. If somebody does talk to you about the case, you need to report that to the Court immediately. Keep an open mind. Leave your notepads there in our chair. We will see you back here at 1:30.

(ALL JURORS LEAVE THE COURTROOM AT APPROXIMATELY 12:15 P.M. FOR THE LUNCH RECESS)

(THE FOLLOWING IS OUT OF THE PRESENCE OF THE JURY)

THE COURT: Mr. Hockaday, do you want to ask questions of Doctor Hall?

MR. HOCKADAY: Your Honor, I had indicated I objected to him being qualified as an expert, but I said I did not wish to be heard. We are prepared for our cross examination of Mr. Hall at the appropriate time.

THE COURT: I thought you indicated that you wanted to be heard on the objection.

MR. HOCKADAY: I said I did not wish to be heard.

THE COURT: Well I am sorry, as Judge Downs might have said, you need to speak up. I apologize, at least you get to eat early today. We will come back at 1:30.

(COURT RECESSED FOR LUNCH AT APPROXIMATELY 12:15 P.M.)

(COURT RECONVENED AT 1:30 P.M. – ALL PARTIES AND THE JURY ARE PRESENT IN THE COURTROOM)

THE COURT: Mr. Hall was tendered as an expert in the field of –

MR. HOLMES: Forensic Pathology.

THE COURT: Just to clarify, Mr. Hockaday do you have an objection to that?

MR. HOCKADAY: We do for the record.

THE COURT: The Court will note that and will receive Doctor Hall as an expert in the field of forensic pathology. Please come around sir.

(WITNESS – BRENT HALL RETURNED TO THE STAND TO CONTINUE WITH DIRECT EXAMINATION BY MR. HOLMES:)

Q. Doctor Hall, were you contacted about the death of Jonathan Russell Whitson?

A. Yes sir.

Q. What is the procedure when you are contacted?

A. I was called by Sergeant Bryan Higgins, on 3/6/11 at 12:30 and informed that he had a 29 year old male decedent.

Q. At what point did you get to see the body of Jonathan Russell Whitson?

A. I saw the body the next morning at 11:30.

Q. Is that when you performed the autopsy?

A. Yes sir.

Q. And will you briefly describe what an autopsy is?

A. Yes sir, an autopsy is a complete examination of the body. We start with an external exam, noting any clothing that the decedent may be wearing, any injuries to the clothing. We then remove the clothing, proceed with the external exam, noting any injuries or abnormalities to the external surface of the body. We then proceed to collect samples from either the femoral vessels or the subclavian vessels, blood samples. Also collect a sample of fluid inside the eye. We then do a – start with the internal exam in which we form a Y shaped incision of the chest and of the abdomen.

We remove all the organs in the chest and in the abdomen as well as the pelvis, examine those organs both grossly, just by looking at the organs, and microscopically, under the scope. While we are obtaining those organs we also get a second blood sample from the Aorta to be used for toxicology, and a piece of liver that can be used for toxicology if needed. We then proceed to the head, we remove the scalp, remove the brain and examine the brain.

Q. Was that the procedure you followed in conducting this autopsy?

A. Yes sir.

Q. And how many autopsies have you performed in your career?

A. Over three thousand.

Q. And in conducting an autopsy, do you take notes while you are doing it?

A. Yes sir.

Q. And do you prepare reports what you concluded?

A. Ye sir.

Q. In this autopsy, what did you determine to be the cause of death?

A. The cause of death was morphine toxicity or morphine overdose.

Q. What was it that you found that led you to come to that conclusion?

A. Well indirect findings were severe pulmonary edema and congestion, along with a marked degree of acute bronchial phenomena. When a person dies from opiate toxicity it is common to have pulmonary edema and congestion as well as with phenomena. Opiates are a respiratory depressant. They act on the area of the brain that controls respiration. And they tend to slow respiration, which makes the body starve for oxygen. And in order to try to achieve oxygenation of the tissues, the lungs will open up the air sacs or the alveolar spaces, as well as the capillaries, the small blood vessels inside the lung to try to kind of facilitate that exchange of oxygen. And in doing so capillaries often become leaky and protein fluid will leak from inside the blood vessels to the alveolar spaces or the air sacs in the lung. That leads to pulmonary edema or the heavy lungs. And that protein fluid serves as a ---------- media for growth of organisms which leads to phenomena.

Q. So you found pulmonary edema and acute bronchial phenomena in the lungs?

A. Yes, those were findings related to the morphine toxicity. In addition morphine was measured in the blood as well as the urine.

Q. What were the findings there?

A. The test that is done on the aortic blood is a screening test to find out what drugs are present in the decedent. That screening test was positive for morphine. Then the blood – there is an attempt to quantitate how much of certain drugs are present. That is typically performed in blood that is removed from peripheral blood vessel, either the femoral vessels or the subclavian vessel. And there was a trace of morphine found there.

In the urine however there was 15 milligrams per liter of morphine there. Morphine is a drug that is metabolized in the liver and excreted through the kidneys into the urine. The cut off point for toxicity resulting in death is 14 milligrams per liter. As I said Mr. Whitson had a level of 15 milligrams per liter in his urine.

Q. Sir, can you tell us the side effects of morphine how dangerous it is, what -- as compared to other drugs?

A. Well Morphine is a Scheduled II controlled substance. It is a drug that is typically used to treat pain. It is quite effective in treating pain. It does in some people, probably in most people create also a feeling of euphoria and that is why morphine is often abused is for the euphoric feeling.

Q. We have heard evidence that the deceased, Jonathan Whitson ingested morphine along with someone else. Would ingestion into anyone the same amount of morphine would it necessarily have the same effect on them?

A. Well there are a lot of variables to consider there. Each person has a individual reaction and tolerance to almost any drug, including morphine. They can act differently on different people. Also, you would have to consider how much morphine each individual took, and the route of administration.

Q. What do you mean by route of administration?

A. Whether it was taken orally, or whether if it were injected. Prior to injection was it diluted with some substance? Was that dilution factor the same for each individual when they injected the drug? Did it go directly into the vein? Did it go through the vein and into the surrounding soft tissue? There are a lot of variables there.

Q. When you were conducting the external exam of Jonathan Whitson's body, what did you note?

A. On the external exam there was a tattoo of the right arm with a Rebel flag and lightening. There were abrasions on both upper legs, measuring up to 2.8 centimeters in greatest diameter. There was a 0.5 centimeter abrasion of the right thumb. There was a 2.0 centimeter ulcer of the left heal. And there were needle marks in the left hand cubital fossa, which is this area of the arm and the left forearm.

Q. Now the abrasion that you saw on his heal, is that consistent with what someone would receive if they were walking for an extended period of time?

A. Well, if they had shoes that were rubbing in that area, that would be consistent with.

Q. Sir, at the time you conducted this autopsy, what was your job title?

A. As previously described, I was pathologist at the various hospitals, and I also served as medical examiner and regional forensic pathologist for five counties in Western North Carolina.

Q. Are you still the medical examiner?

A. No.

Q. How long had you served as medical examiner?

A. For 20 years there in Boone, prior to that and for three years in Durham County.

Q. Do you still perform autopsies as part of your job?

A. Yes.

Q. In conducting the autopsy in your report you also noted that there was an alcohol level that was detected?

A. Yes, sir that is correct.

Q. What was that?

A. There was 40 milligrams per deciliter, which would be equivalent to 0.04 percent on the breathalyzer scale.

Q. What is that called?

A. Alcohol.

Q. And you did not rule that as a cause of death, is that correct?

A. That is correct.

MR. HOLMES: No other questions at this time.

THE COURT: Mr. Hockaday.

CROSS EXAMINATION BY MR. HOCKADAY:

Q. You had been a medical examiner in Boone, prior to that in Durham, you said in Boone for about 20 years, is that right?

A. Yes sir.

Q. And what specific counties are we talking about in addition to Watauga that you cover as medical examiner?

A. Ashe, Avery, Mitchell, and Yancey.

Q. Now that position has now changed, you are no longer the medical examiner for any of those counties, is that right?

A. Correct.

Q. And you resigned from that post in June of 2013, is that correct?

A. Yes sir.

Q. Now on the 6th of March 2011 you were contacted you say at around 12:30 p.m.?

A. Yes sir.

Q. Who contacted you?

A. Sergeant Bryan Higgins.

Q. What did he tell you?

A. He told me that he had a 29 year old male deceased. That the decedent had recently been released from a local jail, and that he had a history of drug use, slash, abuse.

Q. This would have been even before you had even seen the body, which you saw the next day, you are saying Mr. Higgins talked to you and he kind of gave you a background about the decedent having a history of drug abuse?

A. Correct, yes sir.

Q. So you were aware of that before the body go to you and you looked at it on March 7th, correct?

A. Yes sir.

Q. Did you at any point come to Yancey County and go to the Angel home to look at the scene at any point before or after the body was removed from Christine Angel's house?

A. No, I did not.

Q. At any point have you been to her house to view her home?

A. No sir.

Q. At any point – well, when the body was moved do you know where it was first taken before it got to you?

A. Yancey Funeral Service transported the body. I am not sure if they took it to their facility and then to Boone, or if they brought it directly to Boone. You would have to ask them that question.

Q. You are not real sure of the number of places that it was transported to and from once it left the Angel home and got to you, you just know it eventually got to you?

A. Correct.

Q. When did the body get to you?

A. It got to me the morning of the 7th.

Q. The following day?

A. The following day.

Q. Roughly the time you looked at it was roughly 24 hours after the time –

A. Roughly, yes sir.

Q. At any point prior to the time that the body, the autopsy was conducted did you talk to any of the family?

A. No sir.

Q. Did you talk with anyone other than Mr. Higgins?

A. I may have had discussion with Lieutenant Farmer, I am not sure about that.

Q. Well, if the Sheriff's Departments' notes that have been provided in discovery indicate that you did, would you believe that you had a conversation with him?

A. I would say it is highly likely, yes sir.

Q. Do you remember what he told you?

A. No sir.

Q. You are familiar with Mr. Farmer?

A. Yes sir.

Q. You worked with him in the past, right?

A. Correct.

Q. Did he relay to you, or do you recall whether he relayed to you basically a similar summary as Mr. Higgins did that this young man had a history of drug use?

A. I don't recall that conversation.

Q. So if he did you wouldn't have any reason to dispute that?

A. Correct.

Q. At the time you performed the autopsy, or before did you have an opportunity to inspect or view any of the needles that were used, as it has been testified to, the morphine into this deceased body?

A. I never saw any of the needles.

Q. Are you aware that those have been tested by the lab now, and are you aware of what the results of those tests are?

A. Not prior to this morning, I was not aware.

Q. Are you aware now that the lab results are that there was simply a residue amount, but there was no finding of any controlled substance in those syringes, are you aware of that now?

A. Yes sir.

Q. Is it your understanding that that is how at least the deceased girlfriend has described these substances were introduced into Mr. Whitson's body?

A. Yes sir.

Q. Did you have an opportunity to inspect the spoon that was used to crush and melt the morphine, draw out the liquid, to inject the morphine into the deceased body? Did you ever have a chance to look at that?

A. No sir.

Q. And you have no personal knowledge of your own how these drugs were ingested into Jonathan Whitson's body, do you?

A. No sir, there was a finding of needle marks on the left arm, but the morphine could have got there by injection or it could have been taken orally. I have no way of knowing.

Q. So it could have been as Ms. Whitson described, or it could have happened another way, you could have taken it orally and it would have been in his system just as if he would have injected it, right?

A. Yes sir.

Q. Then again, you don't know of your own personal knowledge when these were introduced into his body, whether they were crushed or not crushed or melted, put in a syringe, or taken in any other way, do you?

A. That is correct.

Q. So nothing about your autopsy would allow you to determine the method or manner in which these drugs were taken?

A. Again, other than the fact that there were track marks on the arm, and I noted no residual pills in the gastric contents.

Q. And therefore you wouldn't know what time they were taken, would you?

A. That is correct.

Q. You wouldn't know if that is something you did, whether it be earlier in the day on March 5th, or something he did much later in the day of March 5th. You have no way of knowing the time and the manner in which those pills were taken?

A. That is correct.

Q. Who are Irene Coffee and Katelyn Mack?

A. Irene Coffee is my PA, she assists me with the autopsies, and Katelyn Mack was a student from ASU, they commonly rotate through to observe autopsies.

Q. Did they perform the autopsy in this case?

A. No sir.

Q. Now, you do not know since you were not present, precisely the time that Mr. Whitson died, do you?

A. No sir.

Q. You did prepare the death certificate, or at least signed off on the death certificate for Mr. Whitson, is that correct?

A. That is correct.

Q. Do you remember when you did that the first time?

A. Let me look at the death certificate. It was signed 3/16/11.

Q. (Approaches witness) I am going to ask you to look at Defendant's 2, is that a copy of the death certificate that you signed on March 6 of 2011?

A. Yes sir.

Q. And I think on the back at some point you signed it at a later time, is that right?

A. That is a supplemental death certificate.

Q. This is a two page document for the complete death certificate for this young man, is that right?

A. Actually it is two separate documents.

Q. I just copied it on one page, it is two documents?

A. Yes sir.

Q. But you did sign on March 16 this death certificate. And do you agree that in any case that you determined that the time of death was at 11:00?

A. Eleven o'clock yes, on the death certificate. And that determination is typically made by or from information provided to me from the investigating agencies.

Q. And that information would have come, I am assuming, from either Mr. Higgins or Mr. Farmer?

A. Correct.

Q. There is nobody else that you talked to in Yancey County about this case as far as details of this man's death, is that right?

A. Not to my recollection.

Q. Since you have certified and signed Defendant's 2, to say it was 11:00, would it be your recollection then that is based on the information you were given when you signed it?

A. That is correct, however the supplemental death certificate the time was changed to a.m.

Q. Now, you had been asked about your report. You performed the autopsy on March 7, is that right?

A. Yes sir.

Q. When did you – you made a report on May 31, 2011, is that correct?

A. I am not sure I understand what you mean by making a report.

Q. When did you make your final report? When did you determine – strike that. When did you determine it was your opinion Jonathan Whitson had died of morphine toxicity?

A. Yes sir, you are correct. The report was signed out May 31.

Q. Now when you sent the initial death certificate, or signed it on March 16, as a result of your autopsy you had initially marked that the cause of death was pending, is that right?

A. Yes sir.

Q. So, as of the day that you signed this in March after having conducted your autopsy you had made any type of conclusion at that point as to cause of Mr. Whitson's death?

A. That is correct.

Q. Then you amended it and signed that on July 15, is that right?

A. Yes sir.

Q. That is when you made that conclusion, is that right, on the death certificate, correct?

A. That is when the death certificate was signed, yes sir.

Q. That would have been after you had received the toxicology report, right?

A. Yes sir.

Q. Now, the toxicology report, which is included in the paperwork Mr. Holmes asked you about, indicates the 15 milligrams per liter in the urine of morphine, right?

A. Yes sir.

Q. It also indicates, does it not in this report, or in your findings that the deceased had a .04 alcohol or ethanol level, is that right?

A. By the breathalyzer scale, yes sir, that correct.

Q. What do you mean by the breathalyzer scale?

A. Well it is 40 milligrams per deciliter and if you equate that to the breathalyzer scale, it is 0.04 percent.

Q. That would be – that is a scale that is used when one has been charged with a DWI, that is a similar scale use right?

A. Yes sir.

Q. Same scale. Now you do not know do you sir, just as you would not know the manner in which the morphine was taken or introduced into Jonathan's body. You do not know when or how much actually the deceased – how much alcohol he consumed, do you?

A. That is correct.

Q. But roughly 24 hours after his death you determined that there was a .04 alcohol level, right?

A. Correct, yes sir.

Q. Alcohol is a drug that once one stops drinking, the level at some point recently soon after the drinking would begin to dissipate down, right?

A. Well, there is no metabolism after death.

Q. Sure, but at some point if one drinks, after a few hours their alcohol level begins to go down, correct?

A. If they stop drinking.

Q. If they stop drinking, and obviously if they stay alive.

A. Yes sir.

Q. We agree on that. And generally how long would it take ones level at a .04 to dissipate down to 0, in your experience?

A. Well that depends on –

Q. If they stop drinking.

A. Well that depends on where they were on the metabolism scale. If you were to plot the concentration of alcohol on a Y axis of a graph and time on the X axis of a graph, you would get a bell curve distribution of the blood alcohol level. It would go up, it would plateau, and it would come back down. This 40 milligrams could be anywhere along that bell curve. I have no way of knowing, if you also have a urine alcohol level to compare with, you can tell which side of the curve the metabolism rate was on, whether it was going

up, whether it plateau ore whether it was going down. Because a urine alcohol was not done in this case, I have no idea where it is on the curve.

Q. So that was a test that was not done?

A. Correct.

Q. So you are saying there is no way to know what level of metabolism Jonathan was in at the time of his death?

A. Correct.

Q. I don't know if you were here for any of yesterday's testimony, but there was testimony presented that Jonathan had been asleep since around nine or ten o'clock the night before his death. We have already established that he died at around 11:00 a.m., is that right on the 6th.

A. Somewhere around eleven.

Q. There has been no evidence that he drank anything the morning of the 6th, based on the evidence that has been presented so far. Let me ask it this way. The standard for a drunk driving charge in North Carolina is .08, which is about double what the level was in Jonathan's system at the time of his death, right?

A. Correct.

Q. In your experience, based on normal metabolism factors, how long would it generally take one at a .08 for that to dissipate down to a 0, once they stopped drinking.

A. Well, again, that would be highly individualistic. You know, depending on, you know, how well the person's liver was, how well they are able to metabolize the alcohol. And you know, how well the heart was working to actually pump the blood through the liver. There are a lot of variables there.

Q. (Approaches witness) I want to ask you about some information that I had obtained in preparing for this case. If I could ask you to look at this document, it is a study about

alcohol in the system and dissipation rates. Look at at least the first page of that. I want to ask you your opinion about it. (Pause) Have you had a chance to look at it?

A. Yes sir.

Q. Did you have an opportunity to look at the blood alcohol level and metabolism time, understanding that each person is an individual and different? Would you have any reason to disagree with the statement from this study that alcohol is metabolized at a rate of .015, which is a little less than .02 of blood alcohol every hour? Would you have any reason to disagree with that?

A. That is a general statement, that is close.

Q. It is a little less than a .02 every hour, right? So, if it is a .015 every hour, in two hours at that same rate about .03, right?

A. Correct.

Q. Three hours that would be .045, right?

A. Right.

Q. Four hours that would be .06, right? Let's just say in eight hours, that would be at roughly at about .12, right, we double that.

A. Yes sir.

Q. That would be getting over the legal limit to even drive a vehicle, time and a half that at .12, right.

A. Getting close.

Q. .08, right?

A. Right.

Q. And then if we increase that another four hours, we got to twelve hours that I am asking you about, another 6, that would be about a .18. We are talking .015 every hour, try to make it as simple as I can, if we were at 12 hours that would be a .18 under normal

circumstances based on, if this is the average dissipation rate of alcohol from one's system, right?

A. Yes sir.

Q. You wouldn't have any reason to – I mean you agree that is a fair metabolism rate of alcohol in a given hour, based on your experience as a doctor, right?

A. Yeah, I would say that is close.

Q. So, if the evidence in this case is that Jonathan Whitson did not drink for at least twelve hours before his death, and his rate at death was a .04, he could have been a .18 or higher alcohol, could he not have, if he did not drink anymore at the time he went to sleep that night, correct?

A. At the time he went to sleep, I would say that is possible.

Q. So if that is correct, he could have been more than two times the legal limit even to drive a vehicle at the time that he went to bed on March 5th of 2011, correct?

A. If your assumptions are correct, yes sir.

Q. If my numbers are right, and I am bad at math.

A. Yes sir.

Q. And you have no way of knowing when he last drank, what he drank, how much he drank, and the manner in which he drunk any alcohol that day prior to when he passed, right?

A. That is correct.

Q. Let me ask you this, morphine, what is the significance first of all of time release capsules, explain how that works. What is a 30 milligram time release, or slow release?

A. Well it is released over an extended period of time, so the absorption is over a longer period of time than your typical tablet.

Q. So the manner in which those are to be taken, in your experience they are taken orally and it gives you relief over a period of time, right?

A. Yes sir.

Q. In your experience as a doctor, and that has been a number of years, nobody would recommend that one take such a pill in a manner of crushing and turning it into fluid and injecting it in ones arm, would they?

A. I don't know if no one, but I would say a responsible medical professional would not recommend that.

Q. And the purpose of the time released capsule is to give extended relief, right?

A. Yes sir.

Q. And what would be the significance of one crushing the pill, melting it, getting it in liquid form and injecting it intravenously, what would the difference be in the impact of that drug if one elected to make that individual decision?

A. It would be released much quicker, all at one time rather than over an extended period of time.

Q. A vastly different result of the medication, right?

A. Yes sir.

Q. Now let's talk about the combination of that, well just in general, taking it normal morphine pills and drinking alcohol, how smart is that?

A. Not very.

Q. Why?

A. Because alcohol is also a central nervous system respiratory depressant.

Q. Mixing the two can kill you can't it?

A. Mixing the two can kill you and one by itself can kill you.

Q. And certainly if ones alcohol level is to the extent that potentially Jonathan Whitson's was, mixing that with morphine could be fatal, correct?

A. Any amount of alcohol mixed with morphine could potentially be fatal, yes.

Q. So even much lower than even the numbers I am talking about?

A. Yes sir.

Q. And the literature would support that, that mixing alcohol with this type of drug could cause that result, right?

A. Sure.

Q. Now, let's talk about the impact of mixing alcohol with morphine with the method of introduction of morphine could have been crushing it, melting it, and injecting it, would the risk of the impact be even greater?

A. In my opinion, yes.

Q. Were you aware of the level of drinking that Mr. Whitson – were you made aware of anything before you did this autopsy, any type of alcohol drinking by Jonathan Whitson before March 7, 2011?

A. No sir.

Q. You didn't know anything about that until you got that toxicology report back at some point after March 7th, right?

A. That is correct.

Q. So you knew nothing about the background or the length of time that Jonathan might have been drinking over, or how long it had been since he had stopped drinking, or how long he had slept before he died. You didn't know any of that information when you received that report back, did you?

A. That is correct.

Q. And since you got it back, you did not then go and follow up in anyway, did you, to determine how much Jonathan Whitson maybe had been drinking on the day before he died?

A. No, I make my determination based upon the levels in the system at the time of death?

Q. Yes, sir, I understand. But my question is, you didn't go outside of the documents you then had and try to make any determination of how much Jonathan had been drinking on March 5th?

A. That is correct.

Q. And were you aware that every witness that has gotten up in this case has testified, not a single one of them had given any evidence about Jonathan Whitson drinking a thing the day before he died. Were you aware of that?

A. No sir.

Q. The words have never even been mentioned. You didn't know about that, did you?

A. No.

Q. Obviously he was drinking something for it to be in his system, correct?

A. It got there somehow.

Q. Is it a normal practice for you to go to the scene?

A. I go to the scene occasionally.

Q. When is the last time you did that sir?

A. I don't recall.

Q. Been awhile?

A. No.

Q. Have you been to a death scene in the last three years?

A. Yes sir.

Q. You didn't go to this one, right?

A. Did not go to this scene.

Q. Can you approximate – let's say in the last 100 autopsies that you did, how many times you went to the scene?

A. No sir, I would just be guessing.

Q. Say more than ten?

A. Once again I would just be guessing.

Q. It has been very few, hasn't it?

A. It has been a few.

Q. Generally people who do this kind of work as you have done, don't do that, right?

A. Don't do what?

Q. Go to the scene.

A. No, and I am not required to go to the scene.

Q. Why are you not required to go to the scene?

A. Ask the general assembly who wrote the –

Q. The State of North Carolina don't require you to go?

A. That is correct.

Q. And that is because of budget reasons, right?

A. I am not sure about that.

Q. They don't pay you to go, so you don't go, right?

A. You are paid for the report investigation.

Q. You get paid though to do the autopsy right?

A. I get paid to do the report and investigation and I get paid to do the autopsy, yes sir.

Q. How much did you get paid in this case?

A. Seventy five dollars for the report and investigation and I believe it was a thousand dollars for the autopsy.

Q. So around eleven hundred dollars, a little under eleven hundred dollars all together?

A. Yes, sir, out of which I reimburse the hospital $500.00 for the use of their facilities.

Q. Was there any particular reason that you did not come to this – is there any other reason that you did not come to the scene at this particular case, was there some reason you were unable to drive to that scene?

A. No sir.

Q. It wouldn't have been because your licenses were suspended at the time, would it?

A. No sir.

Q. You had been charged with DWI at that time, correct?

A. Yes sir.

Q. Why did you resign as medical examiner in June of 2013?

A. I didn't come prepared to discuss that today sir.

Q. So you don't want to talk about it?

A. I didn't come prepared to discuss that today.

Q. I am asking you, why did you resign?

MR. HOLMES: Object to relevance.

THE COURT: Sustained.

Q. Sir, have you – you have testified that you have conducted more than three thousand autopsies, right?

A. Yes sir.

Q. Ever been wrong before?

A. In what regard?

Q. You ever made a conclusion in an autopsy of an overdose or toxicity and been corrected at a later time?

A. Not that I am aware of.

Q. That didn't happen in the case in Boone at the hotel?

MR. HOLMES: Objection, relevance.

MR. HOCKADAY: Cross examination.

THE COURT: Sustained.

Q. Did you not as a result of an autopsy that you conducted in 2012, did you not make an error in a cause of death determination that you made in that case?

A. I am not sure what you are referring to.

Q. Didn't – specifically did you not determine in a case in Boone in 2012 that a couple died from an overdose when in fact it was carbon monoxide poisoning. Did you not do that?

MR. HOLMES: Objection, relevance.

THE COURT: Objection sustained.

Q. And you are asking this Court to accept your opinion in this case, or asking this jury to that this young man died of morphine toxicity even though you have done no investigation as to Jonathan's alcohol level at any point prior to his death, correct?

A. My opinion is that he died of morphine toxicity.

Q. But you acknowledge that he had alcohol in his system and depending on what the Jury finds as to the length of time he had stopped drinking before his death, he could have had a high level of alcohol at some point before his death, correct?

MR. HOLMES: Objection, speculation.

THE COURT: Overruled.

Q. True?

A. His alcohol level could have been higher, yes sir.

MR. HOCKADAY: Those would be my questions.

RE DIRECT EXAMINATION BY MR. HOLMES:

Q. Sir, was there any reason for you to go to the scene?

A. Not in my opinion.

Q. And with regard to the alcohol level and metabolism, you referred to a bell curve and with respect to the bell curve that you mentioned, would it be correct to say that the first half of that bell curve would be blood alcohol level rising, and the top is a plateau, and the last half of it is the blood alcohol being metabolized and going down?

A. That is correct, yes sir.

Q. And you would say that without a measure of blood alcohol level, you can't tell if it was going up or going down.

A. That is correct.

Q. Without knowing whether or not it is going up or going down, there is no way for you to determine what this blood alcohol level would have been ten hours earlier or twelve hours earlier, is that correct?

A. Yes sir.

Q. And is it correct to say that your blood alcohol level does not peak, or your blood alcohol level does not plateau as soon as you stop drinking, is that correct?

A. That is correct.

Q. So someone could drink, stop drinking, and their blood alcohol level would continue to rise for some period of time, is that correct?

A. That is correct, yes sir.

Q. Is but for the morphine in Jonathan Whitson's system, is there any other explanation for why he would have died?

A. Not in my opinion.

Q. And again, the levels of morphine that you found in his system were fatal levels, is that correct?

A. That is correct.

MR. HOLMES: No further questions.

THE COURT: Further cross?

RE CROSS EXAMINATION BY MR. HOCKADAY:

Q. The curve you are talking about, the alcohol, and the increase and plateau and then down, understanding that if one stops at some point shortly thereafter they would reach that plateau, right?

A. Correct.

Q. You would not expect it to still be increasing to that plateau some twelve or fourteen hours later, would you, if they had stopped drinking?

A. Highly unlikely.

Q. Likely it would be on the way down, right?

A. That would be.

Q. But more likely it would be on the way down?

A. That is correct.

MR. HOCKADAY: Those would be my questions.

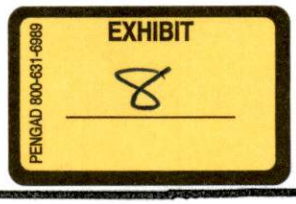
MR. HOLMES: Nothing further.

(Witness excused)

THE COURT: Call your next witness.

MR. HOLMES: Your Honor I believe that is the evidence for the State.

THE COURT: Okay. Members of the Jury I need you to step back into the jury room for a few minutes. Again, I want to remind you to keep an open mind, leave your



Brent Hall

From: documents@ocme.unc.edu
Sent: Monday, April 04, 2011 7:11 AM
To: Brent Hall
Subject: Report T201101851

TOXICOLOGY REPORT

Office of the Chief Medical Examiner
Chapel Hill, NC 27599-7580

Toxicology Folder: T201101851
Case Folder: F201102509
Date of Report: 03-apr-2011
Page: 1

Brent D. Hall
Boone Pathology Associates
336 Deerfield Rd
P.O. Box 2600
Boone, NC 28607-0000

DECEDENT: Jonathan Russell Junior Whitson

Status of Report: Approved
Report Electronically Approved By: Ruth Winecker, Ph.D.

* * *

SPECIMENS received from Brent D. Hall on 09-mar-2011

S110004482: 6.0 ml Blood
SOURCE: Femoral Vessel
CONDITION: Postmortem
OBTAINED: 07-mar-2011

Morphine	Trace			04/03/2011

S110004483: 16.0 ml Blood
SOURCE: Aorta
CONDITION: Postmortem
OBTAINED: 07-mar-2011

Benzodiazepines	None Detected	LCMS		04/03/2011
Cocaine	None Detected	LCMS		04/03/2011
Ethanol	40		mg/dL	04/03/2011
Morphine	Present	LCMS		04/03/2011
Nicotine	Present			04/03/2011
Other Opiates/Opioids	None Detected	LCMS		04/03/2011
Other Organic Bases	None Detected			04/03/2011

S110004484: 5.0 ml Urine
SOURCE: Urinary Bladder
CONDITION: Postmortem
OBTAINED: 07-mar-2011

Morphine	15		mg/L	04/03/2011

S110004485: Liver
SOURCE:
CONDITION: Postmortem
OBTAINED: 07-mar-2011

TOXICOLOGY REPORT

Office of the Chief Medical Examiner
Chapel Hill, NC 27599-7580

Toxicology Folder: T201101851
Case Folder: F201102509
Date of Report: 03-apr-2011
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Decedent: Jonathan Russell Junior Whitson

* * *

040411 07:11 * * * E N D O F R E P O R T * * *

11-0151

YANCEY COUNTY SHERIFF'S DEPARTMENT
CRIMINAL INVESTIGATIONS DIVISION

TITLE: Investigation Notes of Chief Deputy Thomas L. Farmer

OCA NUMBER: 11-
ACTIVITY: March 6, 2011
VICTIM: Jonathon Russell Whitson
OFFENSE: Unattended Death
DISTRIBUTION: (1) Records
(2) Sheriff D.G. Banks
(3) District Attorney G.W. Wilson

On Sunday March 6, 2011 at approximately 12:01 p.m. I Chief Deputy Sheriff Thomas L. Farmer received a telephone call from Sgt. L. Ryan Higgins who had responded to a call for assistance at the residence of Wade and Christine Angel located in the Jacks Creek Community of Yancey County.

Sgt. Higgins stated that he was at the residence of Wade and Christine Angel located at 410 English Branch Road, Burnsville, North Carolina.

Sgt. Higgins stated that he was there to investigate the unattended death of Jonathan Russell Whitson W/M/DOB: 1/20/1982

Sgt. Higgins stated that at approximately 11:33 a.m. on Sunday March 6, 2011 Christine Higgins Angel had called Yancey County 911 and reported that Jonathan Whitson was at her residence on a couch in the living room and was not breathing.

Sgt. Higgins stated that he upon his arrival he observed Whitson in fact deceased laying on the couch in the living room.

Sgt. Higgins stated that he had talked with all present at the Angel residence and had photographed the deceased and the area of the Angel residence where the deceased was observed.

Sgt. Higgins stated that he had been advised that Jonathan Whitson had arrived at the Angel residence around noon on Saturday March 5, 2011 after being released from the Buncombe County Jail on Friday evening March 4, 2011.

Chief Deputy Farmer learned that Jonathon Whitson had been in the Madison County Jail where he had served a 60 day sentence prior to being released on March 4, 2011to authorities in Buncombe County who had a warrant for his arrest for previous matters.

Sgt. Higgins stated that he had learned that Stephanie Whitson had arrived at the Angel residence soon after he arrived home on Saturday March 5, 2011 and the two of them had left together but returned later in the evening of Saturday March 5, 2011 at approximately 10:00 p.m.

I Chief Deputy Farmer advised Sgt. Higgins that I would telephone Medical Examiner Brent Hall and obtain permission to move the deceased body.

I Chief Deputy Farmer advised Sgt. Higgins that I was going to request an autopsy be performed on the deceased in an effort to determine what caused Whitson's death.

Sgt. Higgins stated that he did not see any evidence of noticeable injury to the exterior of Whitson's body.

Sgt. Higgins did stated that he had recovered two used syringes in the coat pocket of a coat that belonged to Whitson that was present at the scene near his body. Sgt. Higgins stated that he had collected the syringes.

I Chief Deputy Farmer telephoned Watauga Medical Center and requested Dr. Brent Hall telephone me or Sgt. Higgins so we could request an autopsy of the deceased and advise him of the scene that Sgt. Higgins had responded to.

Dr. Brent Hall telephoned Sgt. Higgins and authorized the removal of the deceased from the Angel residence and stated that he would perform an autopsy.

Sgt. Higgins made telephone contact with Yancey Funeral Service at the request of the family of Jonathan Whitson and they responded to the Angel residence and removed the deceased body and transported to Yancey Funeral Service and then on to Watauga Medical Center.

Sgt. Higgins requested that Yancey County Deputy Sheriff Bobby Austin travel to the residence of the deceased biological father Russell Wilson and tell him about the death of his son. Deputy

Austin arrived at the Wilson residence and advised him about the death.

Chief Deputy Farmer was notified by Deputy Austin that notification had been made and Chief Deputy confirmed that the biological mother of the deceased Ann Whitson Green had been notified as well and had actually arrived at the Angel residence and remained there with Sgt. Higgins.

At approximately 2:00 p.m. on Sunday March 6, 2011 Sgt. Higgins and Chief Deputy Farmer had a telephone conversation in regard to the matter of Jonathan Whitson. Higgins and Farmer agreed that Stephanie Whitson and others present at the Angel residence be interviewed in detail in an attempt to obtain information about Whitson. Sgt. Higgins stated that he would make contact with Stephanie Whitson and attempt to conduct an interview with her and others present at and nearby the Angel residence on English Branch Road.

At approximately 3:00 p.m. on Sunday March 6, 2011 I Chief Deputy Farmer received a message on my cellular phone from Yancey County Telecommunicator Rhonda K. Voland stating that Russell Wilson had telephoned the Yancey County Sheriff's Department and requested that I telephone him at his residence in regard to the death of his son Jonathan Whitson.

At approximately 3:10 p.m. I Chief Deputy Farmer telephoned Russell Wilson at his residence. Wilson stated that he wanted me to attempt to find out exactly what happened to Jonathan and I assured him that I would be investigating the death of his son and would be getting help in the case from other officers who work at the Sheriff's Department and other agencies. I advised Wilson that an autopsy was going to be performed on Monday March 7, 2011. Wilson stated that Jonathan had been in jail over in Madison County for two months and was clean of drugs and he was so upset that he had died within hours of being released from jail. Wilson also reminded me that Jonathan had dated Christine Latham in 2010 and she was getting ready to deliver his unborn child. Chief Deputy ended the conversation by advising Wilson that he and all family members would be kept informed of the findings of the investigation as it continued.

At approximately 6:00 p.m. on Sunday March 6, 2011 Sgt. Higgins and Chief Deputy Farmer met at the Yancey County Sheriff's Department and Higgins advised that he had completed an interview with Stephanie Whitson in regard to her time spent with Jonathan Whitson on Saturday March 5, 2011.

During the interview Whitson admitted that she and Jonathan Whitson had spent several hours together on Saturday March 5, 2011 at the residence of Christine Angel and away from the residence of Christine Angel. In addition Stephanie Whitson admitted that she and Jonathan Whitson had used prescription drugs together and admitted that they had both "shot up" morphine drugs.

Sgt. Higgins stated that Stephanie Whitson advised him that on Saturday March 5, 2011 while she was present with Jonathan Whitson at the residence of Christine Angel she and Jonathan had a conversation about John Pritchard. Stephanie Whitson stated that Jonathan Whitson told her that he had talked with John Pritchard and that "Johnnie" (Pritchard) had told him (Jonathan Whitson) that he was coming up "Marion Mountain" and would call him when he got home. According to Stephanie Whitson this meant that John Pritchard was on his way home to Turtle Trot Drive with Morphine and he would call Jonathan Whitson when he arrived and arrange a delivery of Morphine to Jonathan Whitson.

Stephanie Whitson stated that John Pritchard did not call Jonathan Whitson but showed up at the residence of Christine Angel instead. Stephanie Whitson stated that she visually observed John Pritchard arrive at the Angel residence driving his silver colored Ford Ranger pick up truck. Stephanie Whitson stated that that Jonathan Whitson got inside the Ford Ranger truck with Pritchard and Pritchard drove away from the residence. Stephanie Whitson stated that after Jonathan Whitson was gone with John Pritchard for approximately 15 minutes they returned to the residence of Christine Angel and Jonathan Whitson got out of the truck and came back inside the house where she was at. Stephanie Whitson stated that Nathan "Fruit" Angel went out and met with John Pritchard fro a few minutes and she has no knowledge what they discussed.

Stephanie Whitson told Sgt. Higgins that when Jonathan Whitson arrived back into the house where she was at he showed her ten (10) dosage units of 30 mg Morphine pills in his possession. Stephanie Whitson told Sgt. Higgins that according to Jonathan Whitson he had received the Morphine 30 mg pills from John Pritchard while they were together during the time they had left the residence of Christine Angel on March 5, 2011. Stephanie Whitson told Sgt. Higgins that Jonathan Whitson told her that John Pritchard had given him the ten dosage units of Morphine 30 mg tablets because he knew Jonathan had been in jail and had not had anything in a while nor did he have any money. Stephanie

Whitson also stated to Sgt. Higgins that Jonathan Whitson told her that John Pritchard had told him that he (Whitson) could purchase the Morphine pills from him for $ 8.00 a pill in the future and then turn around and sell them fro $ 15.00 a pill if he decided to do that. Stephanie Whitson did admit to Sgt. Higgins that she had been with Jonathan Whitson on many previous occasions while Jonathan Whitson was purchasing Morphine 30 mg pills from John Pritchard. Stephanie Whitson stated that she knew for a fact that Pritchard was the person Jonathan Whitson obtained prescription drugs from on past recent occasions. Stephanie Whitson also told Sgt. Higgins that she recalled a conversation that she had with Jonathan Whitson on a prior occasion when Jonathan Whitson told her that John Pritchard had a doctor in South Carolina who was prescribing him Morphine and that Pritchard was traveling to South Carolina to get the prescriptions from the doctor and getting the prescriptions filled in South Carolina as well.
(SEE INTERVIEW WITH STEPHANIE WHITSON CONDUCTED BY Sgt. Higgins on March 5, 2011)

Sgt, Higgins also stated that he had conducted a brief interview with Nathan Angel in regard to the death of Jonathan Whitson.
(SEE INTERVIEW WITH NATHAN ANGEL CONDUCTED ON MARCH 5, 2011 by Sgt. Higgins)

Activity: March 7, 2011

On Monday March 7, 2011 at approximately 10:00 a.m. I Chief Deputy Thomas L. Farmer made telephone contact with S/A Charles E. Vines, Jr. by telephone. I advised Agent Vines that I was working an unattended death in the matter of Jonathan Whitson. I gave Agent Vines a synopsis of the case and I requested that he make contact with Madison County Sheriff Administration and request the jail confinement and medical screening records for Jonathon Whitson that were generated during his recent stay at the Madison County Jail in an attempt to determine if Jonathan Whitson had suffered any medical conditions or been given any medication or prescribed any medication while he was incarcerated at the Madison County Jail. Agent Vines stated that he would make contact with Madison County authorities and attempt to collect the requested documentation.

On Monday March 7, 2011 at approximately 11:00 a.m. I Chief Deputy Thomas L. Farmer received a telephone call from Yancey County Sheriff Gary Banks. Sheriff Banks stated that he had received a telephone call from James Whitson. Sheriff Banks

stated that James Whitson is a brother to Ann Whitson Greene, the mother of Jonathan Whitson (deceased).

James Whitson told Sheriff Banks that his sister (Ann Greene) was concerned about the investigation being conducted in regard to the death of her son stating that she wanted to make sure that her son had died at the residence of Christine Angel and not at any other location.

James Whitson told Sheriff Banks that rumor from unknown persons about the death of Jonathan Whitson was that he had died somewhere other than the residence of Christine Angel and his body had been moved.

I Chief Deputy Farmer advised Sheriff Banks that I did not feel that there was any evidence that the deceased had been moved. I advised Sheriff Banks that I would attempt to interview Ann Whitson Greene about her concerns.

I Chief Deputy Thomas Farmer arrived at the residence of James Whitson located at Woodland Apartments in an attempt to speak with Ann Greene. Upon arrival I was advised by James Whitson that Ann had left his residence.

While I was present I asked James if he had any information in regard to the death of Jonathan Whitson and he stated that he had no information but was very upset that his nephew had died.

At 13:00 p.m. on Monday March 7, 2011 I Chief Deputy Thomas L. Farmer attempted to make telephone contact with Anne Whitson Greene at the residence of her brother James Whitson and I was advised by James Whitson that Ann was very upset and did not feel like talking. I advised James that I would be in contact with her at a later time but was available if needed.
At 14:00 p.m. on Monday March 7, 2011 I Chief Deputy Thomas L. Farmer made telephone contact with Dr. Brent D. Hall by telephone (828)262-4107 at his office located at Watauga Medical Center in Boone, North Carolina. I ask Dr. Hall id he could offer any information in regard to the autopsy of Jonathan Whitson and he stated that in his professional opinion after performing the autopsy that Jonathan Whitson died as a result of an overdose. Dr. Hall stated that there were needle/track marks present on the left arm of the deceased and the marks appeared to have been recently made.

I Chief Deputy Thomas Farmer advised Dr. Hall that the deceased (Jonathan Whitson) had been released from having been confined 60 days in jail on March 4, 2011.

I Chief Deputy Farmer asked Dr. Hall how long controlled substances would remain in the body of the deceased and he stated days.

I Chief Deputy Farmer advised Dr. Hall that I was in the process of getting jail records from the Madison County Jail to determine whether or not Jonathan Whitson had been given any medication while he was incarcerated there.

Dr. Hall stated that the toxicology results would not be available for a couple of weeks.

At 14:00 p.m. March 7, 2011 I Chief Deputy Thomas L. Farmer arrived at the District Attorney's Office in Burnsville, North Carolina and talked with Assistant District Attorney Virginia A. Thompson about the unattended death of Jonathan Whitson. During my conversation with Thompson, I advised her that the name of John Pritchard had been mentioned as a possible source of providing prescription drugs to Jonathan Whitson within hours of his death. I also reminded Thompson that she had prosecuted Pritchard recently for the offense of selling controlled substances that was a result of charges filed by the Burnsville Police Department and also reminded her of a case that I had filed charges alleging that Pritchard did aid and abet Robbie Jean Brown in the sell and deliver of Schedule II Oxymorphone prescription drugs in September 2010. During my conversation with Thompson I reminded Thompson that Pritchard was currently on probation for drug offenses and that I suspected that he did in fact deliver Morphine or some form of Morphine based prescription drug to Jonathan Whitson. I also reminded Thompson that when I had arrested Robbie Brown and John Pritchard in September 2010 my evidence revealed that Pritchard and Brown sold Oxymorphone drugs prescribed to Brown to Jennifer Black who was an informant. I advised Thompson that I felt it was possible that Pritchard may have delivered Morphine type drugs to Jonathan Whitson that were prescribed to his girlfriend Robbie Brown which he has done on past occasions or he had delivered Morphine type drugs to Jonathan Whitson that were prescribed to himself. I requested that Thompson issued subpoenas for the prescription records of both Robbie Jean Brown and John Pritchard. Thompson issued the subpoenas and I served them at CVS Pharmacy in Burnsville, North Carolina and Ingle's Pharmacy in Burnsville, North Carolina. The Patient Prescription record

in regard to Robbie Jean Brown at CVS Pharmacy revealed that Robbie Brown is prescribed Opana ER 40 mg (morphine time released drug) and Oxymorphone HCL 5 mg by Penny Hill NP who is employed by "The Pain Relief Center" located in Morganton, North Carolina. The Pharmacy Patient Prescription Record for Robbie Jean Brown at Ingles revealed that Robbie Brown did not get prescriptions filled at Ingles.
The Pharmacy Patient Prescription Record fro John Pritchard revealed that Pritchard gets no prescriptions filled at CVS or Ingles at any North Carolina location.

Tuesday March 8, 2011

On Tuesday March 8, 2011 I Chief Deputy Thomas L. Farmer received a copy of the Jail Medical Records for Jonathan Whitson while he was incarcerated at the Madison County Jail. The records stated that Jonathan Whitson did not have any medical issues while in custody in Madison County and was not prescribed any medication while he was there and was not taking any medication while he was there.
PLEASE SEE ATTACHED INMATE MEDICAL SCREENING FOR JONATHON RUSSELL WHITSON SENT TO CHIEF DEPUTY FARMER VIA E-MAIL FROM S/A C.E. Vines, Jr.

Wednesday March 9, 2011

On Wednesday March 9, 2011 I Chief Deputy Thomas L. Farmer arrived at the North Carolina Probation and Parole office in Burnsville, North Carolina at the Yancey County Courthouse in an attempt to talk with John Pritchard's supervising Probation Officer. I spoke with David Thomas who was the only official in the office. I ask Thomas if he could tell me whether or not John Pritchard had informed Probation 7 Parole Officers as to whether or not he was taking opiate prescription drugs. Thomas advised that Pritchard had advised that he was an opiate user but recent drug test had not revealed the presence of opiate drugs in his system. Thomas stated that he did not have any information as to who was the medical provider for John Pritchard. No other information was learned in regard to Pritchard prescription drug use. I did confirm from Thomas that John Pritchard is now living in a mobile home where Margaret Penland used to live. The address where Pritchard lives is off of Turtle Trot Road and Turtle Trot Road is off of English Branch Road.

Wednesday March 9, 2011

I Chief Deputy Farmer documented some research on the drug Oxymorphone. See attached information.

Wednesday March 9, 2011

On Wednesday evening March 9, 201 at approximately 8:30 p.m. I Chief Deputy Farmer conducted a telephone interview with Stephanie Whitson by calling her at the residence of her father Steve Whitson (828) 675-5114. **See interview with Stephanie Whitson.**

Rutherford

The Patient Safety League

No One is Immune to Medical Errors

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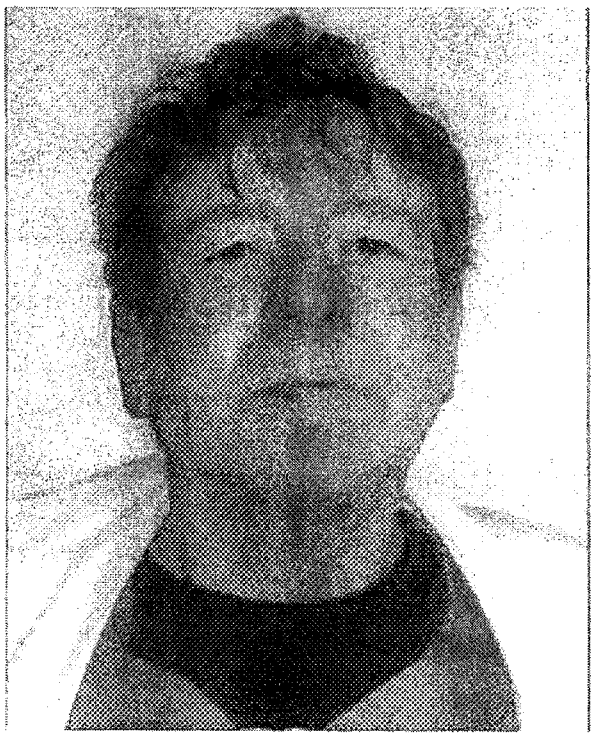
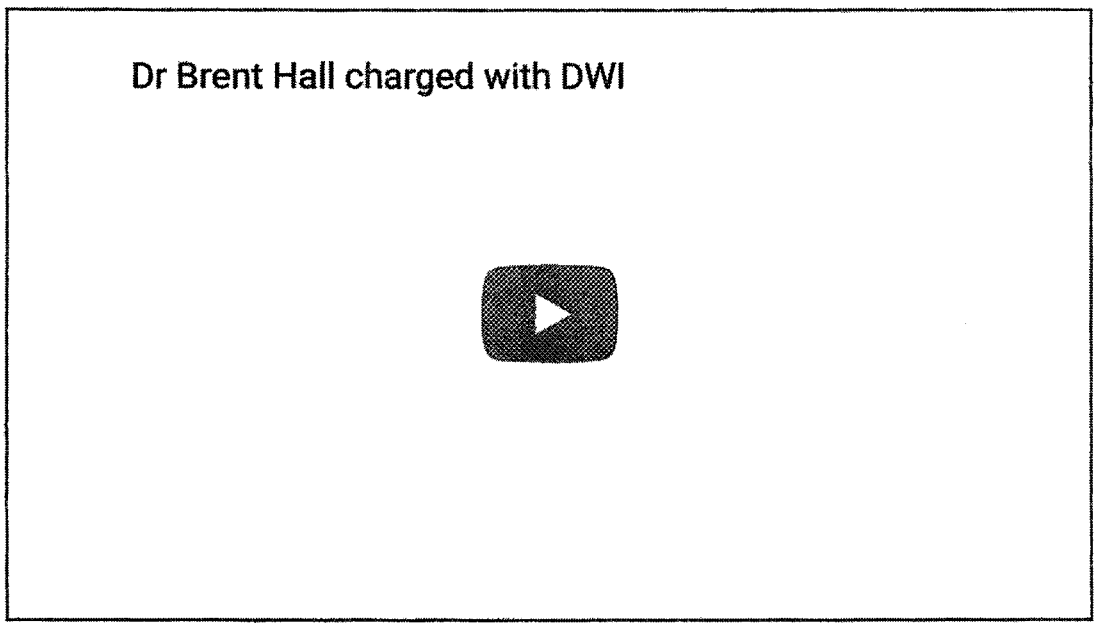
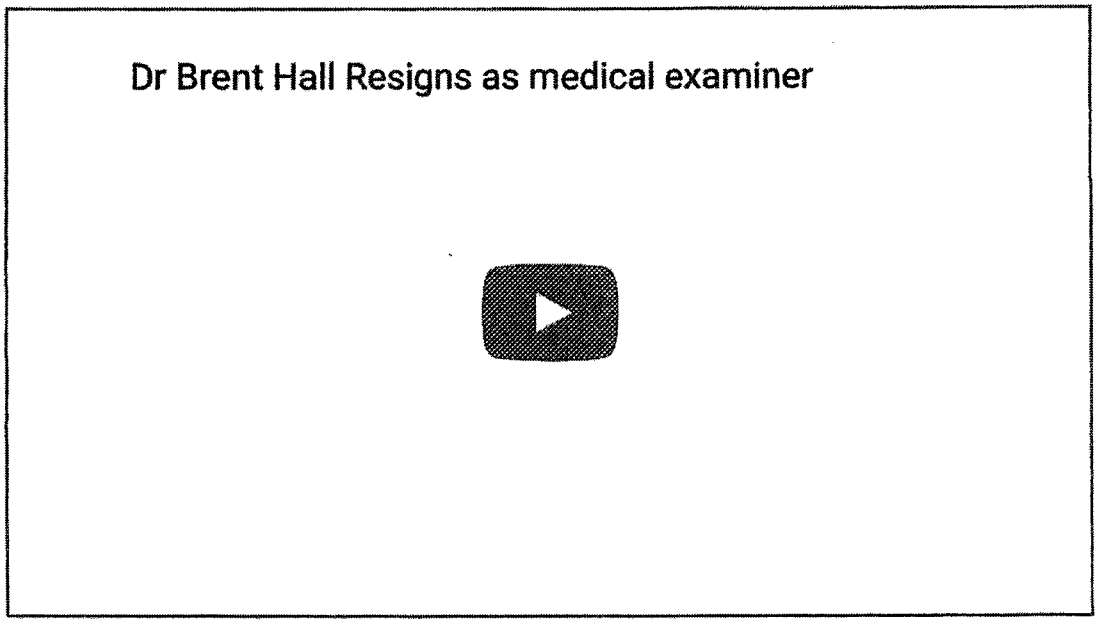
Dr. Brent Hall

May 1, 2018 / Eric Andrist / Uncategorized

aka: Brent Dwayne Hall







NORTH CAROLINA MEDICAL BOARD RECORD— 34026
DISCIPLINARY ACTIONS—*License Active; Interim Non-Practice Agreement*

Medical Examiner Found Carbon Monoxide Danger Before Boy's Hotel Death

A North Carolina county medical examiner has resigned in the wake of three carbon monoxide poisoning deaths that occurred in the same North Carolina hotel room nearly two months apart, officials said.

Watauga County medical examiner **Dr. Brent Hall** resigned from his state-appointed post Friday. The North Carolina Medical Examiner's office learned on June 1 that carbon monoxide might have killed an elderly woman in their Boone, N.C. hotel room, but failed to alert local authorities until after a young boy died in the same room one week later, according to a toxicology report from the Office of the Chief Medical Examiner obtained by ABC News.

A toxicology report dated June 1 by the Office of the State Medical Examiner showed lethal levels of carbon monoxide in the blood of Shirley Mae Jenkins, 72. She and her husband, Daryl Jenkins, 73, of Longview, Wash., were found dead at Best Western Plus Blue Ridge Plaza on April 16.

Jeffrey Williams, 11, of Rock Hill, S.C., died in the same hotel room a week later. An autopsy revealed that he died of asphyxiation.

Following Jeffrey's death, police tested the room for carbon monoxide and ordered toxicology tests on the boy's body and on tissue samples from the elderly couple.

Hall, the Watauga County medical examiner, conducted toxicology tests on the Jenkins shortly after they died, but the results were inconclusive, officials said. He sent the case to the state Medical Examiner's office for further testing, and the state issued a report on June 1 that carbon monoxide poisoning might have killed Shirley Jenkins.

Jeffrey Williams died in the same room on June 8, and his mother was hospitalized.

It wasn't until June 10 that the Boone, N.C., police department issued a statement that said the state Medical Examiner had found lethal levels of carbon monoxide in Shirley and Daryl Jenkins' blood.

On June 14, a police statement said that Hall had determined that Jeffrey's concentration of carbon monoxide in his blood was greater than 60 percent. The boy's carbon monoxide concentration level matched that of both Shirley and Daryl Jenkins, the news release stated.

Elderly Couple and Boy Die in Same Hotel Room Months Apart North Carolina Department of Health and Human Services Secretary Aldona Wos called the three hotel deaths "a tragedy that should have never happened."

"My heartfelt condolences go out to the families and loved ones of Shirley and Daryl Jenkins, and young Jeffrey Williams," Wos said in a prepared statement. "The Department of Health and Human Services is continuing to gather the facts. I have instructed my staff to work with local officials to identify measures to ensure tragedies like this never happen again."

Boone Police Department Sgt. Shane Robbins told ABC News that he was unable to release information as a result of the ongoing criminal investigation.

While Hall has resigned from his state-appointed position, it is unclear if he is still practicing medicine. Calls to his private practice were not immediately returned.

The North Carolina Medical Examiner's office declined to comment to ABC News. (LINK)—6/17/2013

Former Watauga medical examiner's DWI case goes to court

A Superior Court judge heard pretrial evidence this week in a DWI case against **Dr. Brent Hall,**

the former medical examiner at the center of three carbon monoxide deaths in a Boone hotel.

Aside from details of Hall drinking Glenlivet Scotch in his barn around midnight one evening, the hearing provided a rare glimpse of the man whose decisions in the 2013 deaths at the Best Western have been criticized.

Hall, 54, has never spoken publicly about the deaths. This week was no exception. "Believe me, I would like to sit down and tell my side of the story," he said during a break in the DWI hearing. He said lawyers have advised him not to talk.

Hall is a tall man with a lumbering gait. He speaks softly with a mountain drawl, drawing out his vowels.

On the witness stand, he limited most of his answers to questions from attorneys to "Yes, sir" and "No, sir." But occasionally, he interjected colloquial expressions. Asked if he saw two deputies following him on the roadway the night he was arrested for DWI, Hall said, "I was as nervous as a cat. Yes, sir."

Hall resigned as medical examiner in June 2013, a week after 11-year-old Jeffrey Williams died of carbon monoxide poisoning in Room 225 at the Best Western. Two months earlier, Daryl and Shirley Jenkins of Washington state had died in the same room.

The deadly carbon monoxide was eventually traced to a swimming pool water heating system.

An Observer investigation revealed a series of errors and decisions that led to the tragedies – from the actions of maintenance workers hired by the hotel to the inaction of the medical examiner. doesn't work

The state took nearly six weeks to determine that carbon monoxide killed the couple. The results were emailed to Hall on Monday, June 3. Even then, no one alerted the public. The next weekend, the poisonous gas leaked into Room 225 again, killing Jeffrey and seriously injuring his mother, Jeannie.

At the time, Hall was medical examiner for Watauga and four other counties. Like most of the state's medical examiners, he had another full-time job. He works as a private pathologist in Boone, diagnosing disease and performing autopsies.

A 5-year-old case

Hall's arrest for DWI took place three years before the deaths at the Best Western.

Defense attorneys contend that the deputies worked together to "set up" Hall for arrest. Judge

Gary Gavenus indicated that he would rule later this week on the motion to dismiss the charge.

Court documents show that Hall's blood alcohol level was 0.19 – more than twice the legal limit. That fact was not part of the evidence in the pretrial hearing. Hall said he has not drunk alcohol in more than four years.

Hall was pulled over in rural Watauga County at 1:28 a.m. on Jan. 28, 2010, a Thursday morning. He was convicted in District Court in 2011 and appealed to Superior Court, where the case was postponed 20 times before being called for motions Monday.

In the past, it was former prosecutors who did not want the case resolved, according to attorney Robert Speed, who represented Hall in District Court. If Hall was convicted in Superior Court, Speed said prosecutors worried that defense attorneys would make sure that fact was known to jurors in criminal cases where Hall testified as medical examiner. Prosecutors worried, Speed said, that jurors would discount Hall's testimony because of a DWI conviction.

But when newly-elected District Attorney Seth Banks attempted to have the case heard earlier this year, it was Speed who fought for a continuance. Then on Monday, defense attorney Jay Vannoy asked that the charge be dismissed. He argued that Hall's arrest amounted to an illegal seizure.

Watauga County Sheriff's Deputy Aaron Billings testified that he was preparing to stake out a narcotics suspect when he spotted a white Toyota 4Runner outside a barn in rural Watauga County and saw a man pacing in front of the headlights. He said he thought it might be a break-in and stopped to investigate.

The man identified himself as Hall and said he owned the property. Billings testified that Hall had bloodshot eyes, slurred speech and appeared intoxicated. He said he told Hall not to drive on public roads.

Billings and another deputy testified that later that evening Hall drove by while they were staking out the narcotics suspect. They said Hall was speeding, crossed the center line several times and crossed over the fog line twice. When he was pulled over, they said, Hall slurred his speech, had bloodshot eyes and stumbled when he walked. He failed field sobriety tests, they said. (LINK)—4/07/2015

Former Watauga Co. medical examiner charged with DWI, bribing officer

WATAUGA COUNTY, N.C. – A former Watauga County medical examiner was arrested after police said he was driving drunk Sunday in Boone.

Authorities said a Boone police officer encountered an SUV sitting stationary at the intersection of King Street and Highway 105 Extension. The officer said the driver, identified as **Dr. Brent Hall**, appeared to be intoxicated, and also had a loaded handgun and an open bottle of tequila inside his SUV.

According to police, Hall wouldn't get out of his vehicle and offered to pay them money to let him out of the DWI charge.

"He didn't obey the officer's commands and then there was a brief struggle during that process of getting him out of the car," Boone Police Lt. Chris Hatton said.

"And at one time, he offered a bribe?" reporter Dave Faherty asked.

"He is charged with offering a bribe and he did at some point offer a bribe to the officer," Hatton answered.

Hall faces several other charges, including driving while impaired and carrying a firearm after consuming an impairing substance.

Channel 9 tried to reach Hall at Pathology Associates of Boone, which has a picture of Hall on its website. Police were called to have Channel 9 removed from the property.

Hall resigned as medical examiner in Watauga County in 2013 after the deaths of Daryl and Shirley Jenkins and 11-year-old Jeffrey Williams. All three died at the Best Western in Boone within a six-week period.

State officials said they sent the results of the Jenkins' toxicology to Hall, showing they died from carbon monoxide, a week before Jeffrey and his mother checked in to the motel and were overcome by fumes. Police said they didn't receive that crucial information until two days after Jeffrey died.

The police chief told Channel 9 at the time that officials would have been able to find the source of the carbon monoxide in the Best Western motel room before Jeffrey and his mother checked into it.

Channel 9 checked with the state medical board and Hall is still licensed and working at the Watauga Medical Center. (LINK)—2/13/2018

Ex-medical examiner who handled Best Western autopsies facing charges

A Boone physician and former medical examiner for five Northwest North Carolina counties has agreed to temporarily stop practicing medicine under an agreement with the N.C. Medical Board.

The agreement signed by **Dr. Brent Dwayne Hall**, 56, went into effect Feb. 21. He is not permitted to practice medicine until the medical board president gives permission.

Hall was the medical examiner who oversaw autopsies for three people who died from carbon monoxide poisoning at a Boone Best Western hotel in 2013. His investigations have drawn criticism, including from state health officials for lacking key historic information in the toxicology reports.

Hall, of Meat Camp Baptist Church Road, was arrested Feb. 11 by Boone police after his 2015 Toyota Land Cruiser was found stopped in the intersection of U.S. 421 and N.C. 105 at 7:51 p.m. Watauga sheriff's deputies assisted in the arrest.

Hall faces five charges: misdemeanor driving while impaired, resisting arrest, misdemeanor possession of an open container of alcohol in a vehicle, misdemeanor carrying a firearm after consuming an impairing substance, and felonious offering bribes to Boone police officers.

Hall reportedly offered money to the arresting officer in exchange for having the charges dropped, according to Boone Police Sgt. Shane Robbins.

Hall reported the arrest to the board Feb. 12. He is set for a March 16 appearance in Watauga District Court. He was released on a $25,000 bond.

In the agreement, Hall acknowledged his alcohol dependence and unprofessional conduct. The board said that if Hall fails to comply with the agreement, his license could be suspended or revoked.

Hall received his medical license in May 1991. He has practiced pathology and immunopathology in Boone.

The agreement with the medical board lists Hall as having been arrested and convicted of driving while impaired in January 2010. He appealed the conviction, which was dismissed in April 2015.

In June 2011, the board ordered that Hall have a physical examination by the N.C. Physicians

Health Program, which diagnosed him with alcohol dependence. He agreed at that time to a non-practice agreement that lasted from Aug. 5, 2011, to Jan. 15, 2012.

The board sent Hall a formal warning in December 2011 in which it said "repeated arrests for such (DWI) conduct could form the basis for the board charging you with unprofessional conduct or the inability to practice medical acts safely."

Hall served as medical examiner for Ashe, Avery, Mitchell, Watauga and Yancey counties until resigning in 2013.

In June 2013, 11-year-old Jeffrey Williams and his mother, Jeannie Williams, of Rock Hill, S.C., stopped for a night in Boone and stayed at the Boone Best Western. Jeffrey died from carbon monoxide leaking from a swimming pool heating system, while Jeannie suffered serious injuries.

Six weeks earlier, Daryl and Shirley Jenkins of Washington state had died in the same room, but officials did not immediately identify carbon monoxide as their cause of death.

Both families filed wrongful death lawsuits, seeking damages from Best Western International; the hotel's owners and its former manager, Damon Mallatere; as well as from companies and individuals who worked on the swimming pool heating system where the deadly gas originated.

In January, The Charlotte Observer reported the Williams family agreed to settle wrongful death and injury suits against the hotel chain and other parties for $12 million.

An Observer investigation into the deaths uncovered a series of errors and decisions by many different people, including hotel management, town employees and Hall.

The investigation found no indication that officials in Boone or anyone in the state's medical-examiner system acted with urgency to understand what happened following the Jenkinses' deaths.

As it involved Hall, he failed to list in the pertinent history section that the Jenkinses died in the hotel room with no sign of foul play.

In 2014, the N.C. General Assembly adopted a law aimed at preventing such tragedies. That law requires hotels and other lodging establishments to install carbon monoxide alarms near fossil-fuel-burning heaters, appliances and fireplaces.

A subsequent Observer investigation found that state medical examiners routinely skipped basic steps when investigating suspicious deaths — a problem that can cause widows to be

cheated out of insurance money and allow killers to go free.

State lawmakers responded by doubling pay for the state's medical examiners and, for the first time, setting aside money for mandatory training. (LINK)—3/01/2018

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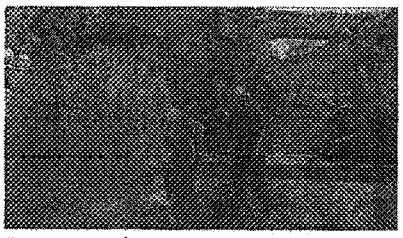

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November 29, 2018
In "*Our Advocates"

Sacramento battle over telling patients about doctors' probation
State Sen. Jerry Hill, D-San Mateo (right), shown last year with then-state Sen. Mark Leno, wants patients to know when their doctors are on probation. Photo:
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November 29, 2018
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BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	INTERIM
Brent Dwayne Hall, M.D.,	)	NON-PRACTICE AGREEMENT
	)	
Respondent.	)	

This matter is before the North Carolina Medical Board ("Board") on information regarding Brent Dwayne Hall, M.D. ("Dr. Hall"). Dr. Hall makes the following admissions and the Board makes the following findings and conclusions:

STATUTORY AUTHORITY

The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted to it in Article 1 of Chapter 90 of the North Carolina General Statutes and the rules and regulations promulgated thereto.

FINDINGS OF FACT

Dr. Hall was first issued a license to practice medicine by the Board on or about May 25, 1991, license number 34026.

At all times relevant hereto, Dr. Hall practiced pathology and immunopathology in Boone, North Carolina.

[redacted]

[redacted]

On June 2, 2011, the Board issued an Order for Examination ordering Dr. Hall to be assessed by the North Carolina Physicians Health Program ("NCPHP").

On June 16, 2011, Dr. Hall was assessed by NCPHP. Dr. Hall was diagnosed with alcohol dependence and NCPHP recommended that he receive psychotherapy and a comprehensive assessment.

From August 2-5, 2011, Dr. Hall attended a four-day assessment at Talbott Recovery.

On August 5, 2011, Dr. Hall signed a medical Non-Practice Agreement in which he agreed not to practice medicine until he was approved to practice by NCPHP and the Board. This medical Non-Practice Agreement was dissolved on January 15, 2012, and Dr. Hall was allowed to return to the practice of medicine.

On December 21, 2011, the Board issued Dr. Hall a private letter of concern [redacted] The private letter of concern states, in part, [redacted]

On February 12, 2018, Dr. Hall self-reported that he had been arrested and charged with Driving While Impaired [redacted]

CONCLUSIONS OF LAW

Dr. Hall acknowledges that his alcohol dependence, if left untreated, constitutes being unable to practice medicine with reasonable skill and safety to patients within the meaning of N.C. Gen. Stat. § 90-14(a)(5) and grounds exist for the Board to suspend, revoke or limit Dr. Hall's license to practice medicine or to deny any application he might make in the future.

Dr. Hall acknowledges that his conduct, as described above, constitutes unprofessional conduct, including, but not limited to, the departure from the ethics of the medical profession, or the committing of any act contrary to honesty, justice, or good morals within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and grounds exist under this section of the North Carolina General Statutes for the Board to annul, suspend, revoke, condition or limit Dr. Hall's license to practice medicine or to deny any application he might make in the future.

PROCEDURAL STIPULATIONS

Dr. Hall acknowledges and agrees that the Board has jurisdiction over him and over the subject matter of this case.

Dr. Hall acknowledges that he has read and understands this Interim Non-Practice Agreement and enters into it voluntarily.

ORDER

Now, therefore, with Dr. Hall's consent, it is ORDERED that:

1. Dr. Hall agrees that he will not practice medicine until such time as he is given permission to do so by the Board President.

2. Dr. Hall shall obey all laws. Likewise, he shall obey all rules or regulations involving the practice of medicine.

3. Dr. Hall shall notify the Board in writing of any change in his residence or practice addresses within ten (10) days of the change.

4. If Dr. Hall fails to comply with any provision of this Interim Non-Practice Agreement, such failure shall constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and shall be grounds, after any required notice and hearing, for the Board to annul, suspend, revoke, condition, or limit Dr. Hall's medical license or to deny any application he might make in the future or then have pending for a license.

5. This Interim Non-Practice Agreement shall take effect immediately upon its execution by both Dr. Hall and the Board, and it shall continue in effect until specifically ordered otherwise by the Board.

6. Dr. Hall hereby waives any requirement under any law or rule that this Interim Non-Practice Agreement be served on him.

7. Upon execution by Dr. Hall and the Board, this Interim Non-Practice Agreement shall become a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies and clearinghouses as required and permitted by law including, but not limited to, the Federation of State Medical Boards and the National Practitioner Data Bank.

By Order of the North Carolina Medical Board this the 21st day of February, 2018.

NORTH CAROLINA MEDICAL BOARD

By: T. E. Lietz MD
Timothy E. Lietz, M.D.
President

Consented to this the 21 day of Feb, 2018.

Brent Dwayne Hall, M.D.

State of NC

County of Polk

I, Cynthia E. Keator, do hereby certify that Brent Dwayne Hall, M.D., personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this the 21 day of February, 2018.

Notary Public

CYNTHIA E KEATOR
Official Seal
NOTARY PUBLIC
RUTHERFORD COUNTY, NC

My Commission Expires: 2-24-19

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Brent Dwayne Hall, M.D.,	)	CONSENT ORDER
	)	
Respondent.	)	

This matter is before the North Carolina Medical Board ("Board") regarding information provided to the Board concerning Brent Dwayne Hall, M.D. ("Dr. Hall"). Dr. Hall makes the following admissions and the Board makes the following findings and conclusions:

STATUTORY AUTHORITY

The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted to it in Article 1 of Chapter 90 of the North Carolina General Statutes and the rules and regulations promulgated thereto.

FINDINGS OF FACT

Dr. Hall was first issued a license to practice medicine by the Board on or about May 25, 1991, license number 34026.

At all times relevant hereto, Dr. Hall practiced medicine in Boone, North Carolina.

On February 12, 2018, Dr. Hall self-reported that he had been arrested and charged on February 11, 2018, with Driving While

Impaired [redacted]

Dr. Hall thereafter met with the North Carolina Physicians Health Program ("NCPHP"). Dr. Hall was diagnosed with alcohol use disorder and attended inpatient treatment for this beginning on February 14, 2018. On February 21, 2018, Dr. Hall and the Board entered into an Interim Non-Practice Agreement where Dr. Hall agreed not to practice medicine until given permission to do so by the Board President.

On May 8, 2018, Dr. Hall successfully completed inpatient treatment. On May 9, 2018, Dr. Hall signed a monitoring contract with NCPHP. On May 31, 2018, Dr. Hall's Interim Non-Practice Agreement was dissolved by a Board Order.

NCPHP has determined that Dr. Hall is safe to practice medicine and Dr. Hall has returned to work as a physician. Dr. Hall is also in compliance with his NCPHP contract.

CONCLUSIONS OF LAW

Dr. Hall acknowledges that his alcohol use disorder, if left untreated, constitutes being unable to practice medicine with reasonable skill and safety to patients within the meaning of N.C. Gen. Stat. § 90-14(a)(5) and grounds exist under this section of the North Carolina General Statutes for the Board to annul,

suspend, revoke, condition or limit Dr. Hall's license to practice medicine or to deny any application he might make in the future.

Dr. Hall acknowledges that his conduct, as described above, constitutes unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and grounds exist under this section of the North Carolina General Statutes for the Board to annul, suspend, revoke, condition or limit Dr. Hall's license to practice medicine or to deny any application he might make in the future.

PROCEDURAL STIPULATIONS

Dr. Hall acknowledges and agrees that the Board has jurisdiction over him and over the subject matter of this case.

Dr. Hall knowingly waives his right to any hearing and to any judicial review or appeal in this case.

Dr. Hall acknowledges that he has read and understands this Consent Order and enters into it voluntarily.

Dr. Hall desires to resolve this matter without the need for more formal proceedings.

The Board has determined that it is in the public interest to resolve this case as set forth below.

ORDER

NOW, THEREFORE, with Dr. Hall's consent, it is ORDERED that:

1. Dr. Hall's North Carolina license to practice medicine is hereby SUSPENDED for a period of ninety (90) days from the date

of this Consent Order. The entire suspension is hereby IMMEDIATELY STAYED upon the following terms and conditions.

2. Dr. Hall shall maintain his current contract with NCPHP and abide by all of its terms, including the timely payment of any fees required by NCPHP.

3. Unless lawfully prescribed for him by someone other than himself, Dr. Hall shall refrain from the use or possession of all mind-altering and mood-altering substances including, and not limited to, all controlled substances.

4. Upon request by the Board, Dr. Hall shall supply urine, blood, hair or any other bodily fluid or tissue sample the Board might reasonably require for the purposes of analysis.

5. Dr. Hall shall obey all laws. Likewise, he shall obey all rules and regulations involving the practice of medicine.

6. Dr. Hall shall meet with the Board or members of the Board for an investigative interview at such times as requested by the Board.

7. Upon request, Dr. Hall shall provide the Board with any information the Board deems necessary to verify compliance with the terms and conditions of this Consent Order.

8. If Dr. Hall fails to comply with any of the terms of this Consent Order, that failure shall constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6). Dr. Hall agrees that any failure to comply with any of the terms of

this Consent Order is sufficient evidence for the Board to summarily suspend Dr. Hall's medical license. If Dr. Hall fails to comply with this Consent Order and the Board summarily suspends his medical license, Dr. Hall waives his right to a prompt hearing.

9. This Consent Order shall take effect immediately upon its execution by both Dr. Hall and the Board, and it shall continue in effect until specifically ordered otherwise by the Board.

10. Dr. Hall hereby waives any requirement under any law or rule that this Consent Order be served on him.

11. Upon execution by Dr. Hall and the Board, this Consent Order shall become a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies and clearinghouses as required and permitted by law including, but not limited to, the Federation of State Medical Boards and the National Practitioner Data Bank.

By Order of the North Carolina Medical Board this the 25th day of October, 2018.

NORTH CAROLINA MEDICAL BOARD

By: T. E. Lietz MD

Timothy E. Lietz, M.D.
President

Consented to this the 15TH day of OCTOBER, 2018.

Brent Dwayne Hall, M.D.

State of NC

County of WATAUGA

I, JOHN TRAVERS, do hereby certify that Brent Dwayne Hall, M.D. personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this the 16 day of OCTOBER, 2018.

Notary Public JOHN TRAVERS

JOHN TRAVERS
NOTARY PUBLIC
WATAUGA COUNTY
NORTH CAROLINA

(Official Seal)

My Commission Expires: 09/29/2020

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Brent Dwayne Hall, M.D.,	)	ORDER DISSOLVING INTERIM
	)	NON-PRACTICE AGREEMENT
Respondent.	)	

This matter is before the North Carolina Medical Board ("Board") regarding Brent Dwayne Hall, M.D. ("Dr. Hall"), license number 34026.

FACTUAL FINDINGS

On February 21, 2018, the Board entered into an Interim Non-Practice Agreement with Dr. Hall in which he was prohibited from practicing medicine until such time as he was given permission to do so by the Board President.

Dr. Hall successfully completed in-patient treatment on May 8, 2018.

Dr. Hall signed a five (5) year monitoring contract with the North Carolina Physicians Health Program ("NCPHP") on May 9, 2018. The NCPHP monitoring contract includes periodic urine drug screens.

The in-patient treatment center and NCPHP have deemed Dr. Hall fit to practice medicine.

Dr. Hall has requested that the Board dissolve the Interim Non-Practice Agreement and allow him to return to practice.

ORDER

The Board hereby orders that the Interim Non-Practice Agreement be dissolved. Nothing herein shall affect the public nature of Dr. Hall's Interim Non-Practice Agreement and it shall remain a public document on the Board's website.

This the 31st day of May, 2018.

NORTH CAROLINA MEDICAL BOARD

By: _____

Timothy E. Lietz, M.D.
President

CERTIFICATE OF SERVICE

I, the undersigned attorney for the North Carolina Medical Board, hereby certify that I have served a copy of the foregoing Order Dissolving Interim Non-Practice Agreement on Respondent by depositing a copy with the United States Postal Service, postage paid, and by electronic mail to the following:

Brent Dwayne Hall, M.D.
P.O. Box 1818
Boone, NC 28607
Email: bhall@paboone.com

This the 31st day of May, 2018.

Brian Blankenship
Deputy General Counsel
North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609
1.800.253.9653, ext. 239

Handout 3

Dr. Jerri McLemore

Report

Expert Report – Dr. Jerri L. McLemore, Forensic Pathologist

State v. John Pritchard – Yancey County
11 CRS 304-305

September 6, 2021

I. Scope

I reviewed materials related to the death of Jonathan Whitson. I was asked to review the court transcript of "John Pritchard" and related investigative reports from various agencies, the autopsy report of Jonathan Whitson, review the original histology slides from the autopsy of Jonathan Whitson, and provide opinions related to the following general topics:

a. Jonathan Whitson's cause of death
b. Whether opiates/opioids had a proximate role in the cause of death of Jonathan Whitson

I have provided my opinions in full below and reserve the right to add additional opinions and/or information as may be necessary to answer any questions during my testimony at the Commission Hearing in this matter.

II. Professional Qualifications

My Curriculum Vitae has been provided in full as Exhibit A to my report. I received my Bachelor of Arts from the University of Kansas in 1987 and I received my medical degree from the University of Kansas Medical Center in 1992. I completed my residency in Anatomic Pathology and Clinical Pathology at the University of New Mexico Affiliated Hospitals in 1997. I completed a forensic pathology fellowship at the Office of the Chief Medical Examiner, which is part of the University of New Mexico Affiliated Hospitals, in 1999. I am Board Certified by the American Board of Pathology in Anatomic, Clinical, and Forensic Pathology. To date, I have supervised or performed approximately 8,000 autopsies and external examinations.

III. Materials Reviewed

I have reviewed the following materials:

a. Autopsy Report including histology slides by Dr. Brent Hall (AP11-5)
b. State Bureau of Investigation reports (SBI 2011-02340)
c. Yancey County Sheriff's Office files (OCA 11-0151)
d. Review of trial transcripts from April 14, 2014-April 17, 2014
e. Buncombe County Sheriff's Office booking report
f. Madison County Sheriff's Office booking report
g. Opinions provided by Dr. Christena Roberts
h. Letter from Mr. Pritchard to Dr. Roberts
i. Medical Records of Jonathan Whitson

IV. Areas of Expertise

I anticipate being presented and qualified as an expert in forensic, anatomic, and clinical pathology. I have reviewed the records enumerated above, which comport with the types of records I would typically review in a criminal case. I have applied my training and expertise in analyzing these records and in forming my opinions.

V. Anticipated Opinions

I anticipate providing opinions based on my education, training, experience, and review of the above materials regarding the following:

Evaluation of supplementary reports including witnesses' statements

Narrative of background:

Jonathan Whitson had just been released from incarceration where he had served approximately 2-3 months. Per a cousin's testimony, when the cousin picked Mr. Whitson up from a designated spot and drove him to another's house, the cousin described Mr. Whitson as looking "good; his face and everything looked good." Although not clear, there may have been the possibility that the decedent walked some unknown number of miles to a spot where he was ultimately picked up. A witness knew about the decedent's arm abscess and that it was bothering him, being swollen and hurting. The day/evening after his release from incarceration, witnesses saw the decedent crush up pills, although one witness thought the pills were Opana (hydromorphone) while others thought he used morphine. One witness described 10 pills, purple in color, that he/she believed were 30 mg morphine pills. Another report references "30s," which is a term for morphine. The decedent was observed to inject a substance into himself at various times through the evening. The last time anyone saw the decedent crush up pills was at approximately 20:00-21:00 on 3/4/2011 where a partial amount of drug was used with 6 syringes left. In the narrative, one other witness confirmed drug use, intravenous route, by melting down pills in the bathroom. The decedent was heard going to the bathroom about 3

times throughout the night; however, no concrete time interval was given. The next morning, the decedent, Jonathan Whitson, was on the couch, asleep, snoring. At approximately 06:00-07:00; his grandmother and others left to buy groceries returning at around 09:00-10:00. The decedent was possibly still snoring at this time, but he was found dead at an unknown time later although the 911 call was recorded as 11:33. Two syringes were found in the decedent's pocket. After review of available reports, I did not find any witnesses' statements indicating that the decedent had consumed any alcoholic beverages.

Review of Autopsy Findings:

The original autopsy report is minimalistic in terms of gross and histologic description; however, lung weights are not inconsistent with weights seen in drug-related fatalities. Of note, there is no description of any cutaneous abscesses, erythema, or purulent drainage of any kind of the antecubital fossae.

Evaluation of Autopsy Findings of Original Report:

While sparse in description in some areas, especially descriptions of histologic findings, Dr. Hall's opinion that the decedent died from morphine toxicity is not entirely incorrect. The histologic findings of the lungs are absolutely characteristic of aspiration pneumonia with foci of bacterial colonies and foamy macrophages admixed with neutrophils. Of note are foci of foreign body material that has elicited a granulomatous reaction consistent with probable pill/capsule filler components that have entered the bloodstream and become entrapped in the lungs, which is not inconsistent with the narrative that the decedent crushed up pills and then injected them into himself.

No mention of a subcutaneous or noticeable abscess of the arm or anywhere else on the body was in the original autopsy report. Because I cannot assess the body as it was at the time of autopsy, I cannot confirm or eliminate the possibility that an abscess did exist; however, the suggestion that the decedent died from pneumonia caused by sepsis due to an abscess of the arm or other part of the body is not likely due to the histologic findings of aspiration pneumonia, the lack of any histologic changes of other organs suggestive of sepsis, and the lack of anecdotal complaints of fever or other symptoms of sepsis other than non-specific complaints of general fatigue, which would also be indicative of use of an opiate/opioid.

No other compelling natural causes of death or reasons for incapacitation can be gleaned from this autopsy report. The heart weight was at the upper threshold of normal weight given body weight and height (and in some recent normal heart weight charts was well within normal size), and no histologic abnormalities with the heart muscle were found. Notation from the original autopsy report indicated that possible genetic studies had been done on heart muscle; however, I was not provided with any possible genetic testing results.

The toxicology reports indicated trace morphine in blood, 15 mg/dL morphine in urine, and 40 mg/dL of ethanol (ETOH) in blood.

Drug-related fatalities do not just encompass quick deaths due to use of drug that causes respiratory or cardiac arrest within minutes. Drug-related fatalities encompass eventual deaths related to the initial use of the drug due to recognized complications of the drug. Aspiration pneumonia is a known complication of any drug that suppresses respiratory function and gag reflex. Opiates like heroin/morphine and opioids like oxymorphone, hydrocodone, and fentanyl can be associated with aspiration pneumonia. Aspiration pneumonia can develop over a prolonged time interval that includes from hours to 1-2 days; however, the longer the interval for development of this pneumonia, the more likely symptoms of pneumonia including cough, fever, and shortness of breath will be apparent. No such symptoms in Jonathan Whitson were observed in witnesses' statements.

A person who has aspirated must still be alive, although the person can be unconscious/in a deep sleep, in order for the pneumonia to develop. If the aspiration pneumonia is due to opiate/opioid or other drug that dampens respirations, the person will still metabolize the drug associated with the respiratory system from the bloodstream and into the urine while aspiration pneumonia develops, possibly metabolizing most of the drug from the bloodstream before succumbing to the developing pneumonia. I believe this scenario occurred and resulted in Jonathan Whitson's death.

The low level of ethanol (alcohol) does not have a clear origin. No witnesses supplied any information that they saw the decedent ingest alcohol prior to death. The decedent may have ingested ethanol prior to death and was either not seen by anyone else or no one remembered him doing so. Another possibility is that the toxicology specimens may have created ethanol. Ethanol that is indistinguishable from exogenous alcohol in beverages can be generated by fermenting bodily tissues and fluids that undergo decomposition, either due to decomposition within the body or by decomposition of tissues stored in adverse conditions. I do not know how Dr. Hall submitted his specimens to the State Toxicology Laboratory during the time of Jonathan Whitson's autopsy; however, it was common during this time to submit specimens through the United States Postal Service where ambient temperatures may have fluctuated significantly. With the available information provided, I cannot confirm or exclude that the ethanol detected in Jonathan Whitson's blood was from consumed ethanol.

Based on available reports and examination of the original histology slides from the autopsy of Jonathan Whitson, my opinion is that a drug, morphine, contributed to death, and my determination of cause of death would be the following:

Cause of death: Aspiration pneumonia
Due to
Obtundation

Due to
Drug (morphine) intoxication

Manner of death: Accident

I reserve the right to make additional opinions as requested by Commission staff and/or during the Commission hearing based on what I have reviewed and my education, training, and experience.

Jeri M Lemmer MD

Dr. Jerri McLemore

Handout 4

Dr. Jerri McLemore CV

WAKE FOREST UNIVERSITY
SCHOOL OF MEDICINE
CURRICULUM VITAE

NAME: Jerri L. McLemore, M.D.

CURRENT ACADEMIC TITLE: Associate Professor of Pathology
Medical Director, Autopsy Service

ADDRESS:

Business:

Department of Pathology
Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, North Carolina 27157-1072
Telephone: 336-716-2634

EDUCATION:

1987-1992	Kansas University School of Medicine Kansas City, Kansas Doctor of Medicine
1989-1990	Post-sophomore fellowship, Pathology Kansas University School of Medicine, Kansas City, Kansas
1988	Fellowship, Department of Philosophy and History of Medicine, Kansas University School of Medicine, Kansas City, Kansas
1982-1987	University of Kansas, Lawrence, Kansas B.A. Human Biology

POSTDOCTORAL TRAINING:

1996-1997	Chief resident in pathology, University of New Mexico Health Sciences Center
1998-1999	Fellow in Forensic Pathology, Office of the Medical Investigator, Albuquerque, New Mexico
1992-1997	Resident in Anatomic/Clinical Pathology, University of New Mexico Health Sciences Center, Albuquerque, New Mexico

PROFESSIONAL LICENSURE:

2010 - present	North Carolina
2003 - 2012	Iowa
1996 - 2009	New Mexico

SPECIALTY CERTIFICATION:

Sept.1999	Diplomat of American Board of Pathology in Forensic Pathology
Nov. 1997	Diplomat of the American Board of Pathology in Anatomic and Clinical Pathology

EMPLOYMENT:

Academic Experience:

Dec. 1, 2012- present	Associate Professor Department of Pathology Wake Forest University School of Medicine Medical Center Boulevard Winston-Salem, North Carolina
July 1, 2010-2012	Assistant Professor Department of Pathology Wake Forest University School of Medicine Medical Center Boulevard Winston-Salem, North Carolina
July 2009-June 2010	Professor in Forensic Pathology Clinical Adjunct Faculty Des Moines, University College of Osteopathic Medicine Des Moines, Iowa
2006-2009	Associate Professor in Forensic Pathology Clinical Adjunct Faculty Des Moines, University College of Osteopathic Medicine Des Moines, Iowa

2005-2006	Assistant Professor in Forensic Pathology Clinical Adjunct Faculty Des Moines, University College of Osteopathic Medicine Des Moines, Iowa
2004-2010	Assistant Professor, Adjunct Faculty Position Department of Pathology University of Iowa Iowa City, Iowa
1999-2003	Assistant Professor Department of Pathology University of New Mexico Health Sciences Center Albuquerque, New Mexico
2017-present	Medical Director, Autopsy Service, Department of Pathology, Wake Forest School of Medicine, Winston Salem, North Carolina
2019-present	Interim Forensic Pathology Program Director Department of Pathology, Wake Forest School of Medicine, Winston Salem, North Carolina
2016-2018	Interim Forensic Pathology Program Director Department of Pathology, Wake Forest School of Medicine, Winston Salem, North Carolina
2016- present	Abstracts reviewer, United States and Canadian Academy of Pathology (USCAP), annual meeting
2012- present	Lecturer, medical student pulmonary block, non-neoplastic pulmonary disease, Wake Forest School of Medicine, Winston Salem, North Carolina
2011-2018	Activity Director, Annual Western North Carolina Death Investigation Conference Department of Pathology- Autopsy Service Wake Forest School of Medicine Winston-Salem, North Carolina
2011-2015	Pathology Interest Club, mentor Medical school students, Wake Forest School of Medicine Winston-Salem, North Carolina
2010	High School Graduation Project Program, mentor

	Caldwell High School student oversight November 12, 13, and 16, 2010
2011	Medical Student Research Program, mentor, Wake Forest School of Medicine Winston-Salem, North Carolina, summer of 2011
2006-2010	Coordinator of the University of Iowa medical students Community-Based Primary Care Clerkship Iowa Office of the State Medical Examiner Ankeny, Iowa
2006 –2010	Director of the Physicians' Assistant Program elective rotation, Des Moines University College of Osteopathic Medicine, Iowa Office of the State Medical Examiner Ankeny, Iowa
2005-2010	Director of Medical Student's Education State Medical Examiner's Office Des Moines, University College of Osteopathic Medicine Des Moines, Iowa
2000-2001	Mentor for medical students, continuity care clinic University of New Mexico School of Medicine Albuquerque, New Mexico
2001-2003	Director of the University of New Mexico Hospital and Veterans Administration Hospital Autopsy Service, University of New Mexico Health Sciences Center Albuquerque, New Mexico
2001- 2003	Faculty Advisor/Career Counselor University of New Mexico School of Medicine Albuquerque, New Mexico
1999-2003	Director of Residents' Education Office of the Medical Investigator Department of Pathology University of New Mexico Health Sciences Center Albuquerque, New Mexico

OTHER PROFESSIONAL APPOINTMENTS AND ACTIVITIES:

Employment and practical experience:

Sept 2003-May 2010	Associate State Medical Examiner Iowa Office of the State Medical Examiner Ankeny, Iowa
July 1999-Aug 2003	Medical Investigator Office of the Medical Investigator Albuquerque, New Mexico
2014	Inspector, National Association of Medical Examiners accreditation inspection Cook County Medical Examiner Office Chicago, Illinois
2012	Participation in the National Association of Medical Examiners accreditation inspection Office of the Chief Medical Examiner of the Commonweath of Massachusetts Boston, Massachusetts
1997-1998	Instructor /Surgical & Cytopathology University of New Mexico Health Sciences Center Albuquerque, New Mexico
Oct 1997 and Feb 1998	Staff Pathologist, locum tenens Gila Regional Medical Center Silver City, New Mexico
Feb 1996 and Mar 1997	Staff Pathologist, locum tenens Rehoboth-McKinley Christian Memorial Hospital Gallup, New Mexico

OTHER PROFESSIONAL APPOINTMENTS AND ACTIVITIES

1997-1998	Pathologist, locum tenens Autopsy Service Office of the Medical Investigator Albuquerque, New Mexico
1995	Participation in College of American Pathologists (CAP) inspection Rehoboth-McKinley Christian Memorial Hospital Gallup, New Mexico
1994	Participation in CAP inspection Presbyterian Hospital Gallup, New Mexico

Committee appointments:

2018-present	National Association of Medical Examiners (NAME) Standards Committee, member
2013-2017	National Association of Medical Examiners (NAME) Ad hoc committee-Research, member
2012-2015	Faculty Development Advisory Committee Wake Forest Baptist Health Winston-Salem, North Carolina
2011-present	National Association of Medical Examiners (NAME) Education, Program and Publications Committee Forensic Fellow In-Service Exam Subcommittee, member
2011-2014	Forsyth County Child Fatality Prevention Team Forsyth County Public Health Department Winston-Salem, North Carolina
2010-2016	Residency Committee Department of Pathology Wake Forest School of Medicine Winston-Salem, North Carolina
2009- 2010	National Association of Medical Examiners (NAME) Education, Program and Publications Committee Education/Program Subcommittee Member

Committee appointments (continued):

2003-2006	Iowa Child Death Review Team, Committee Member Iowa Department of Public Health Des Moines, Iowa
2003-2004	Bio-emergency Response Committee Iowa Department of Public Health Des Moines, Iowa
2003	Metabolic Screening Subcommittee Iowa Department of Public Health Des Moines, Iowa
July 2000- 2003	Post-sophomore Fellowship in Pathology Selection Committee Department of Pathology University of New Mexico Health Sciences Center Albuquerque, New Mexico
2000-2003	New Mexico Intimate Partner Violent Death Review Team, Committee Member University of New Mexico Health Sciences Center New Mexico Crime Victims Reparation Commission Albuquerque, New Mexico
July 2001-2003	Tissue, Transfusion, and Autopsy Committee, University of New Mexico Health Sciences Center Albuquerque, New Mexico
July 1999- 2003	Residency Selection Committee Department of Pathology University of New Mexico Health Sciences Center Albuquerque, New Mexico
July 1999- 2003	Residency Training Committee Department of Pathology University of New Mexico Health Sciences Center Albuquerque, New Mexico

PROFESSIONAL MEMBERSHIPS:

American Academy of Forensic Sciences
National Association of Medical Examiners

HONORS AND AWARDS:

2013	Appalachia & Native Health Service Award Western Carolina University College of Health & Human Services, Cherokee Studies, and The Center for Native Health Cullowhee, North Carolina
2010	Director's Medallion Award Iowa Division of Criminal Investigation Iowa Department of Public Safety Ankeny, Iowa
1997	Young Investigators Award, Academy of Clinical Laboratory Physicians and Scientists (ACLPS) Meeting Minneapolis, Minnesota
1996	Young Investigators Award, Academy of Clinical Laboratory Physicians and Scientists (ACLPS) Meeting St. Louis, Missouri
1991	William H. Bailey Award for Research in Pathology
1991	Russell J. Eilers Award for Pathology

RESEARCH GRANTS (Funded)

September 13, 2010 – December 13, 2011	National Institute of Justice (PI) "The Effects of Acquisition of Postmortem Blood Specimens on Drug Levels and the Effects of Transport Conditions on Degradation of Drugs," Technical report submitted Sept. 30, 2013

BIBLIOGRAPHY:

Book Chapters:

McLemore J, Zumwalt RE. Postmortem changes. In: Froede RC, editor. Handbook of Forensic Pathology. Chicago: College of American Pathologists Press, February, 2003

Journal Articles:

Dasgupta A, Mahle C, McLemore J. Elimination of fluconazole interference in gas chromatography/mass spectrometric confirmation of benzoylecognine, the major metabolite of cocaine using pentafluoropropionyl derivative. J Forensic Sci. May, 1996; Vol 41 (3), pp. 511-3

Dasgupta A, McLemore JL. Elevated free phenytoin and free valproic acid concentrations in sera of patients infected with human immunodeficiency virus. Ther Drug Monit. Feb, 1998; 20(1): pp. 63-7

McLemore JL, Beeley P, Thorton K, Morrisroe K, Blackwell B, Dasgupta A. Rapid automated determination of lipid hydroperoxide concentrations and total antioxidant status of sera from patients infected with HIV: elevated lipid hydroperoxide concentrations and depleted total capacity of sera. American Journal of Clinical Pathology, March, 1998; Vol 109 (3), pp. 268-273

Newman J, McLemore J. Forensic medicine: matters of life and death. Radiol Technol. Nov-Dec, 1999; 71(2), pp. 169-85

Wright B, McLemore J. "Murderous mullosks." Check sample for The American Society for Clinical Pathology Check Sample series, Forensic Pathology, 2001; Vol.43(6), pp 71-78

Stefan VH, Aronica-Pollak P, McLemore JL. Coronal cleft vertebra initially suspected as an abusive fracture in an infant. Journal of Forensic Sciences, July, 2003;Vol. 48, No. 4,; pp. 1-3

Nolte KB, Lathrop SL, Nashelsky MB, Nine JS, Gallaher MM, Umland ET, McLemore JL, Reicard RR, Irvine RA, McFeeley PJ, Zumwalt RE. "Med-X: A medical examiner surveillance model for bioterrorism and infectious disease mortality." Human Pathology (2007) 38, 718-725

Thomas N, McLemore J. "Methamphetamine mishaps: Anhydrous ammonia." Check sample for The American Society for Clinical Pathology Check Sample series, Forensic Pathology, 2009; No. FP09-6 (FP-347), pp.71-81

McLemore J, Hallengren A. "X-ray appearance of subcutaneous gemstones as part of alternative/holistic medicine: A case report and review of the literature." Clinical Imaging. 2010, 34: 316-318

McLemore J, Hodges W, Wyman A. "Impact of identity theft on methods of identification." Am J Forensic Med Pathol. 2011 June. 32(2): 143-5

Valente K, McLemore J. "Sudden death from spontaneous coronary artery dissection: A discussion of risk factors." American Society of Clinical Pathology Case Reports Series, Forensic Pathology, Exercise 4, 2013

Shrestha BK, Miles MC, McLemore JL. "Sudden death by acute cor pulmonale from intravenous drug abuse during an inpatient admission: Implications for unexplained in-hospital deaths." Clinical Pulmonary Medicine 2013 July, 20(4): 192-5

Journal articles (continued):

Still B, McLemore J. "Ruptured sinus of Valsalva aneurysm: A rare cause of sudden, unexpected death." Wake Forest Journal of Science and Medicine. 2016 May. 2(1): 119-121

Giffen M, McLemore J. "Forensic radiology pitfalls: CT imaging in gunshot wounds of the head." J Forensic Sci. March, 2018; 63(2): 631-634

Giffen MA, McLemore J. "Hyperoxalosis secondary to vitamin C administration as a non-allopathic treatment for cancer." AFP. March-June, 2019; 9(1-2): pp. 118-126

Davis GG, Cadwallader AB, Fligner CL, GilsonTP, Hall ER, Harshbarger KE, Konstrand R, Mallak CT, McLemore JL, Middleberg RA, Middleton OL, Nelson LS, Rogalska A, Walterscheid JP, Winecker RE. "Position Paper: Recommendations for the Investigation, Diagnosis, and Certification of Deaths Related to Opioid and Other Drugs." Am J Forensic Med Pathol, 2020;41: pp.152-159

Palmer RF, McLemore J. "Autopsy findings of coronary artery dissection occurring during coronary angiography." Online Journal of Cardiovascular Research. July, 2020; DOI: 10.3352/OJCR.2020.04.000588

Abstracts:

Tawfik O, McLemore J, Chauduri R. Localization of immune cells in the endometrium during the menstrual cycle. Abstract. Annual meeting of the Society for the Study of Reproduction, Vancouver, Canada 1991

Tawfik O, McLemore J, Wood G. Immunolocalization of growth factors in the human endometrium during the menstrual cycle. Abstract. Annual meeting of the United States and Canadian Academy of Pathology 1991

Palmer RB, Walker, MK, Church MJ, Kim NH, McLemore JL. Developmental cardiotoxicity of BNMPA, a by-product of illicit methamphetamine synthesis. Abstract presentation at the American Academy of Forensic Sciences meeting, Reno, Nevada, February 21-26, 2000

Aronica-Pollak PA, Stefan VH, McLemore J. Notochord regression failure initially suspected as an abusive fracture in an infant. Abstract presented at the American Academy of Forensic Sciences meeting, Atlanta, Georgia, February 11-15, 2002

Hodges W, Wyman A, McLemore J. Impact of Identity Theft and False Identities on Primary Identification Methods. Abstract, platform presentation at the National Association of Medical Examiners conference, Savannah, Georgia, October 15, 2007

McLemore J. Motor Vehicle Crash Involving an Elderly Woman with Undiagnosed Giant Cell Myocarditis. Abstract, platform presentation at the American Academy of Forensic Sciences Annual Conference, Washington DC, February, 2013

Abstracts (continued):

McLemore J, Zhou T. Pulmonary Emboli Associated With Leiomyomatous Uteri. Abstract, platform presentation at the National Association of Medical Examiners Conference, Milwaulkee, WI, October 11-15, 2013

McLemore J, Schwilke G, Klein D, Shanks K. Comparison of Drug/Metabolite Stability in Specimens Transported in Ambient Temperature Versus on Dry Ice. Abstract, platform presentation at the National Association of Medical Examiners Conference, Portland, OR, September 23, 2014

Morrell-Lopez L, McLemore J. Institutional Experience with the Molecular Autopsy. Abstract, platform presentation at the American Academy of Forensic Science Conference, Orlando, FL, February 17, 2015

O'Neill TE, McLemore JL, Lantz PE. Non-abusive Bilateral Retinal Hemorrhages Extending to the Ora Serrata in an Infant with a Ventriculo-Peritoneal Shunt for Post-Hemorrhagic Hydrocephalus. Abstract, platform presentation at the National Association of Medical Examiners Conference, Charlotte, NC, October 6, 2015

Giffen MA, Powell J, McLemore J. Forensic radiology pitfalls: CT imaging in gunshot wounds of the head. Abstract, platform presentation at the American Academy of Forensic Sciences, Las Vegas, NV, February 27, 2016

Pomper G, Appt S, Register T, Palavecino E, Beaty M, Lantz P, McLemore J, Hausman J, Wilson E, Dennard D, Oliphant E, Wong SH. Developing a policy/protocol for testing of non-human and forensic samples by a clinical core laboratory. Abstract, 69th AACC Annual Scientific Meeting and Clinical Lab Expo, San Diego, CA, July 30-August 3, 2017

Giffen MA, McLemore J. Hyperoxalosis secondary to intravenous vitamin C administration as a non-allopathic treatment for cancer. Abstract, platform presentation at the National Association of Medical Examiners, West Palm Beach, FL, October 15, 2018

Jackson A, McLemore J. Fatal angioedema due to delayed hypersensitivity reaction associated with hair dye and temporary tattoo. Abstract, platform presentation at the American Academy of Forensic Sciences, Baltimore, MD, February 22, 2019

WAKE FOREST UNIVERSITY
SCHOOL OF MEDICINE
TEACHING PORTFOLIO

TEACHING RESPONSIBILITIES:

Instructor for medical students' laboratories and poster sessions: cardiovascular-pulmonary lab, 1998 to 2003, neoplasia lab, 1999 and 1997, neuropathology lab, 1996, renal lab, 1995, anatomic pathology lab, 1994, hematopathology lab, 1993, University of New Mexico School of Medicine, Albuquerque, NM

Lecturer in the medical students' cardiovascular block, "Atherosclerosis and other vascular diseases," University of New Mexico School of Medicine, March 2000, March 2001

Program coordinator for the pathology material in the cardio-vascular block for medical students at the University of New Mexico School of Medicine, Albuquerque, NM, spring of 2001

Tutorial leader for phase I medical students, Mechanisms of Disease block, problem based learning format, University of New Mexico School of Medicine, Albuquerque, NM, Fall, 2002

"Death certification," presentation to housestaff, Department of Internal Medicine, geriatrics division, University of New Mexico Health Sciences Center, June, 2002 and 2003

"What is the OMI?" presentation to housestaff, University of New Mexico Health Sciences Center, June 2003

Presentation of various anatomic and clinical pathology cases to various departmental specialties as part of the clinical-pathologic correlation conferences, University of New Mexico Health Sciences Center, Albuquerque, NM 1992- 2003

Lecture series for the mortuary science class, Des Moines Area Community College, spring term, "Introduction to Medical Examiners" and "Autopsies" (Jan. 19, 2005),
"Hereditary Disease" and "Infectious Diseases" (2005-2010), "Respiratory System" (2005-2008), "Digestive System" (2005-2010)

Guest lecturer, Department of Anatomy, Des Moines University College of Osteopathic Medicine, Des Moines, Iowa, 2007-2010

Selected forensic pathology topics, guest lecturer, Nebraska Weslyan University Forensic Masters Program, Lincoln, Nebraska, April 25, 2009

TEACHING RESPONSIBILITIES: (Continued)

Lecturer, Monthly didactic lectures in forensic pathology, pathology residents, Department of Pathology, Wake Forest School of Medicine, Winston-Salem, North Carolina, 2010-present

Moderator, medical students' case-centered learning block, Wake Forest School of Medicine, Winston-Salem, North Carolina, Fall of 2010, 2011

Lecturer, Non-neoplastic pulmonary disease, medical students curriculum, Wake Forest University School of Medicine, Winston-Salem, North Carolina, Fall block, Oct. 1-16, 2012-2017

Guest lecturer, North Carolina State Highway Patrol EMT Continuing Education, Wake Forest Baptist Health, Winston-Salem, NC, 2013-2014

Lecturer, County Medical Examiner Statewide Training, Charlotte, NC, November 10, 2015

Participant for "Sisters in Science" program, Wake Forest School of Medicine, Winston-Salem, NC, 2012, 2013, 2015

Lecturer, Davie High School Science, Technology, Engineering and Math program, Department of Pathology, Wake Forest School of Medicine, Winston-Salem, NC, April 28, 2016

Guest speaker, Wake Forest University Summer Immersion Program, Winston-Salem, NC, June 28, 2016

LECTURES/PRESENTATIONS:

"Positional Asphyxia" at the dinner presentation for the Annual Medicolegal Investigation of Death Seminar, Albuquerque, New Mexico, February, 1993

"Mercury Poisoning" for New Mexico Society for Clinical Laboratory Science (NMSCLS), Albuquerque, New Mexico, April 1997

"Interference of Salicylate and Valproic Acid with Bactrim in Sera from HIV Positive Patients" at the Academy of Laboratory Physicians and Scientists, Minneapolis, Minnesota, 1997

"Ricochet Bullets" at the dinner presentation for the Annual Medicolegal Investigation of Death Seminar, Albuquerque, Albuquerque, New Mexico, September, 1998

"Asphyxial Deaths" seminar presentation for the Annual Medicolegal Investigation of Death Seminar, Albuquerque, New Mexico, September, 1998, 1999, and 2000

LECTURES/PRESENTATIONS: (Continued)

"The Microscopic Autopsy" presentation for the New Mexico Histology Society Meeting, Albuquerque, New Mexico, April 17, 1999

"Patterned Injuries" presentation for the Conference on the Prosecutor's Response to Sexual Violence Cases, Albuquerque, New Mexico, November 2-3, 1999

"Postmortem Changes" and "The Forensic Autopsy" presentations for Medicolegal Investigation of Death workshops in Farmington, New Mexico and in Gallup, New Mexico, July 26-27, 2000

"Nurses and the Office of the Medical Investigator," Association of Perioperative Registered Nurses (AORN), Sept. 16, 2000

"Determining cause and manner of death using a traditional approach," dinner seminar presentation at the Medicolegal Investigation of Death Seminar, Albuquerque, NM, Sept. 2000

"Forensic radiography: How radiology is used in medicolegal death investigation," presentation at the New Mexico Society of Radiologic Technologists conference, Albuquerque, NM, April, 2001

"Electrifying concepts about fire, water, and more," presentation at the Medicolegal Investigation of Death Seminar, Albuquerque, NM, Sept. 2001

"Attitudes toward death," guest speaker for undergraduate course, "Pop Culture," University of New Mexico, Jan. 2002

"Forensic implications of complementary and alternative medicine," Pathology Grand Rounds, Department of Pathology, University of New Mexico Health Sciences Center, Albuquerque, NM, Jan. 2002

"Forensic implications of complementary and alternative medicine," New Mexico Society for Clinical Laboratory Science, Albuquerque, NM, April, 2002

"Identification of human remains," New Mexico Field Investigators' Training, Gallup, NM, May 30, 2002

"Medical Therapeutic complications," New Mexico Department of Health, Albuquerque, NM, June, 2002

"Injuries," New Mexico Field Investigators' Training, Office of the Medical Investigator, Albuquerque, NM, June 10, 2002, October 8, 2002, and May 11, 2003

"Strangulation," Domestic Violence Training Class, Albuquerque Police Department Academy, Albuquerque, NM, July 30, 2002 and August 12, 2002

LECTURES/PRESENTATIONS: (Continued)

Preparation of videotape, segment on medical complications of alcohol, "Second Chance," project for Driving While Intoxicated convictions, funded by the Traffic Safety Bureau of the Highway and Transportation Department, Sept. 2002

"The Wrongful Death Autopsy." Lecture for private investigators, The Academy of Private Investigators at Des Moines Area Community College, Oct. 30, 2003

"Asphyxial Deaths." Lecture for the Division of Criminal Investigation (DCI), Des Moines, IA, Dec. 9, 2003

"Suicide." Lecture for the Division of Criminal Investigation (DCI), Des Moines, IA, Dec. 9, 2003

"Iowa State Medical Examiner's Office." Lecture for the Department of Public Health, Des Moines, IA, March 2004 and 2010

"Fire-related deaths." Lecture fire investigators at the Iowa Fire Service Training Bureau, Ames, IA, Sept. 22, 2004

"Complementary and Alternative Medicine." Lecture at Grand Rounds, University of Iowa, Dept. of Pathology, Iowa City, Iowa, Oct. 7, 2004

"Where there's smoke, there's fire, and an autopsy is not far behind." Lecture at the Iowa Association of County Medical Examiners conference, Des Moines, Iowa, Nov. 13, 2004

"Overview of the Medical Examiner System." Career Day for Dowling High School students, Iowa Dept. of Public Health, Des Moines, Iowa, Feb. 16, 2005

"What is up with the State Medical Examiner's Office?" Lecture to the Ankeny Citizen Police Academy, Ankeny, Iowa, March 17, 2005

"What is a Medical Examiner?" Lecture to Ankeny High School students, Career Day, Ankeny High School, Ankeny, Iowa, April 13, 2005

"Overview of the Iowa State Medical Examiner's Office." Lecture to medical assistants, Des Moines Area Community College, Ankeny, Iowa, April 20, 2005

"What is a Medical Examiner?" Lecture to Urbandale High School students, Urbandale High School, Urbandale, Iowa, April 28, 2005

Personal Protective Equipment lecture to members of the Division of Criminal Investigation office, Iowa State Medical Examiner's Office, Ankeny, Iowa, May 11, 2005

LECTURES/PRESENTATIONS: (Continued)

"County and State Medical Examiner Procedures." Lecture for the Des Moines Public Safety Basic Academy training, Ft. Hood, Johnson, Iowa, May 12, 2005, Oct. 2006, May 2008, Oct. 2008

"Speaking Medical Examinese." Seminar presentation for the Iowa Court Reporters Association, Des Moines, Iowa, Jan. 2006

"The Medical Examiner and the ER Physician." Lecture for Des Moines University ER Club, Des Moines University College of Osteopathic Medicine, Des Moines, Iowa, Oct. 5, 2006

"Firearm-related deaths." Lecture for Des Moines University ER Club, Des Moines University College of Osteopathic Medicine, Des Moines, Iowa, March 30, 2007

"The Iowa Office of the State Medical Examiner." Lecture for the Iowa Division of the International Association for Identification, Marshalltown, Iowa, May 2007

"Methods of Identification." Lecture for the Iowa Association of County Medical Examiners annual conference, West Des Moines, Iowa, November 2, 2007 and at the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, March 31, 2012 and at the Eastern Carolina University-Brody School of Medicine Death Investigation Conference, Greenville, NC, December 12, 2012

"The Finer Points of Death Certification." Lecture for the Iowa Association of County Medical Examiners annual conference, West Des Moines, IA, November 7, 2008

"Careers in Forensic Science." Lecture for biology students at Grandview College, Des Moines, IA, September 23, 2009

"Iowa Office of the State Medical Examiner." Lecture with Mr. Matthew Lunn for the 2009 IEMSA Conference, Des Moines, IA, November 13, 2009

"Basics in Forensic Pathology." Lecture for high school students' forensic course, East Burke High School, Morganton, NC, September 22, 2010

"The Value of Scene Investigations." Lecture at the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, March 26, 2011

"Medicolegal vs. Hospital-Based Autopsies." Lecture for the Pathology Interest Club, Wake Forest University School of Medicine, Winston-Salem, NC, Sept. 21, 2011 and Sept. 10, 2012

"Forensics: 101." Lecture for laboratory personnel, Pathology Laboratory week, Wake Forest Baptist Health, Winston-Salem, NC, April 23, 2012

LECTURES/PRESENTATIONS: (continued)

"Forensics: 101." Lecture for the North Carolina State Highway Patrol EMT Continuing Education, Wake Forest Baptist Health, Winston-Salem, NC, May 8 and Sept. 4, 2013

"Postmortem Changes." Lecture for the Eastern Carolina University-Brody School of Medicine Death Investigation Conference, Greenville, NC, December 11, 2013

"Crash Course in Motor Vehicle Fatalities: The Medical Examiner's Perspective." Lecture for the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, March 22, 2014

"Scenes From Final Destination." Lecture for the North Carolina State Highway Patrol EMT Continuing Education, Wake Forest Baptist Health, Winston-Salem, NC, April 25, 2014 and September 10, 2014

"Death Certification: The Coding System for Death Investigation." Guest lecturer for the Piedmont Healthcare Symposium for Professional Coders, Greensboro, NC, September 20, 2014; guest lecturer for the American Academy of Professional Coders, Blue Cross and Blue Shield of NC Chapel Hill East, December 3, 2015

"Deaths In and Around Water." Lecture for the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, March 21, 2015

"When Animals Attack." Lecture for the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, March 21, 2015

"Hypothermic/Hyperthermic-Related Deaths." Lecture for the Annual Western North Carolina Death Investigation Conference, Winston-Salem, NC, April 23, 2016

"A Mulidisciplinary Approach to a Local High-Profile Double Homicide." Department of Pathology Grand Rounds presentation, Wake Forest Baptist Health, Winston-Salem, NC, November 1, 2017; Annual Western North Carolina Death Investigation Conference, Wake Forest School of Medicine, Winston-Salem, NC, April 28, 2018

"Women in Criminal Justice Career Information Fair." Speaker, Winston-Salem Police Department, Winston-Salem, NC, April 21, 2018

"The Impact of the Current Drug Epidemic on the Medicolegal Death Investigation System." Lecturer at The Many Faces of Addiction, Wake Forest School of Medicine/Northwest Area Health Education Center, Winston-Salem, NC, August 30, 2019

POSTER PRESENTATIONS:

Swaninathan A, McLemore J, Clark DA, McKinney DR, Crooks LA, Tzamaloukas AH. Renal involvement by mycosis fungoides. Poster presentation. Annual meeting of the New Mexico Chapter of the American College of Physicians, Albuquerque, New Mexico 1993

McLemore J, Azikiwi CN, Malhoutra D, Saddler MC, Murata GH, Tzamaloukas AH. Erythrocytosis with high serum erythropoietin in a hemodialysis patient. Poster presentation. Annual meeting of the New Mexico Chapter of the American College of Physicians, Albuquerque, New Mexico 1994

McLemore J, Dasgupta A, Wallis T. Significant cost reduction in new magnetic HDL-cholesterol assay by reducing reagent and sample volume. Poster presentation. Annual meeting for American Association for Clinical Chemistry and Canadian Society of Clinical Chemists 1996

Tvrdik S, McLemore J. "Homicides Staged as Suicides." Poster presentation at the American Academy of Forensic Sciences Annual Conference, Washington, DC, February, 2008

Umesi N, McLemore J. "The Utility of Extensive Dissection of Autopsied Hearts". Poster presentation at the 2011 Medical Student Summer Research Training Program, Wake Forest University School of Medicine, Medical Student Research Day. Winston Salem, NC. October 2011.

Lenfest S, McLemore J. "Sudden Death from Aggressive Pansinusitis and Pituitary Abscess With Clinical Features Suspicious for Intracranial Trauma." Poster presentation at the American Academy of Forensic Sciences Annual Conference, Washington DC, February, 2013

Brown S, Lantz PE, Jason DR, McLemore J. "Use of Therapeutic Intravenous Catheters in Drug Addiction: A Series of Three Cases." Poster presentation at the American Academy of Forensic Sciences Annual Conference, Washington DC, February, 2013

Philip, JKSS, Qasem SA, Enweluzo C, McLemore JL. "Widely Metastatic Hepatic Angiosarcoma Mimicking Hereditary Telangiectasia Presenting During Pregnancy And Diagnosed At Autopsy." Poster presentation at the College of American Pathologists (CAP) annual meeting, Gaylord Palms, Orlando, October, 2013

Curry B, McLemore JL. "An Unusual Death By A Homemade Medical Device." Poster presentation at the American Academy of Forensic Sciences Annual Conference, Seattle, WA, February, 2014

Haer ER, McLemore J. "Homemade Deer Hunting Tree Stand: A Unique Cause of an Asphyxial Death." Poster presentation at the National Association of Medical Examiners Annual Conference, Charlotte, NC, October 2015

POSTER PRESENTATIONS (CONTINUED):

Wolanin SA, McLemore J. "Autopsy Confirmed Signet-Ring Cell Adenocarcinoma of the Gallbladder with an Endometrial Polyp Metastasis." Poster presentation at the College of American Pathologists (CAP) annual meeting, Gaylord Opryland Resort & Convention Center, Nashville, TN, October 2015

McLemore J., Sweede S. "Dehiscence and Exsanguination of a Surgical Chest Incision Mimicking Traumatic Injury in a Non-decomposed Person." Poster presentation at the National Association of Medical Examiners Annual Conference, Scottsdale, AZ, October 2017

Green M., McLemore J., Ross A. "Variation in Degree of Decomposition of Two Bodies Buried in Close Proximity." Poster presentation at the National Association of Medical Examiners Annual Conference, Kansas City, KS, October 2019

Palmer RF, McLemore J. "Naegleria Fowleri Diagnosed with Hospital Autopsy in a Toddler: A Case Study." Poster presentation accepted for The American Society of Clinical Pathologists, virtual meeting to be held September 9-12, 2020

Handout 5

Dr. Christina Roberts

Report

CJ Consulting of America, LLC
Christena Roberts, MD

Attorney Work Product
Innocence Inquiry Commission

Court Case/ Ref. #: 11 CRS 304 and 11 CRS 305
County: Yancy
Attorney: Julie Bridenstine

Decedent: Jonathan Whitson
Re: State of North Carolina v. John Pritchard

The following draft report was prepared in affidavit format for the North Carolina General Court of Justice; Superior Court Division on January 11th 2021. This document was prepared in the above referenced matter for the Wake Forest Innocence & Justice Clinic. Paragraph two (2) lists the records that were available to me at the time the affidavit was prepared. As part of the report items still needed to be reviewed to independently review the death investigation are listed within the paragraphs and summarized is list format in paragraph fourteen (14). In November 2021, I received additional documents from the Innocence Inquiry Commission. The documents reviewed and amendment to this report are attached here as Amendment A.

1. The attorneys with the Wake Forest Innocence & Justice Clinic (the Clinic), who are representing the Defendant, John Pritchard, have asked me to review records concerning the death of Jonathan Russell Whitson (date of death March 6, 2011), the alleged homicide victim in this case, and to give opinions as to the accuracy of the determination of the cause and manner of his death as reflected in the autopsy report and testimony of Brent D. Hall, M.D.
2. I have reviewed the following records, attached as Exhibits hereto, in order to arrive at my opinions:
    a. Report of Autopsy Examination for Jonathan Russell Whitson (date of autopsy – 3-7-2011), Autopsy No. AP-11-5, Yancey County, by Brent D. Hall, M.D.
    b. Report of Investigation by Medical Examiner for Jonathan Russell Whitson, OCME Case No. 11-2509 (received by OCME on 3-9-2011), prepared by Brent D. Hall, M.D.
    c. OCME Toxicology Report on specimens taken from Jonathan Russell Junior Whitson (OCME Toxicology Folder No. T201101851 and Case Folder No. F201102509)
    d. Transcript of Trial, State v. John Pritchard, April 14, 2014 Session of Yancey County Superior Court (and summary of transcript)
    e. Letter from Defendant John Pritchard
3. Dr. Hall testified at trial that the cause of Mr. Whitson's death was morphine toxicity. In my opinion, the death of Mr. Whitson cannot be attributed to acute morphine

toxicity because there is no evidence, from the autopsy report, toxicology reports from the OCME, or clinical presentation to support that conclusion.

4. It appears that although only a trace level of morphine was found in the blood, the death was called morphine toxicity by Dr. Hall because there was morphine in the urine. Dr. Hall testified that the cut off level for toxicity in the urine was 14 mg/L and since there was 15 mg/L in the urine that was a toxic level. Dr. Hall did not apply the correct methodology in arriving at his conclusions. A value in urine cannot be interpreted in isolation. For the cause of death to be called a death by acute toxicity of morphine, there must be an appreciable level of morphine in the blood, which is not the case here.
5. Morphine levels in the blood must be interpreted using literature to determine what represents in general: therapeutic, supratherapeutic and toxic levels. That level then is interpreted with the clinical information such as the person's tolerance and the decedent's clinical presentation in the time preceding their death.
6. As shown by the toxicology report, no opiates (morphine is an opiate) were detected by the LCMS screen of the aorta blood. A quantification was performed the on femoral blood that showed "trace" amounts of morphine.
7. As morphine is a respiratory and central nervous system depressant the clinical presentation of acute toxicity would include somnolence, unable to be awakened, snoring and labored breathing, comatose, followed by death.
    a. Mr. Whitson allegedly crushed, melted and injected three (3) pills into two (2) syringes and injected himself with one (1) of them and injected his friend with the other.
    b. Over the next approximately 5.5 hours six (6) more pills were crushed and injected between them.
    c. No is no evidence that Mr. Whitson was stuporous during this timeframe. In fact, they were "hanging out" and driving in a vehicle. His grandmother reported to police that once he went to bed that night around 10:00 pm he got up three (3) times to go to the bathroom and each time he popped his head in her bedroom door and told her he loved her.
    d. Clearly, he was not comatose if he was up walking and talking.
8. It may be possible that Dr. Hall opined enough time had passed to metabolize the morphine out of the blood. Liquid morphine used for surgical patients is designed to have a very short half-life, approximately 2-3 hours. The half life of a drug is the amount of time that it takes for the body to eliminate half of the concentration in the blood.
    a. In this case the morphine pills that were allegedly crushed, melted and injected were sustained release morphine pills. The half life of sustained release morphine pills the when ingested is approximately 16-18 hours. This reviewer is not aware of literature studying the half life of a sustained release pill when it is crushed, melted and injected.
9. At autopsy one can find a situation where low levels of an opiate like morphine or heroin can cause acute toxicity by direct cardiotoxicity. In this situation a person who lost their tolerance to a drug tries to inject the same amount as they had built up to prior to a drug absence. In these cases, the decedent is often found with the syringe still in their arm or nearby. The victim is often slumped over or witnessed by others to be "passed out", unarousable and snoring loudly.

a. This scenario clearly doesn't match the clinical presentation of Mr. Whitson that evening.

10. In my opinion, Dr. Hall also did not completely explore competing causes of death. No blood, lung or viral cultures were performed at the time of autopsy to rule out a bacterial or viral underlying medical condition. This would be especially important as Mr. Pritchard reported that when Mr. Whitson was released from jail, he had a fever and he had a large abscess of his left arm. There is no documentation in the autopsy of an abscess. To independently evaluate this possible mechanism of death I would need to review the autopsy photographs and Mr. Whitson's jail medical records.
11. The autopsy did document an ulceration of the left heel. There is no description provided of the stage of the ulceration (depth, presence of purulent exudate). No culture swab was performed on the heel ulceration to rule out infection. As noted above no blood cultures were performed to rule out sepsis as a cause of death.
12. Autopsy did find that Mr. Whitson had "moderate" acute bronchial pneumonia. The extent of the pneumonia was not documented further. I would need to review the original or recut microscopic slides from the lungs to independently evaluate the extent of the pneumonia. Acute bronchial pneumonia can be a primary cause of death. The presence of chronic lung disease could be a contributing factor. Changes consistent with pulmonary emphysema were described in the autopsy report.
13. Based on the information available to me at this time with the limitations of the autopsy performed, the cause of death would be better listed as acute bronchial pneumonia with pulmonary emphysema as a contributing factor. The manner of death would therefore be listed as "Natural".
14. In order to arrive at a more definitive opinion as to Mr. Whitson's cause of death, I would need copies of or access to the following information:
    a. All jail records, including medical, psychiatric, psychological and prescription records for Mr. Whitson during his incarceration in the months before he died from the jails in Madison and Buncombe counties.
    b. All autopsy photographs of Mr. Whitson.
    c. Any and all other law enforcement or medical examiner photographs of Mr. Whitson after his death.
    d. The original file for the medical examiner, Dr. Hall, in this case, including any notes, documents, correspondence or reports relating to the death investigation of Mr. Whitson.
    e. All law enforcement reports concerning the death investigation of Mr. Whitson.
    f. Access to either the original microscope slides from autopsy or recuts of those slides.

Amendment A:

Additional documents reviewed concerning the death of Jonathan Whitson:

- Watauga Medical Examiner Office autopsy file
- Exhibit labeled Files from Dr. Hall
- Office of the Chief Medical Examiner of NC autopsy file
- Madison county jail records from 1/6/2011 until 3/4/2011
- Buncombe county jail records from 3/4/2011
- Transcript of Trial, State v. John Pritchard, April 14, 2014 Session of Yancey County Superior Court
- Summary of trial transcript
- Mission hospital medical records from 12/27/2010 admission
- Yancy County Sheriff office file
- State Bureau of Investigation file
- Dr. McLemore's report
- Dr. Wolf's report
- Dr. Behonick's report
- Original microscopic slides from autopsy

Review of Sgt Higgins report; Yancy County Sheriff's Office:

The 911 dispatch call was placed on March 6, 2011 at 11:33 am. In the initial report Christine Angel (Jonathan's step-grandmother) tells officer Higgins that Jonathan arrived at 1:00 am on March 5, 2011. His girlfriend Stephanie came over at 2:30 pm and they left for 1 ½ hrs. Stephanie left at 9:30 pm. Christine stated she woke at 9:00 am and Jonathan was asleep on the couch, snoring. She and her husband left and went to the store and returned at 10:30 am. When they returned he was still sleep on the couch and snoring. Later when they tried to wake him, they discovered he was deceased and called 911.

When she testified at trial Christine Angel stated that Stephanie left that night at 10:00 or 11:00 pm and during testimony then changed that to 9:00 pm. Jonathan prepared to go to bed on the couch. She did not see him go to bed. She stated that Jonathan got up three (3) times that night she presumed to go to the bathroom. Each time he got up he "poked his head around the corner and said, "Granny I love you"" and that he had never done that before. She testified that she woke early the next morning at 6:00 or 7:00 am and Jonathan was asleep on the couch. At the time of the incident she told police she woke at 9:00 am. She conceded at trial that her memory wasn't good and what she told officers at the time may be more accurate. She went to the grocery store at 10:00 am and was back at 10:30 am. When interviewed she stated Jonathan was still snoring when she returned from the store. At trial she stated she didn't know if he was snoring then because she was in the kitchen (cooking breakfast).

During trial when Christine was told the autopsy report said that Jonathan had pneumonia, she stated she was not aware that he had pneumonia because he was in jail. She testified his medical history included asthma and that he had "a lot of breathing problems". He also had history of a blood clot and a hole in his heart.

Christine denied that Jonathan drank alcohol while in her home. Note she also testified a few of Jonathan's friends came by to see him that day.

Review of the trial testimony of Christine Angel shows that when Jonathan arrived at 1:00 am he was pounding on the door and telling her to let him in "he was tired". She told him to go to bed that she was sick and had a fever. He said no and that he was going to stay in the recliner and "aggravate her all night". She noted each time she would doze off he would talk again and wake her up.

Review of Interview with Nathan Angel:

Handwritten notes are included in the Yancey County Sheriff's Office notes from an interview with Nathan Angel who was staying at the house. He was deceased at the time of trial and I'm told his statements weren't heard by the jury.

Nathan Angel stated that the night of March 5, 2011, Jonathan came to his home (close by but electric malfunctioning so he was staying at his parents Christine and Wade House). They walked together up to his parent's house and talked for a few minutes. Nathan went to bed. Nathan did not make a statement about what time Jonathan went to bed. He noted that when Nathan went to bed Jonathan was sitting in the living room watching TV. Nathan awoke at 4:00 or 4:30 am and Jonathan was asleep on the couch and was snoring loudly. He stated that his father Wade Angel shook Jonathan which caused him to "snore less". When he woke at 8:00 am Jonathan was asleep and snoring (no volume noted). He stated around 10:40 am his son mentioned Jonathan was "sleeping good" and he told him to wake him. He stated that when his son put his hands on Jonathan's chest, he knew then that he was dead. He also shook him and confirmed he was dead. The 911 call was placed at 11:33 am. During this call the dispatch was told there was no need for an ambulance, just to send police.

Review of SBI file:

SBI interviewed Robbie Jean Brown (John Pritchard's girlfriend). She did not directly see John give Jonathan pills but stated he told her that he gave him eight (8) morphine pills. She later stated that John told her he did not give Jonathan pills.

She also testified around Christmas time Jonathan's arm was swollen and was hurting.

Review of trial transcript of Stephanie Whitson:

Stephanie testified that after leaving with John Pritchard for about 15 minutes Jonathan showed her 10 morphine pills that were 30 mg each. One (1) pill was given to Nathan Angel. Initially Jonathan crushed three (3) pills and made two (2) syringes, injecting himself first, then her.

They were in her Jeep talking and later they crushed two (2) more pills and injected them. She later dropped Jonathan at Christine's house at 6:00 pm and she had the remaining four (4) pills with her when she went to Hardees to eat. She came back to Christine's house at 7:30 pm. She

and Jonathan hung out and went to the bathroom and crushed and liquified the remaining four (4) pills in a spoon. They both injected 3 more time each. She stated the spoon with remaining liquid was placed under the bathroom sink and the two (2) remaining syringes didn't have anything in them. ((two (2) empty syringes were found in Jonathan's coat pocket after his death and when tested by the NC Crime lab each contained no controlled substances)). She testified she left at "10 till 10" (9:50 pm).

Stephanie denied any alcohol use that day by Jonathan.

Stephanie testified that in November or December Jonathan went to the hospital for an abscess in his arm.

Review of officer Higgins's testimony:

Officer Higgins arrived on scene at 11:40 am. No information is provided in his report about the condition of the body at the time of his arrival. Specifically, family noted there was no need for an ambulance which may suggest he was cold or stiff. There is no mention in Sgt. Higgins report or testimony if the arms and legs were stiff or if the body was cold to the touch.

Officer Higgins testimony indicated the spoon was not found at the scene. Stephanie's car wasn't searched.

The photos that he took at the scene included Jonathan as found, clothed and with a blanket up to his neck. No photographs were taken of his upper extremities without clothing in place. Specifically, no photos showing the condition of his arms.

Review of Jonathan Whitson Mission Hospital Medical records:

On December 27, 2010 Jonathan went to the Emergency Department (ED) complaining of arm pain, redness and swelling. He stated he had a fever at home but was afebrile on admission. He stated that a friend injected him in the vein in his left antecubital fossa and these symptoms developed after 2 days and worsened over the week. When he developed a fever and chills his girlfriend encouraged him to go to the ED.

On exam the left antecubital fossa was red and indurated (soft tissues hardened). It was noted to be tender to the touch. He was not able to fully extend his left arm and had to keep it bent as it hurt too much to extend it.

CT scan of the elbow showed a probable small subcutaneous abscess in the antecubital region with associated cellulitis and venous thrombosis. Blood cultures were negative and he was treated with intravenous Clindamycin (antibiotic). The thrombosis was treated with warm compresses. Following treatment, on discharge he had pain with extending his arm and he had a firm induration in the antecubital region.

He was discharged on December 30, 2010. Jonathan was to follow up at the Yancey County Health Center in two (2) weeks. It is unknown at this time if he had a follow up appointment,

but it is unlikely as he was incarcerated seven (7) days later in Madison County. He was given a prescription for Clindamycin 300 mg; to be taken four (4) times a day for two (2) weeks. It is unknown if he filled this prescription.

Review of Madison County jail records:

Jonathan Whitson was confined in this jail on January 6, 2011. No medical records are included in the file. The questionnaire on intake indicated that he was not on any medications. These documents do not specifically list when he was released but do note an unsecured bond was approved on March 4, 2011.

Review of Buncombe County jail records:

Officer Framer's report noted that Jonathan was released from the Buncombe County jail on March 5, 2011. Review of the Buncombe County jail records indicate that he was confined there on March 4, 2011. A letter accompanying the records indicate that he wasn't there long enough to have medical records.

The inmate log showed he was booked at 7:37 pm and released at 7:40 pm.

Review of Floyd Ayers testimony:

Floyd was Jonathan's first cousin. He received a call from Jonathan on March 4, 2011 at 9:30 or 10:00 pm to come pick up after he got out of jail and give him a ride to Christine's. Jonathan was walking and met Floyd at a service station. He noted that the location of this station was probably 15 miles from the Buncombe County jail. It took Floyd around 45 minutes to get the service station and another 45 minutes to a one (1) hour to arrive at Christine's house. On cross examination it appears there were two (2) calls, the first at 9:42 pm and there wasn't good cell service. Another call was at 11:07 pm.

Review of autopsy photos:

Review of the Watauga Medical Center Autopsy Documents (Exhibit 3) contains one (1) identification photo and two (2) dark photos that appear to be copies of an identification photo. The OCME Autopsy Documents (Exhibit 4) contain no autopsy photos.

The file labeled documents from Dr. Hall (Exhibit 5) shows a .pdf file with 3 photos. Two (2) are identification photos and only show the face. The third photo appears to show part of the left shoulder and hand and appears the photo is not completely visualized. A complete copy of this photo would be important to assess if an abscess was present and not documented in the autopsy report. These photos were sent to Dr. Hall via email on July 27, 2021 by Brenda Taylor of Appalachian Health Care System with a note that said "here are the photos we have. It might help jog your memory". The subpoena for records to Watauga Medical Center was dated March 23, 2021. Clearly this half-seen photo of possibly the left arm was attached to an email either scanned as a pdf or embedded in the email. One would assume this photo is therefore available in a digital format. It is possible this half-seen photo is not related to the case.

Review of Experts Opinion Reports:

The reports of Dr. McLemore, Dr. Wolf and Dr. Bohenick were reviewed. I will not detail review here as my opinion is not based on their reports. Two (2) item needs to be brought to light here.

Dr. McLemore puts in her report that a notation from the original autopsy report indicated that possible genetic testing had been performed on heart tissue from Jonathan Whitson's autopsy and no results were given to her. I have rechecked all copies of the autopsy report and related files made available to me, and I don't see this notation. Inquiry of attorney Julie Bridenstine revealed that Jonathan's old girlfriend was pregnant at the time of his death. A histology block had been sent for paternity testing in Asheville, NC and then sent to a lab in Pennsylvania for genetic testing. Any testing results from this genetic testing would be important information to have.

Second, Dr. McLemore noted that it was common practice in 2011 to send toxicology samples via US mail. Bacteria produce ethanol during decomposition in the body and within the collection tube after being taken at autopsy. I agree that variation in temperature would facilitate ethanol production. One can't rule out that some or all of the ethanol detected at autopsy was from postmortem production.

Discussion:

The following is the basis of my opinions in this case after review of the additional discovery obtained by the Innocence Commission, further research and further consultation with Forensic Toxicologist Dr. Andy Ewans.

Regarding toxicology: I continue to disagree with the opinion that Dr. Hall testified to that the morphine level in the urine was a toxic level. Toxicology performed on urine can only show presence of drug use over days. It can not be used to interpret drug levels at the time of death or acute toxicity.

Jonathan Whitson was released from Buncombe County jail at 7:40 pm on March 4, 2011. He met his cousin at a store some 15 miles away somewhere around midnight. His cousin gave him a ride to his grand mother's home where he arrived around 1:00 am on March 5, 2011. Although when he was pounding on the door he was saying "let me in" and I'm tired" he kept his grandmother awake through out the night despite her asking him to let her asleep as she was sick and had a fever. This discourteous behavior may have been because he was high on drugs. We have no information who he encountered before his cousin picked him up. This could account for some of the morphine in the urine (either from morphine or possibly heroin).

As noted in my draft report, surgical morphine has a very short half life by design. Sustained release morphine tablets have an elimination half life of 16 to 18 hours. One of my main questions for Forensic Toxicologist Dr. Andy Ewans (who will provide his own report) was how does crushing, liquifying and injecting change the elimination half-life? He stated that it would

speed up the elimination half-life which literature shows for surgical morphine is from 1.3 to 6.7 hours. He further calculated that the highest concentration of morphine in Jonathan's and Stephanie's blood would have been after the second round of injections.

It should be noted that Jonathan and Stephanie were injecting the same drug and the same amount. Stephanie testified she only did drugs when she was around Whitson. So the two (2) months that he was in jail they would have both reduced their tolerance to opiates. As noted in the draft report acute toxicity can come from direct toxicity to the heart. In this scenario a person is found slumped over and dead with either the needle still in their arm or the syringe and spoon next to them. This is not the clinical presentation here. Following the second round of injections when their blood concentration would be at it's highest they were driving and talking. Stephanie dropped Jonathan off at his home and took the remaining pills with her. She drove her Jeep to Hardees and met a friend to eat. Jonathan was visiting with friends who came over. When she returned they injected more drugs. There isn't a single interview note or testimony that stated that either one of them was acting like they were out of it, sedated or groggy. They were not found sitting or lying and nodding off that day.

When Christine Angel testified the attorney suggested that Jonathan was sleeping and snoring for 12 hours which she appeared to adopt. Christine testified that she told Jonathan to go to bed around 9:00 pm (other testimony it was 10:00 or 11:00 pm). She testified she did not see him go to bed. She also noted that he came to her room three times after that and told he loved her. She could not provide the times when he came to her room. Stephanie noted she left at "10 to 10" (9:50 pm). In Nathan Angle's interview with police, he stated Jonathan was at his house after Stephanie left and he and Jonathan walked up to Christine's house and they talked for a few minutes. When Nathan went to bed Jonathan was sitting in the living room watching TV. Interviews and court testimony note that Nathan also had a history of drug abuse. Surely, if he noted Jonathan was acting sedated, groggy or obtunded when he last saw him he would have relayed that to police.

We have no information what time Jonathan went to bed that night. We do know that at 4:00 or 4:30 am when he was heard snoring loudly that when he was shook, he snored less. Therefore, he was arousable. We have information that Jonathan was snoring at 8:00 am (by Nathan) and 9:00 am (by Christine) but aren't provided with a volume. There is conflicting information if he was seen snoring at 10:30 am. This isn't likely as at 10:40 am when Nathan's son shook Jonathan, Nathan could tell then he was dead. It may be that he was cold or stiffening at this point because they did not attempt bystander CPR or make an emergency call to 911. With a history of drug abuse Nathan would likely know that EMS may be able to resuscitate with Narcan. In fact, 911 wasn't called until 11:33 am.

So, we have a window of 5 hours known that Jonathan was sleeping and snoring. After review of the microscope slides I don't agree that the level of acute bronchopneumonia seen could have developed in that time frame. In my opinion the bronchopneumonia was pre-existing. Although no symptoms were related such as coughing, his family noted he had asthma and "lots of breathing problems" so they may not have thought it was out of his baseline.

Further, I do not agree with Dr. Hall's opinion that the granulomas found in the lung were part of the acute pneumonia. Pills have large particle inactive ingredients that when crushed and injected can cause embolism (as seen in the thrombosis that Jonathan had in his arm in December). The granulomas seen in the lung slides are the bodies way of "walling off" the foreign body. This takes days to weeks to develop and would have been from his drug use prior to going to the Madison County jail.

It is still my opinion that Dr. Hall didn't rule out other causes of death at the time of autopsy. In a sudden death in a healthy male with a history of drug abuse one must also rule out natural causes of death. In my training and experience it would be important to take blood cultures, lung cultures and viral nasal swab cultures.

Jonathan was admitted to Mission Hospital on December 27, 2010 for cellulitis and venous thrombosis in his left antecubital fossa that resulted from his crushing and injecting drugs. He was placed on IV antibiotics. When he was released from the hospital on December 30, 2010 his arm was noted to still be indurated (firm soft tissue) and it was painful for him to extend his arm. He was given a prescription for Clindamycin 300 mg; to be taken four (4) times a day for two (2) weeks. It is unknown if he filled this prescription. Clinically it is hard to get patients to adhere to a medication schedule that requires them to take a medication four (4) times a day. He was incarcerated in Madison County jail seven (7) days later on January 6, 2011. During his stay there until March 4, 2010 he received no medical care and was not taking any medications. Even if he was taking the antibiotic before he was incarcerated, stopping the medication before the two (2) weeks of dosing can result in the return of infection.

No photos were provided of the extremities of Jonathan Whitson after death. The photos taken by police showed him clothed and covered with a blanket. The autopsy photos that were sent in response to subpoena were identification photos of the face.

Summary and Opinion:

I do not agree that the clinical presentation or findings at autopsy with toxicology is consistent with acute toxicity of morphine. Bronchopneumonia was present and pre-existing and therefore could be the cause of death with emphysema as a contributing factor. In my opinion, multiple cultures should have been performed at the time of autopsy that may have provided additional information. Without this information one could opine the Cause of Death is undetermined.

Qualifications:

I am a medical doctor licensed in Florida and Virginia and an expert in Forensic Pathology. I was formerly an Assistant Chief Medical Examiner for the Office of the Chief Medical Examiner in Roanoke, Virginia, and a former Associate Medical Examiner for District 5 in Leesburg, Florida. I received a B.S. from the University of Florida and attended medical school at the University of South Florida College of Medicine. I performed an Anatomic Pathology Residency at the University of South Florida College of Medicine and the University of Florida College of Medicine with an additional 6 months of Forensic Pathology training than was required. My Forensic Pathology Fellowship focused on crime scene investigation and was at

the Hillsborough County Medical Examiner's Office through the University of South Florida College of Medicine. After my fellowship, I was employed as a medical physician practicing in forensic pathology for several years. I currently operate CJ Consulting of America (LLC), a company specializing in forensic pathology consulting and private autopsies.

I have been qualified as an expert and testified in Forensic Pathology in multiple jurisdictions in Florida, Virginia and North Carolina in civil, criminal and post-conviction cases. I have never been excluded as an expert. In criminal consulting the majority of times I was hired by the defense. In only a couple of cases was I asked to review discovery by the prosecution. Generally, the prosecution has the Medical Examiner that performed the autopsy to testify for them. In civil cases I have been hired by both the plaintiff and the defense (probably 50/50).

A copy of my copy of my *curriculum vitae* describing my education, training and experience, and current employment will be sent with this report.

Handout 6

Dr. Christina Roberts CV

Christena L. Roberts, MD

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151 NC Highway 9, Suite B, #201
Black Mountain, NC 28711

E-mail: **cj-consulting@live.com**

FORENSIC EXPERIENCE:

Established Jan/07	CJ Consulting of America, LLC Forensic pathology consulting and private autopsies
12/ 2007 – 9/2010	Assistant Chief Medical Examiner Office of the Chief Medical Examiner Roanoke, VA
7/2005 – 7/2007	Associate Medical Examiner District 5 Medical Examiners Department, Leesburg FL

EDUCATION:

2004 – 2005	Hillsborough County Medical Examiners Office University of South Florida College of Medicine, Tampa, Florida Forensic Pathology Fellowship
2002 - 2004	University of Florida, Gainesville, Florida Anatomic Pathology Residency Program
2000 - 2002	University of South Florida College of Medicine, Tampa, Florida Anatomic and Clinical Pathology Residency Program
1995 - 2000	University of South Florida College of Medicine, Tampa, Florida Doctor of Medicine Received Excellence in Forensic Pathology Annual Award
1992 - 1995 1984 - 1985	University of Florida, Gainesville, Florida Bachelor of Science, Interdisciplinary Studies Major - Biochemistry and Molecular Biology Minor - Chemistry Graduated with High Honors, Phi Beta Kappa

ADDITIONAL FORENSIC EXPERIENCE:

2010	Member of Advisory Board American Institute of Forensic Education
2001	Associate Medical Examiner Appointment, Hillsborough County, FL Dr. Vernard Adams, Medical Examiner (6 months, as part of residency credentialing year) All aspects of death investigation, including crime scene, autopsy and court testimony

1994 - 1995	Forensic Anthropology - Volunteer Human Osteology Course Dr. William Maples, CA Pound Human Identification Lab, Univ. of Florida
1984 - 1985	Forensic Anthropology - Lab Assistant Dr. William Maples, Florida Museum of Natural History, Univ. of Florida On-site crime scene investigation and reconstruction of skeletal remains.
LICENSES:	Medical License, State of Florida Medical License, Commonwealth of Virginia
EMPLOYMENT:	
1987 - 1993	CH2M Hill – International Environmental Engineering Firm, Project Assistant. Worked directly with clients in all aspects of their multi-million dollar projects including contract and technical documents and project budgeting. Coordinated and presented at meetings on local, state and national level.
RESEARCH: 1994 - 1995	Genetics research – Preliminary Linkage Analysis to map the gene responsible for a novel form of X-linked mental retardation. Principal Investigator: Thomas Yang, Ph.D. Affiliation: Department of Biochemistry, University of Florida
PUBLICATIONS:	Rosenberg AS, Langee CL, Morgan MB. (2002). Malignant peripheral nerve sheath tumor with perineural differentiation: "malignant perineuroma". *J Cutan Pathl*; 29: 362-367.
PRESENTATIONS:	*Consulting a Forensic Pathologist.* IDS Capital & Serious Felony Training. Charlotte, NC. December 15, 2011 *Child Death Investigation.* IDS Capital & Serious Felony Training. Durham, NC. March 1, 2012. *Motor Vehicle Accidents, Medical Records and Autopsy Reports; Driver vs. Passenger*. As part of "Forensics: From Crime Scene to Courtroom". North Carolina Advocates for Justice (NCAJ). Raleigh, NC. April 13, 2012. *Medical Death Investigation: Time of Death; Time Since Injury*. IDS Capital & Serious Felony Training. Asheville, NC. May 17, 2012 *Forensic Science: DNA and Pathology. Pathology topics included: Shaken Baby Syndrome/Child Death Investigation; Time of Death and Interplay of a Crime Scene, DNA and Pathology*. North Carolina Advocates for Justice and the Forsyth County Criminal Defense Trial Lawyers Association. Winston-Salem, NC. September 28, 2012. Variety of educational presentations in Florida to medical students and residents; Department of Children and Family Services and Elder Services, District 5, FL ; and to Marion County Sheriff's Officer Education Program

PRESENTATIONS:

Postmortem morphine concentrations – Are they meaningful? American Academy of Forensic Sciences, 56th Annual Meeting, Forensic Toxicology Section. Dallas, TX, February 2004.
Principal Investigators: Bruce A. Goldberger[1], Ph.D. and Julia Martin[2], MD
Affiliations: [1]University of Florida, Department of Pathology, Immunology and Laboratory Medicine. [2]District 5 Medical Examiners Office, FL

TEACHING:

Intern training of residents and medical students in Forensic Pathology
Office of the Chief Medical Examiner
Roanoke, VA

TRIALS:

Previously qualified as an expert witness in multiple Florida, Virginia and North Carolina courts on a variety of case types.

Handout 7

Dr. Andy Ewens

Report

Affidavit of Dr. Andrew Ewens, PhD, DABT of Ewens Toxicology Consulting, LLC

State vs John Pritchard, death of Jonathan Whitson on March 6th, 2011

1. I am Dr. Andrew Ewens, a board-certified toxicologist in the Raleigh, North Carolina area. I obtained my Bachelor of Science in Biochemistry from Virginia Tech University in 1997 and my Ph.D. in Molecular Pharmacology from the State University of New York at Buffalo in 2004. I am the owner of Ewens Toxicology Consulting, LLC located in Cary, NC.

2. I have 25 years' experience in the biomedical sciences, and I complete 20 hours of continuing education in toxicology every year.

3. My areas of expertise involve antemortem and postmortem toxicological interpretation. I have 10 years' experience in providing independent toxicology consulting, 9 years' providing this service in the context of legal cases. I've spent the previous 6 years testifying as an expert witness.

4. I've testified regarding toxicological interpretation 7 times in court, been deposed 4 previous times, provided case consulting 4 times, and have been qualified as an expert in North Carolina, Maryland, Texas, and Michigan.

5. For 16 years, I've served as a toxicologist with 5 different federal government agencies, and I've assisted police officers during a DWI checkpoint.

6. In this matter I was asked to review and analyze drug and alcohol tests of the decedent Jonathan Whitson to determine if his death was caused by an overdose of drugs and alcohol.

7. I reviewed and based my opinion on the autopsy report and toxicology test results of Mr. Whitson, a transcript summary of the trial of John Pritchard, and interview of Nathan Angel, and the reference book Baselt 2020.

8. During the autopsy, Mr. Whitson's blood was found to contain 0.04 g/dl of ethanol and "trace" amounts of morphine. Mr. Whitson's urine contained 15 mg/l of morphine.

9. Metabolism is a major component of removing ethanol and morphine from the body. Metabolism of these two chemicals occurs within cells, predominantly of the liver, and require cellular energy in the form of NAD^+, which is only made in live cells. Once a person dies, their cellular energy quickly becomes exhausted and metabolism of ethanol and morphine stops. Ethanol and morphine are excreted from the body through the urine, feces, or breath, all of which are no longer formed after death. Because both metabolism and excretion stop soon after death, the concentrations of ethanol and morphine in the blood and urine generally do not change, so that their concentrations in the body represent the concentrations that were present at the time of death or shortly thereafter. There is the possibility of redistribution of drugs and alcohol after death occurs, but this postmortem redistribution takes time to allow the drugs to diffused to other parts of the body and Mr. Whiston's autopsy was the day after his death. Postmortem redistribution mostly occurs after oral consumption of drugs with high concentrations of unabsorbed drug remaining in the stomach diffusing out into neighboring tissue. This could occur with ethanol found in Mr. Whitson, but the morphine was intravenously injected which bypasses the stomach. The blood with "trace" concentrations of morphine was from the femoral artery which is resistant to postmortem redistribution due to its peripheral location away from the body. However, ethanol was detected in blood from the aorta which is sensitive to postmortem redistribution. The effect of most incidences of postmortem redistribution cause the drug concentration in blood to increase,

not decrease. If there was postmortem redistribution of ethanol in Mr. Whitson, it would mean that his actual concentration of alcohol at the time of death was lower than what was reported from the toxicology test. Considering that the autopsy was performed the day after Mr. Whitson's death, any effect from postmortem redistribution would likely be minimal.

10. When a person dies from a morphine or ethanol overdose, they usually die because the concentration of morphine or ethanol in the brain at the respiratory center is so high that the person stops breathing. The concentration of morphine or ethanol in the brain at the respiratory center is very difficult to measure, so instead of measuring it directly, the concentrations are measured in the blood. The blood supplies all of the tissues in the body so that drug blood concentrations offer a fairly good estimate of the effect of a drug on the brain.

11. Urine is created from blood in the kidneys and is then stored in the urinary bladder until it is urinated out of the body. Various factors change the concentration of drugs in the urine from that in the blood. These factors are not easily predicted and can quickly change throughout the day. Urine stored in the bladder contains urine that was just recently created, as well as urine that was created hours earlier. Therefore, drug urine concentrations cannot be used to predict blood concentrations, let alone drug brain concentrations. The only forensic use of drug urine concentrations is to show qualitatively if a person had used a drug in the recent past. Drug urine concentrations can not be used to determine the degree of intoxication or the likelihood of death caused by a drug overdose.

12. Mr. Whitson's urine contained 15 mg/l of morphine. All that can be interpreted from this finding is that Mr. Whitson had recently consumed morphine. Since morphine was found in the urine, it means that Mr. Whitson didn't die so quickly after consuming morphine that his body didn't have time to create urine that contained morphine. This is consistent with statements

made during John Pritchard's trial that Mr. Whitson injected himself with morphine during three separate sessions and didn't die until many hours later.

13. Morphine was found in Mr. Whitson's blood, which can predict its effect on the brain's respiratory center, but the morphine was reported as only existing at trace concentrations. Morphine decreases breathing in a concentration-dependent manner. The more morphine present in the respiratory center of the brain, the more breathing is decreased. With only trace concentrations of morphine in the blood, the effect on Mr. Whitson's breathing would be negligible to nonexistent at the time of his death.

14. Ethanol was found in Mr. Whitson's blood at a concentration of 0.04 g/dl. This concentration of ethanol is half that of what is considered illegal to have in your blood while driving a car. This concentration of ethanol is much too low to decrease breathing and certainly would not be high enough to cause death. Even the combined effect of 0.04 g/dl of ethanol and traces of morphine in the blood would not cause a significant decrease in Mr. Whitson's breathing.

15. Morphine has a half-life of between 1.3 to 6.7 hours[a]. The time difference between the last known injection of morphine at around 8:30 pm and the time of death, around 11:00 am the next day is 14.5 hours. If the half-life of morphine in Mr. Whitson was 6.7 hours, there would be 22% of the last dose in his blood. If the morphine had reached a fatal concentration, then 22% of the fatal concentration would still be readily detectable. However, only trace amounts of morphine were found in Mr. Whitson's blood. If the half-life of morphine in Mr. Whitson was 1.3 hours, then 0.05% of the last dose would still be in Mr. Whitson's blood, which likely would result in a trace amount of morphine. This suggests that Mr. Whitson's half-life for morphine was on the low end of the range, around 1.3 hours.

16. There were about 2.25 hours between Mr. and Mrs. Whitson's first session of morphine injections at 3:45 pm and their second session of injections that had to have occurred before 6:00 pm, when Mrs. Whitson left to eat dinner. This means that about 30% of the first dose of morphine was likely still within Mr. and Mrs. Whitson's blood at the time of the second session of injections.

17. Mr. and Mrs. Whitson were on Star Branch Rd, which they had driven to after the first session of morphine injections at Mrs. Christine Angel's house. They injected morphine a second time and even with this additional morphine were still able to drive from Star Branch Rd, back to Mrs. Angel's house. When a person is highly intoxicated by morphine, they become extremely sedated and would not be able to drive a car. The fact that Mr. and Mrs. Whitson were able to drive a car after their first session of injections and after their second session of injections suggests that they were not even close to having a fatal concentration of morphine.

18. By the time of the third session of morphine injections, around 8:30 pm, it would have been about 4.75 hours since the first dose of morphine. This would mean that when the last dose of morphine was administered, there was only about 8% of the first dose remaining in Mr. Whitson's blood. This small amount of morphine would have a negligible contribution to the total concentration of morphine in Mr. Whitson's blood at the time he had his third dose, so that at any time, he only had about two doses worth of morphine in his blood. As stated before, Mr. and Mrs. Whitson were able to drive back to Mrs. Angel's house after having two doses of morphine.

19. Intravenous injection is the fastest route of administration of drugs and results in a very rapid rise in drug concentration, reaching the highest drug concentration very shortly after injection. Since the risk of death from morphine increases as the concentration of morphine increases, the most likely time a person will die from an overdose is shortly after they inject the

morphine. Mr. Whitson injected morphine during three separate sessions around 3:45, sometime before 6:00 pm, and around 8:30 pm. Mrs. Whitson was present during each of those injections, and she did not witness Mr. Whitson die. Mr. Whitson was still alive after the third session of morphine injections before he went to bed, as witnessed by Mrs. Angel. So, Mr. Whitson was still alive after the most likely time in which he would have died from a third morphine dose. Mr. Whitson was even able to get up and go to the bathroom and tell Mrs. Angel he loved her three times during the night, suggesting that he wasn't heavily sedated as would be expected if he was highly intoxicated by morphine and near death. Nathan Angel stated that he woke up sometime between 4:00 am and 4:30 am and Mr. Whitson was still alive, as he was sleep and snoring loudly. The next morning, Mrs. Angel said that Mr. Whitson was still alive and snoring between 6:00 am to 7:00 am up to around 10:30 am. Nathan Angel stated that he woke up at 8:00 am and notice Mr. Whitson was still asleep and snoring. This means that Mr. Whitson did not die overnight, but instead died sometime between 8:00 am to 10:40 am. Since the risk of death is highest right after intravenously injecting morphine, and Mr. Whitson was known to have been alive and asleep from around 4:00 am to 10:40 am and unable to inject morphine, it seems very unlikely that Mr. Whitson died from a morphine overdose. Additionally, the lack of morphine in his blood suggests that Mr. Whitson hadn't injected morphine in the last several hours before his death.

20. Mr. Whitson had shared the same morphine with Mrs. Whitson and Mrs. Whitson did not die. After the third session of morphine injections, Mrs. Whitson was able to leave Mrs. Angel's house and drive home. In fact, Mrs. Whitson stated that she had no physical problems the next day. This suggests that the morphine was not the cause of Mr. Whitson's death.

21. Based on the above analysis, it is my opinion that Mr. Whitson most likely did not die from the effects of morphine and alcohol. If Mr. Whitson had died from a morphine overdose,

he would have had a much higher blood concentration of morphine, he would have died soon after he injected the morphine, and Mrs. Whitson would have either died as well or would have been close to dying and unable to have driven a car home. If the doses of morphine were so high as to bring Mr. Whitson close to death, then neither Mr. nor Mrs. Whitson would have been able to drive to and from Star Branch Rd. If Mr. Whitson had died during the night, he wouldn't have been snoring in the morning.

This, the 14th day of November, 2021.

Andrew Ewens, PhD, DABT

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Cary, NC 27513

Bibliography

[a] Randall C. Baselt, Disposition of toxic drugs and chemicals in man, 12th ed, 2020.

Handout 8

Dr. Andy Ewens CV

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Andrew D. Ewens, PhD, DABT
Owner/Toxicologist

RELEVANT QUALIFICATIONS

- Doctorate in pharmacology and board certification in toxicology with 26 years of experience in the biomedical sciences and a minimum of 20 hours of continuing education in toxicology a year
- Area of expertise – antemortem and postmortem toxicological interpretation
- 10 years - independent toxicology consulting (2011)
- 9 years working on legal cases (2012)
- 6 years working testifying as an expert witness (2015)
- Types of legal cases include: DUI, parole/probation violation, assault/murder, poisoning, cause of death, personal injury, employment, child custody, postconviction and medical malpractice
- 4 years (2017) – conducting independent research of human and non-human experiments in drug-induced impairment detection by improving alcohol breath detection, CBD oil-induced false positive drug tests, as well as human experiments to test several aspects of performing field sobriety tests and drug recognition and classification tests
- Taught forensic toxicology to attorneys (2 classes) and to high/middle school students (4 classes)
- Order additional drug tests from a contracted toxicology lab
- Qualified to testify in North Carolina, Maryland, Michigan and Texas – antemortem toxicological interpretation; in North Carolina – postmortem toxicological interpretation
- Testified 7 times in court, deposed 4 times, and wrote 38 letters of opinion or affidavits, retained for 88 case out of a total of 126 legal cases I consulted on
- 16 years - toxicologist on contracts with 5 federal government agencies
- 10 years - academic research (pharmacology, diagnostics, molecular biology)
- Completed Medical Review Officer certification training
- Certified alcohol Seller/Server by the Texas Alcohol Beverage Commission (#8702837, until 09-06-23)
- Trained up to a HazMat Technician, including use of field chemical detection instruments using the same principles as the Intoximeter EC/IR II evidentiary breathalyzer, followed by 4 years of continuing education classes
- Assist police officers during DUI checkpoints, help test bomb detecting dogs for the TSA, and patrol parks
- First responder, deployed twice on missing person searches and an influenza vaccination drive

EDUCATION

2021-2021 Ongoing – **DOT Breath Alcohol Technician – Self-study Course**, AlcoPro, Knoxville TN

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www.ToxicologistExpert.com

2021-2021	Completion – **Comprehensive Medical Review Officer Course**, American Association of Medical Review Officers, RTP, NC
2018-2018	Completion – **Citizens Police Academy**, Cary Police Department, Cary, NC
2013-2013	Continuing education - **Forensic Toxicology**, RTI International, RTP, NC.
2011-Present	Self-study - **Forensic Toxicology**, Ewens Toxicology Consulting, Cary, NC.
2010-2014	Passed and continuing education - **Hazardous Materials Technician (NFPA 472 level II)**, Wake Technical Community College Raleigh, NC.
2009	Completion – **Mid-America Toxicology Course**, Kansas City, MO.2008 Certificate - **Hazardous Materials Awareness, Operations, and Terrorism (NFPA 471 level I)**, North Carolina Office of the State Fire Marshal, Raleigh NC.
2008-2013	Completed and continuing education - **Emergency Responder**, Cary Community Emergency Response Team, Cary NC.
1997-2004	Ph.D. - **Molecular Pharmacology**, State University of New York at Buffalo, Buffalo NY.
1992-1997	B.S. - **Biochemistry**, Virginia Tech, Blacksburg, VA.

WORK EXPERIENCE

2020-Present	**Toxicologist**, Integrated Laboratory Systems, RTP, NC. Review, classify, and extract data from primary papers of endocrine disruptor studies for a contract with the Environmental Protection Agency.
2020-2021	**Council Member**, Gerson Lehrman Group, Inc. (GLG), New York, NY. Provide consulting and expert witness services for GLG clients.
2018-Present	**Member**, Citizens Assisting Police, Cary Police Department, Cary, NC. Support the Cary police department at DUI checkpoints. This includes helping to set up the evidentiary breathalyzers by providing blank breath specimens. I parked cars of DUI suspects and perform whatever task I am asked to do, which has included telling the police if I noticed smelling marijuana in a suspect's car that I parked. I must be careful not to disrupt any evidence that may be present inside the suspect's car. Helped the U.S. Transportation Security Administration (TSA) by posing as a decoy, carrying a concealed live explosive, to see if the dogs could detect me in an airport. Patrolled parks for evidence of vandalism, robbery, and to show a presence to residents.
2017-2020	**Associate Editor**, MedCrave Online Journal of Toxicology, Edmond, OK. Provide peer-review of submitted articles for publication. This includes evaluations of experimental design, the scientific data, study rationale, completeness or the article, proper citations, and checks for plagiarism.
2017-Present	**Primary investigator**, Ewens Toxicology Consulting, LLC, Cary, NC. Plan, fund, and conduct original research on alcohol detection and drug-induced impairment. For alcohol detection, I am working on developing a raman spectroscopy-based breath alcohol evidentiary analyzer and I am investigating factors involved in false positive

	alcohol breath tests. I am also conducting test on the reliability of the Intoximeter EC/IR II evidentiary breathalyzer, used by police agencies in North Carolina. For drug-induced impairment, I am investigating the SFST and DRE evaluation techniques to determine their strengths, weaknesses and to develop improvements to the techniques to increase accuracy. Studying the effects of consuming CBD oil on urine drug testing and the mechanism of false positives.
2013-2013	**Task Force Member**, Wake County Public School System, Cary, NC. Recommended improvements in school and police responses to active shooting incidences in public schools. The task force was chaired by Wake County Sheriff Donnie Harris and the task force voted to include my recommendation in the final proposal sent to the school board.
2012-Present	**Institute Animal Care and Use Committee Member**, Integrated Laboratory Systems, RTP, NC. Review and vote on the acceptance of research animal use protocols and inspect animal facilities.
2011-Present	**Owner/Toxicologist/Expert witness**, Ewens Toxicology Consulting, LLC, Cary, NC. Provide consulting and expert witness services for clients with legal and non-legal toxicological needs. Most of my initial clients were not involved in legal issues, but in 2015 I switched my focus to clients involved in legal issues. My clients include people who had been accused of drug use or drug-induced impairment. Cases have included DUI arrests, causes of death determination, probation violations due to alleged drug use, cause of vehicle accident and injury, employment drug testing, other drug testing situations. Provide pre-trial consultation, letters of opinion, and expert witness testimony for both clients who want me to verify or to disprove drug use or drug-induced impairment. Can also order additional drug testing if needed and incorporate that into my expert opinions.
2010-Present	**Toxicologist**, Integrated Laboratory Systems, Research Triangle Park, NC. Evaluate laboratory animal carcinogenicity studies and write the carcinogenicity section of monographs of the 13th and 14th Report on Carcinogens for a contract with the National Toxicology Program/National Institute of Environmental Health Sciences.
2010-2010	**Training Material Reviewer**, Dartmouth Medical School, Lebanon, NH. Reviewed the instructor's features of the expanded edition of the Virtual Terrorism Response Academy training program for firefighters.
2009-2009	**Toxicologist**, SRA International, Durham, NC. Identified drugs with pharmacokinetic behaviors similar to a Physiologically Based Pharmacokinetic computer simulation model.
2008-2008	**Data Submitter**, World Health Organization – Expert Meeting to Review Toxicological Aspects of Melamine and Cyanuric Acid, Switzerland. Updated the Food and Drug Administration's risk assessment of melamine and cyanuric acid in farm animal feed as a risk to humans consuming those animals.
2008-2013	**Community Emergency Response Team member/trainer**, Cary Community Emergency Response Team, Cary, NC. Responded to emergencies as activated by

the Cary Fire Department, taught the terrorism response section of the basic training course, and taught continuing education in hazardous substance response. Developed a novel technique for removing a contaminated pull-over shirt while minimizing exposure to the contaminant. Deployed on two missing person searches and to help the Wake County Department of Health with an influenza vaccination drive.

2006-2008 **Toxicologist/Task Manager**, SRA International, Durham, NC. Managed the collection and evaluation of toxicological data needed to train a quantitative structure activity relationship computer program that predicts toxicity. This work was for a contract with the Environmental Protection Agency's National Homeland Security Research Center.

2006-2008 **Toxicologist/Task Manager**, SRA International, Durham, NC. Managed the toxicological support staff for the physicians working at the top tier of the call center (1-800-CDC-INFO) for a contract with the Centers for Disease Control and Prevention.

2005-2010 **Toxicologist**, SRA International, Durham, NC. Evaluated research animal carcinogenicity studies and human epidemiology studies of cancer and wrote the updated carcinogenicity sections of the profiles for the 12th Report on Carcinogens for a contract with the National Toxicology Program/ National Institute of Environmental Health Sciences.

2005-2005 **Toxicologist**, Technical Resources International, Bethesda, MD. Recommended chemicals for carcinogenicity testing by the National Toxicology Program that are used in semiconductor manufacturing and that have a high potential for causing cancer.

2005-2005 **Toxicologist**, Technical Resources International, Bethesda, MD. Provided quality assurance of updated drug records to the Hazardous Substance Data Bank for a contract with the National Library of Medicine.

2004-2004 **Researcher**, Pharmacology, Roswell Park Cancer Institute, Buffalo, NY. Investigated the specificity of the anti-cancer immune memory induced by the treatment of breast cancer in mice with a combination of doxorubicin and interleukin-2.

RESEARCH EXPERIENCE

2017-Present **Drug use and impairment detection studies**, Ewens Toxicology Consulting, LLC, Cary, NC. 1.) Investigating the SFST and DRE evaluation techniques to determine their strengths, weaknesses and to develop improvements to increase objectivity and accuracy. 2.) Studying the effects of consuming CBD oil on urine drug testing and the mechanism of false positives. 3.) Investigating factors involved in false positive alcohol breath tests, including tests on the reliability of the Intoximeter EC/IR II evidentiary breathalyzer, used by police agencies in North Carolina. 4.) Developing a gas chromatography/raman spectroscopy-based evidentiary breathalyzer.

1998-2004 **Thesis Project**, Pharmacology Department, Roswell Park Cancer Institute, Buffalo, NY. Developed a curative treatment for breast cancer in mice that imparted immune

memory toward the cancer. The treatment was a combination of doxorubicin and interleukin-2.

1997-1998 **Laboratory Rotations**, Pharmacology Department, Roswell Park Cancer Institute, Buffalo, NY. Worked to clone the gene for the NAD(P)H:quinone oxoreductase.enzyme. In another rotation used structure activity relationship analysis of taxane based Pgp multidrug efflux pump inhibitors to determine chemical attributes that increase potency.

1996-1996 **Summer Internship**, Pharmacology Department, Roswell Park Cancer Institute, Buffalo, NY. Developed a method to measure the activation state of the Ran protein using high performance liquid chromatography.

1995-1995 **Summer Internship**, Cancer Genetics Department/Amniotic Fluid Department, Genetics and IVF Institute, Fairfax, VA. Mentored a student and developed a research project to develop a novel technique to detect chromosomal aberrations. Karyotyped patient's amniotic fluid and bone marrow samples.

1995-1997 **Undergraduate Research Project**, Biochemistry Department, Virginia Tech, Blacksburg, VA. Characterized the tetramerization site of the GlpR protein in E. Coli bacteria.

1994-1994 **Summer Internship**, Cancer Genetics Department/Amniotic Fluid Department, Genetics and IVF Institute, Fairfax, VA. Conducted the studies for a graduate student's master's thesis project, which tested the ability of sex mismatching between donor and recipient to predict the prognosis of bone marrow transplantations. I karyotyped patient's amniotic fluid and bone marrow samples.

MEMBERSHIP

- **Diplomate**, American Board of Toxicology, Raleigh, NC.
- **Full Member**, Society of Toxicology, Reston, VA.
- **Associate Member**, Society of Forensic Toxicology, Mesa, AZ.
- **Associate Member**, National Association of Criminal Defense Lawyers, Washington D.C.
- **Associate Member/ DRE Section member**, International Association of Chiefs of Police, Alexandria, VA
- **Member**, American Association of Medical Review Officers, Research Triangle Park, NC

WRITTEN COMMUNICATIONS

Publicly Released Government Documents:

1. Report on Carcinogens Nomination Document for PFAS, Research Triangle Park, NC, National Toxicology Program, (draft in progress).
2. Report on Carcinogens Nomination Document for wood smoke, Research Triangle Park, NC, National Toxicology Program, (draft in progress).

3. Report on Carcinogens Fifteenth edition, Research Triangle Park, NC, National Toxicology Program, (draft in progress).
4. Report on Carcinogens Nomination Document for Cell phone radiation, Research Triangle Park, NC, National Toxicology Program, (draft on hold).
5. Report on Carcinogens Nomination Document for PAHs, Research Triangle Park, NC, National Toxicology Program, (draft in progress).
6. Report on Carcinogens Nomination Document for NitroPAHs, Research Triangle Park, NC, National Toxicology Program, (draft in progress).
7. NTP, Report on Carcinogens Monograph for Shiftwork involving light at night, Research Triangle Park, NC, National Toxicology Program, 2019. https://ntp.niehs.nih.gov/pubhealth/roc/listings/shiftwork/index.html
8. Report on Carcinogens Monograph for Helicobacter pylori, Research Triangle Park, NC, National Toxicology Program, 2018. https://ntp.niehs.nih.gov/pubhealth/roc/listings/hpylori/index.html
9. Report on Carcinogens Monograph for Antimony trioxide, Research Triangle Park, NC, National Toxicology Program, 2018. https://ntp.niehs.nih.gov/pubhealth/roc/candidates/antimonyt.html
10. Report on Carcinogens Monograph for Haloacetic acids, Research Triangle Park, NC, National Toxicology Program, 2018. https://ntp.niehs.nih.gov/ntp/about_ntp/monopeerrvw/2017/july/haafinalmonograph_508.pdf
11. Report on Carcinogens Fourteenth edition, Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/pubhealth/roc/index-1.html#toc1
12. NTP, Report on Carcinogens Monograph on Epstein-Barr virus, Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/ntp/roc/monographs/ebv_final201608_508.pdf
13. NTP, Report on Carcinogens Monograph on Kaposi sarcoma-associated herpesvirus, Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/ntp/roc/monographs/kshv_final201608_508.pdf
14. NTP, Report on Carcinogens Monograph on Human immunodeficiency virus type 1 (HIV), Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/ntp/roc/monographs/hiv_final201608_508.pdf
15. NTP, Report on Carcinogens Monograph on Human T-cell lymphotropic virus type 1 (HTLV-1), Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/ntp/roc/monographs/htlv_final201608_508.pdf
16. NTP, Report on Carcinogens Monograph on Merkel-cell polyomavirus (MCV), Research Triangle Park, NC, National Toxicology Program, 2016. https://ntp.niehs.nih.gov/ntp/roc/monographs/mcv_final201608_508.pdf
17. Report on Carcinogens Monograph for Cobalt and cobalt compounds, Research Triangle Park, NC, National Toxicology Program, 2016.

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http://ntp.niehs.nih.gov/ntp/about_ntp/monopeerrvw/2015/july/cobalt_finalmonograph_508.pdf

18. Report on Carcinogens Monograph for Trichloroethylene, Research Triangle Park, NC, National Toxicology Program, 2015. http://ntp.niehs.nih.gov/ntp/roc/monographs/finaltce_508.pdf
19. Report on Carcinogens Thirteenth edition, Research Triangle Park, NC, National Toxicology Program, 2014. http://ntp.niehs.nih.gov/pubhealth/roc/roc13/index.html
20. Report on Carcinogens Monograph for Pentachlorophenol and synthesis by-products, Research Triangle Park, NC, National Toxicology Program, 2014. http://ntp.niehs.nih.gov/ntp/roc/thirteenth/monographs_final/pentachlorophenol_508.pdf
21. Report on Carcinogens Monograph for o-Toluidine, Research Triangle Park, NC, National Toxicology Program, 2014. http://ntp.niehs.nih.gov/ntp/roc/thirteenth/monographs_final/otoluidine_508.pdf
22. Report on Carcinogens Monograph for Cumene, Research Triangle Park, NC, National Toxicology Program, 2013. http://ntp.niehs.nih.gov/NTP/roc/thirteenth/Monographs_Final/Cumene_508.pdf
23. Report on Carcinogens Monograph for 1-Bromopropane, Research Triangle Park, NC, National Toxicology Program, 2013. http://ntp.niehs.nih.gov/NTP/roc/thirteenth/Monographs_Final/1Bromopropane_508.pdf
24. Report on Carcinogens, Twelfth edition. Research Triangle Park, NC, National Toxicology Program, 2011. http://ntp.niehs.nih.gov/ntp/roc/twelfth/roc12.pdf
25. Report on Carcinogens Background Document for Formaldehyde, Research Triangle Park, NC, National Toxicology Program, 2010. http://ntp.niehs.nih.gov/ntp/roc/twelfth/2009/November/Formaldehyde_BD_Final_508.pdf
26. Report on Carcinogens Background Document for Glass Wool Fibers, Research Triangle Park, NC, National Toxicology Program, 2009. http://ntp.niehs.nih.gov/NTP/roc/twelfth/2010/FinalBDs/GlassWoolBD20100408_508.pdf
27. Report on Carcinogens Draft Background Document for Cobalt–Tungsten Carbide Powders and Hard Metals, Research Triangle Park, NC, National Toxicology Program, 2009. http://ntp.niehs.nih.gov/NTP/roc/twelfth/2010/FinalBDs/HardMetalsBD20100408_508.pdf
28. Report on Carcinogens Background Document for Styrene, Research Triangle Park, NC, National Toxicology Program, 2008. http://ntp.niehs.nih.gov/NTP/roc/twelfth/2010/FinalBDs/Styrene_Final_508.pdf

Research Articles:

1. Ewens A., Treatment of athlete's foot with povidone iodine, (Draft in progress)
2. Ewens A., Case report of THC positive urine test from CBD exposure, (Draft in progress)

3. Ewens A., Strengths and weaknesses of the Drug Recognition Expert evaluation, (Draft in progress)
4. Ewens A., Mouth alcohol detection from tobacco products and foods, (Draft in progress).
5. Boyd W., Lunn R. M., Blask D. E., Coogan A. N., Figueiro M. G., Gorman M. R., Hall J. E., Hansen J., Nelson R. J., Panda S., Smolensky M. H., Stevens R. G., Turek F. W., Vermeulen R., Carreon T., Caruso C. C., Lawson C. C., Thayer K. A., Twery M. J., Ewens A. D., Garner S. C., Schwingl P. J.. Health Consequences of Electric Lighting Practices in the Modern World: A Report on the National Toxicology Program's Workshop on Shift Work at Night, Artificial Light at Night, and Circadian Disruption, Sci Total Environ. 607-608:1073-1084, 2017.
6. Ewens A., Mihich E., Kanter, P., Alderfer J., Wollman R. and Ehrke J., Efficacy, toxicity and mechanism of interleukin-2 plus doxorubicin chemoimmunotherapy against breast cancer in mice. Cancer Res., 66:5419-26, 2006. http://cancerres.aacrjournals.org/content/66/10/5419.full.pdf+html
7. Ewens A., Mihich E. & Ehrke J., Distant Metastasis from Subcutaneously Grown E0771 Medullary Breast Adenocarcinoma. Anticancer Research 25:3905-3916, 2005. http://ar.iiarjournals.org/content/25/6B/3905.full.pdf+html
8. Ewens A., Mihich E. & Ehrke J., Fluorouracil plus leucovorin induced submandibular salivary gland enlargement in rats. Toxicologic Pathology, 33:507-515, 2005. http://tpx.sagepub.com/content/33/4/507.full.pdf+html
9. Ewens A., Custodio C. and Stanley W., Superimposition of routine G-banded and FISH chromosome images. Cell Vision, 4(1):81-83, 1997.

Abstracts:

1. Wang A., Arroyave W., Ewens A., Schwingl P., Atwood S., Garner S., Lunn R. M., Scoping review of polycyclic aromatic hydrocarbons (PAH) human and experimental animal cancer studies, 32nd annual conference of the International Society of Environmental Epidemiology (ISEEE), 2020.
2. Wang A., Trgovcich J., Witt K., Ewens A., Geter J., Garner S., Jahnke G., Smith-Roe S., Lunn R., Mechanistic evidence integration case study: using ten key characteristics of carcinogens and a systematic review approach for antimony trioxide (Sb2O3) cancer hazard identification, Annual meeting poster session, Society of Toxicology, Baltimore, MD, 2019.
3. Ewens A., Mihich E., Alderfer J., Wollman R. and Ehrke J., Mechanism of doxorubicin plus interleukin-2 chemoimmunotherapy in a syngeneic mouse breast tumor model, Roswell Park Graduate Student Poster Competition, Buffalo, NY, 2003.
4. Ewens A., Mihich E., Alderfer J., Wollman R. and Ehrke J., Mechanism of doxorubicin plus interleukin-2 chemoimmunotherapy in a syngeneic mouse breast tumor model, Proceedings of the American Society of Clinical Oncology, 22:181, 2003.

5. Luo, L., Ewens, A., Ehrke, M.J. and Mihich, E., Immunomodulation –dependent therapeutic effects of doxorubicin plus interleukin 2, Proceedings of the American Association for Cancer Research, 43: 972, 2003.
6. Ewens A., Eppolito C., Cao S. and Ehrke J., Immune involvement in the enhancement of 5-fluorouracil plus leucovorin induced anti-cancer response by the addition of IL-15, Proceedings of the American Association for Cancer Research, 42:4693, 2001.
7. Ewens A., Eppolito C., Mihich E. and Ehrke J., Roles of interleukin-15, fluorouracil and leucovorin in combination treatment of rat Ward colon cancer, American Association for Cancer Research's Pathobiology of Cancer Workshop poster session, Keystone, CO, 2000.
8. Ehrke J., Eppolito C., Ewens A., Cao S. and Mihich E., Investigation of the role of the host defenses in the efficacy of the FURA + LV + IL-15 combination treatment of rats bearing the Ward colon tumor. Regional Cancer Center Consortium for Biological Therapy of Cancer, (Symposium Proceedings) 2:25-27, 1999.

Videos:

1. North Carolina Office of Indigent Defense Services, Forensic Toxicology for Child Custody, DSS, and Probation Violation cases Day 1. https://youtu.be/QDqF2Ho-INc
2. North Carolina Office of Indigent Defense Services, Forensic Toxicology for Child Custody, DSS, and Probation Violation cases Day 2. https://youtu.be/VkbCZDzQ0Jk
3. Ewens Toxicology Consulting, LLC, Mock Voir Dire. https://www.toxicologist.expert/videos?wix-vod-comp-id=comp-kf0f19hs
4. Ewens Toxicology Consulting, LLC, Forensic Toxicology. http://prezi.com/j65-wydfhzxk/?utm_campaign=share&utm_medium=copy
5. DrEwensDABT. Surviving School Shootings Evacuation. https://youtu.be/jS4PNcv5JtI?list=PLjnLInf7wzxfkK7skYLtPyrhyBGKNyT7W
6. DrEwensDABT. Decon – Removal of a Contaminated Pull-Over Shirt. https://youtu.be/2QYcYaEWVqI
7. Doc Andy. Removal of powder from surfaces. https://youtu.be/sRwhSH-4Nnk

ORAL COMMUNICATIONS

Speaker presentation:

1. **Carcinogenic studies of haloacetic acids**, National Toxicology Program Informational Workshop on haloacetic acids, Research Triangle Park, NC, 2016.
2. **Immunotoxicity of trichloroethylene,** National Toxicology Program Peer Review meeting of Draft RoC Monograph on Trichloroethylene, Research Triangle Park, NC, 2014.

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3. **Human quantitative risk assessment of synergistic melamine and cyanuric acid consumption from animals that ate adulterated pet food from China**, Epidemiology Branch, North Carolina Department of Health and Human Services, Raleigh, NC, 2008.
4. **Curative treatment for breast cancer in mice**, Monthly seminar series, SRA International, Durham, NC, 2008.
5. **Immunotherapy for cancer in rodents,** Annual student seminar series, Pharmacology Department, RPCI, Buffalo, NY, 1997-2004.
6. **Summer Research Seminar**, Roswell Park Summer Research Participation Program, RPCI, Buffalo, NY, 1996.
7. **Monthly Seminar Series**, Cancer Genetics Department/Amniotic Fluid Department, Genetics and IVF Institute, Fairfax, VA, 1994.

Poster presentations:

1. **Mechanism of chemoimmunotherapy**, Graduate student poster competition, Buffalo, NY, 2003.
2. **Mechanism of chemoimmunotherapy**, Annual meeting poster session, American Society of Clinical Oncology, Chicago, IL, 2003.
3. **Immunomodulation dependent therapeutic effects**, Annual meeting poster session, American Association for Cancer Research, New Orleans, LA, 2003.
4. **Immune involvement in the enhancement of anti-cancer response**, Annual meeting poster session, American Association for Cancer Research, Philadelphia, PA, 2001.
5. **Role of IL-15 in colon cancer treatment**, Pathobiology of Cancer Workshop poster session, American Association for Cancer Research, Keystone, CO, 2000.
6. **Role of immune defense in colon cancer treatment**, Poster session, Regional Cancer Center Consortium for Biological Therapy of Cancer, Pittsburg, PA, 1999.

Teaching:

1. **Science of the Intoximeter EC/IR II breathalyzer**, NC DWI Guy podcast with Jake Minick, Virtual, 2021.
2. **Science of Breath Alcohol**, NC DWI Guy podcast with Jake Minick, Virtual, 2021.
3. **Forensic Toxicology – 7th Annual Whiskey in the Courtroom**, Duke Law's Center for Criminal Justice & Professional Responsibility/North Carolina Office of Indigent Defense Services, Virtual, 2021.
4. **Forensic Toxicology for Child Custody, DSS, and Probation Violations**, North Carolina Office of Indigent Defense Services, Virtual, 2020.
5. **Advanced Forensic Toxicology**, 12th grade Forensics Elective, Apex Friendship High School, Apex, NC, 2018.
6. **Forensic Toxicology,** Lab Busters Elective, Moore Square Middle School, Raleigh, NC 2018.
7. **Forensic Toxicology,** Youth and the Law Elective Mock Trial Competition team, Moore Square Middle School, Raleigh, NC 2018.

8. **Forensic Toxicology**, 8th grade Forensics Elective, Moore Square Middle School, Raleigh, NC, 2016.
9. **Chemical weapons of WWI**, 7th grade social studies classes, Moore Square Middle School, Raleigh, NC, 2015.
10. **Terrorism and CERT**, Community Emergency Response Team/Cary Fire Department – Station 7, Cary NC, 2009-2011.
11. **Hazardous Materials Emergency Response Guide**, Community Emergency Response Team/Cary Fire Department – Station 1, Cary NC, 2009.
12. **Elements of Toxicology**, CDC-INFO staff, SRA International, Rockville, MD, 2006.
13. **Biology of cancer**, Roswell Park Summer Research Participation Program, RPCI, Buffalo, NY, 2001.

Mentor:

1. **Research Intern**, Roswell Park Summer Research Participation Program, RPCI, Buffalo, NY, 2000.
2. **Research Intern**, Cancer Genetics Department, Genetics and IVF Institute, Fairfax, VA, 1995.

POST DOCTORAL EDUCATION

Continuing education classes:

Texas Alcohol Beverage Commission
Certification - Seller/Server training (#8702837, expires 09-06-23)

1. Introduction
2. Texas alcohol sales laws
3. Sales to minors
4. Sales to intoxicated persons

American Association of Medical Review Officers
Comprehensive Medical Review Officer Training Program, 2021

1. Overview of drug testing and alternative medical explanations
2. Specimen collection procedures
3. Toxicology laboratory procedures
4. MRO practices and procedures part I
5. US DOT overview
6. FMCSA clearinghouse
7. MRO practices and procedures part II
8. MRO practices and procedures part III
9. Oral fluid drug testing
10. Designer drugs
11. Alcohol testing

12. Substance abuse professional evaluations
13. Drugs and alternative medical explanations
14. Drug and alcohol regulatory update
15. MRO's daily life
16. Hair and nail drug testing
17. Legal issues and risk management

Agilent
Eliminate the Fear Factor of LC/MS, 2021

1. Why Good Chromatography Matters for LC/MS
2. Fundamentals of Turning Liquid into Ions
3. LC/MS the Basics: Matching the Performance of the LC/MS to Analytical Solutions
4. System Maintenance & Troubleshooting
5. Basics of LC/TQ Operation

AlcoPro
Alcohol Pharmacology, 2021
DOT Breath Alcohol Technician Comprehensive Self-study Course, 2021

Godoy Medical Forensics, Inc
2020

1. Traumatic Brain Injury and Intoxication
2. Reading Medical Records

North Carolina Office of Indigent Defense Services
Forensic Education Series, 2021

1. Understanding the roles of forensic mental health experts
2. Biomechanical injury in criminal cases
3. Drug screen testing
4. Drug confirmatory testing
5. Social and cognitive bias of criminal investigations and trials

Drug Testing, 2020
Expert's Seminar 2020
Expert's Seminar 2019

International Association of Chiefs of Police
Webinars, 2021

1. What if no drug is detected?

Drugs, Alcohol, and Impaired Driving conference, 2020

1. Linking SFST Impairment to Individual Driving Tasks
2. Do You Have Skin in the Game

3. ONDCP What You Need to Know About Today's Drug Mule
4. To Draw or Not to Draw: Why Your DRE Program Should Include LR Phlebotomists
5. Traditional and Designer Benzodiazepines in Impaired Driving Casework
6. Overcoming Defense Challenges
7. Networking Session: Toxicology Challenges
8. NHTSA Update
9. Beyond Eye Movements: How Intoxication Affects Visual Perception
10. Take a Breath and Reconstruct
11. Winning the Case with Testimony
12. Courtroom Testimony from a Judge's Perspective
13. Dusted in Houston: Spike in PCP-Driving
14. Noteworthy Supreme Court Cases
15. Fatal Combination: Alcohol and Cannabis Impairment
16. Drugs You May Not Have Heard About & Just May Be The Cause of Your False Negative
17. DRE Testimony: Opportunities and Pitfalls in Frye & Daubert Hearings
18. Physiology: Back to the Basics and a Little Bit More
19. People v Kidane – Drug Impairment or Mental Health

Drugs, Alcohol, and Impaired Driving conference, 2019

1. DEC program road to progress
2. High in plain sight
3. Defending the use of field sobriety test evidence in drug-impaired driving cases
4. Training your prosecutors: Ensuring prosecutors get the most out of DREs and cross examination of the expert witness
5. The big three: the Colorado, Florida, and San Diego SFST field evaluation studies
6. Officer survival during a marijuana jury trial
7. Marijuana impacts: A toxicology perspective
8. Mellanby effects, impairment, & homeostasis: Why impaired drivers are never safe behind the wheel
9. CopTox: What's new on the street
10. Mining for Gold: A deeper look into the manual
11. Development of SFSTs and their detection of drug impairment

Drugs, Alcohol, and Impaired Driving conference, 2017

1. New drug recognition expert orientation
2. Spit it out!, Implementation and validity of roadside oral fluid testing
3. A look at marijuana studies and their practical use in impaired driving cases
4. Inhaled vs. edible cannabis: Effects on interpreting cannabinoid concentrations and impairment
5. Prescription drugs and driving
6. Designer drugs and their impact on driving

Center for Forensic Science Research and Education
Current Trends in Forensic Toxicology, 2021

1. Global issues in toxicology
2. Instrument method development
3. Novel psychoactive substances
4. Alternative biological specimens
5. Cannabis

TIAFT Educational Symposium, 2020

1. Expert Validity
2. Juror comprehension of expert testimony
3. Discussion panel
4. Strategies for sample preparation in the forensic toxicology analysis of biological fluids
5. THC and CBD in driving
6. Markers of alcohol consumption in hair
7. Determination of the direct alcohol biomarker phosphatidylethanol in dried blood microsamples
8. My career as a forensic pathologist and a forensic toxicologist
9. Maintaining research, education, operations, and clinical care in 2020
10. Application of HighResNPS for suspect screening of new psychoactive substances
11. Sensitive screening method to detect new psychoactive substances (NPS) in oral fluid
12. Can current guidelines for postmortem sample selection and interpretation prevent errors?
13. Analytical challenges in postmortem toxicology
14. Death investigations – what can(‘t) toxicology tell us?

Applied pharmacodynamics, 2020

1. Generalities
2. Modeling and concentration versus time graphs
3. The concept of clearance
4. Chronic dosing and steady state concentrations
5. Multi-compartment analysis
6. Nonlinear pharmacokinetics
7. Model-independent pharmacokinetics

Current Trends in Forensic Toxicology Symposium, 2020

1. Cadaverous changes & Post-mortem Toxicology
2. Kratom and Mitragynine in forensic casework
3. Postmortem redistribution – application of CT-Guided biopsy
4. Reference postmortem blood drug concentrations
5. High resolution screening of NPS in postmortem samples
6. Pharmacogenomic testing for forensic toxicology
7. Ultrafast screening of 263 drug targets in blood
8. Molecularly imprinted polymers for detection of drugs of abuse
9. Automated determination of phosphatidylethanol (Peth) from dried blood spots
10. High resolution LC-MS in forensic toxicology – Trials and tribulations, Tips and Tricks
11. Routine screening of drugs in whole blood using LC/Q-TOF
12. Discovery of NPS in forensic toxicology casework

13. Pharmacology and toxicology of synthetic cannabinoids
14. Eliminating backlog for forensic analysis with Intuvo 9000 GC technology
15. Are we guilty of being ethically corrupt court witnesses?
16. Targeted high-throughput screening 68 common drugs of abuse in human serum and urine

Society of Forensic Toxicology
Annual Meeting, 2020

1. SOFT topics discussion group
2. Drug facilitated crimes
3. Developing an oral fluid drug testing program workshop
4. DUID
5. DUID and human performance
6. Cannabis impaired driving workshop
7. Postmortem
8. Analytic toxicology
9. GC/MS and LC/MS/MS method development workshop
10. General/analytical
11. Post mortem
12. NPS

Annual Meeting, 2015

1. Postmortem toxicology workshop
2. Analysis and interpretation of GHB workshop
3. Expert witness testimony workshop

National Association of Criminal Defense Lawyers
CEU classes taken in 2020

1. DUI Defense: Mastering the Science & Technique
    a. Gas Chromatography for Jurors
    b. Therapeutic or Impaired? Prescription Medication Issues in DUI cases
    c. Officer's Common Mistakes Using SFSTs
    d. Understanding DREs
    e. The Mysteries of Retrograde Extrapolation: Understanding & Overcoming Them
    f. Fundamental Principles of Breath Testing
    g. NHTSA's Vehicle in Motion & Personal Contact: The Two Forgotten Phases of a DUI Investigation
    h. Don't Believe Everything You Read: An Introduction to Blood Testing
    i. DUI Trial Tips & Tricks to Take Home
    j. The ABSs of DUI; ETG, UA, IID & SCRAM
    k. NHTSA's Advanced Roadside Impaired Driving Enforcement (ARIDE)
    l. Do You Want to Know a Secret" The Hidden Treasures of Brady in DUI Cases
    m. Botched Breath Tests

   n. Using Cross-Examination to Unlock Mysterious Experts
2. Secrets Revealed: Overcoming the Illusion of Guilt
   a. An introduction to blood testing
3. Defending the Modern Drug Case (2015)
   a. Cannabis DUIs
4. Cannabis and cars (2014)
5. Defending the Modern Drug Case (2014)
   a. Investigating quality control inside the lab
   b. Ambien DUI cases
   c. Cross of the toxicologist & government experts
6. The Art and Science of DUI Defense
   a. Extrapolation of blood test results
7. Defending the Modern Drug Case (2013)
   a. Per se limits for illicit drugs
8. Making Sense of Science (2013)
   a. Determining cause of death
   b. Forensics pathology & toxicology
   c. Interpretation of crime lab report
   d. The science of SFST's: Probable cause or probably mistaken?
9. DWI Means Defend with Ingenuity (2012)
   a. Blood test discovery

RTI /National Institute of Justice

1. Agilent Event: DART-TOF for Analysis of Bulk Drugs
2. Emerging Topics and Research in Sexual Assault Investigation
3. Human Identification in Mass Fatality Incidents
4. Introduction to Uncertainty in Forensic Chemistry and Toxicology
5. Map It Out: Models in Forensic DNA & Pathology - Part II
6. Novel Techniques and Tools for Forensic Analysis - Part II
7. One pot methamphetamine production and bath salt stability, Just science Podcast
8. Fundamentals of Chromatography used in Toxicology, 2013
9. Fundamentals of Immunoassay Testing Used in Toxicology, 2013
10. Fundamentals of Mass Spectrometry used in Toxicology, 2013
11. Fundamentals of Sample Preparation used in Toxicology, 2013
12. Fundamentals of Non-Mass Selective Detectors, 2013
13. Postmortem Interval and Molecular Autopsy - Part I, NIJ Grantees Meeting, 2013

MidAmerican Toxicology Course, 2009

1. General principles of toxicology
2. Chemical disposition and risk assessment
3. Forensic toxicology

4. Clinical toxicology
5. Developmental toxicology
6. Carcinogenicity
7. Mutagenesis
8. Inhalation toxicology
9. Blood and immunologic toxicology
10. Endocrine toxicology
11. Ocular toxicology
12. Toxic response of the nervous system
13. Toxic response of skin
14. Toxic response of the liver
15. Toxic response of the kidney
16. Pesticides
17. Toxic metals
18. Naturally occurring toxins

Miscellaneous

1. NMS Laboratory webinar, Is it Hemp or Marijuana, 2020
2. Regional chapter meeting, chemical mixtures, North Carolina Society of Toxicology, 2019
3. National Institutes of Health Podcast shines light on prescription drug abuse in women, National Institute on Drug Abuse, 2019
4. National Institute on Drug Abuse teleconference discussion of results from cocaine vaccine study, 2019
5. What science can teach us about prevention/diagnosis/treatment of alcohol use disorder, National Institute on Alcohol Abuse and Alcoholism, 2019
6. Hyperkatifeiaoptimizea, National Institute on Alcohol Abuse and Alcoholism, 2019
7. Fourth generation chemical agents Part I/II (Novichok), The HazMat Guys podcast, 2019
8. Sensitive forensic screening for drugs of abuse in human urine using single quadrupole GC/MS and a single solid phase extraction, ThermoFisher webinar, 2018
9. The power of high-resolution mass spectroscopy to detect fentanyl analogs, Agilent webinar, 2017
10. Identify synthetic opiates using ambient ionization TOF-MS, Forensic Technology Center for Excellence, 2017
11. Journal of medical toxicology podcast – September 2014 and October 2014 episodes, 2016
12. “Crazy Monkey” and a man and his dog (synthetic cannabinoids), The Poison Review podcast, 2016
13. Chemical suicide, The HazMat Guys podcast, 2016
14. Hemodialysis in poisoning, The Poison Review podcast, 2016
15. Method validation for quantitation and confirmation of amphetamines, phenteramine, and designer drugs, Agilent webinar, 2015
16. GC/MS, Thermo Scientific Productivity Seminar Series, 2015

17. H impairment index: Estimating alcohol impairment, ToxNow podcast, 2015
18. DART-TOF analysis for bulk drugs, 2014
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20. Pharmacokinetics, Basic Principles, 2013
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28. Management of common childhood poisoning reviewed, Medscape, 2010

Self-study:

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2. Drug Recognition Expert Course (DRE) 7-day School Participant Manual, National Highway Traffic Safety Administration, 2013 edition
3. Preliminary training for drug evaluation and classification, National Highway Traffic Safety Administration, 2010 edition
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5. Advanced Roadside Impaired Driving Enforcement Manual, National Highway Traffic Safety Administration, 2007 edition
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10. Karch's pathology of drug abuse, Karch S. B., 3rd ed, CRC press, 2002
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13. Technician's guide for postmortem examinations: Practical guidelines for the application of postmortem procedures and their techniques, 1st ed, Ferguson W. R., Xlibris Corporation, 2010
14. Death investigation: Systems and procedures, Hanzlick R., CRC press, 2007
15. Drug-induced ocular side effect, 7th ed, F. T. Fraunfelder, F. W. Fraunfelder, W. A. Chambers, Elsevier Sunders, 2015
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22. Forensic pathology, 2nd ed, DiaMaio V. J., DiMaio D., CRC Press, 2001
23. Mass Spectrometry, 2nd ed, Analytical chemistry by open learning, James Bater, 1999
24. Breath testing for prosecutors by American Prosecutors Research Institute
25. Horizonal gaze nystagmus, American Prosecutors Research Institute
26. Drug recognition expert for prosecutors, American Prosecutors Research Institute
27. Alcohol toxicology for prosecutors, American Prosecutors Research Institute
28. Drug toxicology for prosecutors, American Prosecutors Research Institute

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LEGAL CASE WORK

Case list (cumulative count)

Evaluatee	Attorney/client	Year	Type	Drug test	Hearing	Jurisdiction	Consultation	Case review	Letter of Opinion or Affidavit	Deposition Testimony	Courtroom Testimony	Trial Consultation
	Client											
John ?	?	2011	Cause of death	P	?	?	1	1				
Chris Williams	Lauren Williams	2012	Cause of death	P	Inquest	United Kingdom	2	2	1			
?	NA	2012	Cause of death	P	Life Insurance	?	3	3				
Sam ?	?	2012	Retrograde extrapolation	A	?	Australia	4	4				
?	?	2014	Child custody	A	Criminal	VA	5	5				
Nancy Dibisceglie	Nicolette Gallows	2014	Cause of death	P	?	FL	6	6				
Dustin	?	2014	Cause of death	P	?	Canada	7	7				
Kristin August	Elizabeth Quesnel	2014	Cause of death	P	?	UT	8	8				
Richard Marinos	?	2014	DUI	A	Criminal	OH	9	9				
James Sanders	Jackie Teal	2014	DUI	A	Criminal	TX	10	10	2			
Denton Boswell	Kay Finley	2015	Probation	A	Criminal	TN	11	11	3			
Shane C.	Shane C.	2015	Probation	A	Criminal	?	12	12				
Christopher Gustave	Sarah Clayton	2015	Cause of death	P	Author	NA	13	13	4			
Jeri Harrison	Jeri Harrison	2015	Medication compliance	A	Civil	NY	144	14	5			
Timothy Smarth	Timothy Smarth	2016	Life Insurance application	A	Life Insurance	?	15	15				
Matthew Lambert	Matthew Lambert	2017	Employment drug test	A	Civil	Federal	16					
Rebecca Wilson	Rebecca Wilson	2017	DUI	A	Criminal	NC	17					
Renee Lee	Renee Lee	2018	DUI	A	Criminal	NC	18	16				
	Attorney											
Christina Scioli	Robert Currie	2015	Probation	A	Criminal	MI	19	17	6,7		1	
?	Kimberly Trimble	2015	Parole	A	Criminal	Federal	20	18	8			
Christopher Leggett	Kenneth Tisdale	2016	DUI	A	Criminal	NC	21	19				
James Sanders	Dan Simmons	2016	DUI	A	Criminal	TX	22	20	9		2	
James Sanders	Jackie Teal	2016	Parole	A	Criminal	TX	23	21	10			
Patrick Kummerer	Paul Toland	2017	Personal injury	A	Civil	NC	24	22	11			
?	Jill Clancy	2017	Child custody	A	Criminal	?	25					

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Avinash Gandhi	Kenneth Tisdale	2017	DUI	A	Criminal	NC	26	23	12			
Boyce Lee	Kenneth Tisdale	2017	DUI	A	Criminal	NC	27	24	13			
Jeremy Doub	Kenneth Tisdale	2017	DUI	A	Criminal	NC	28	25	14			
Jerry Watson	Dawn Gray (client)	2017	Cause of death	P	Insurance	TX	29	26	15			
Emanuele Avaro	Anthony Ison	2018	Employment	A	Civil	Federal	30	27	16			
Maria Robey	Tyler Benson	2018	DUI	A	Criminal	NC	31	28				
Darius Johnson	Caroline Johnson	2018	Sports doping	A	Civil	Italy	32	29				
Peter Kyriakides	Anthony Ison	2018	Employment	A	Civil	Federal	33	30	17			
?	Don Ennis	2018	Cause of death	P	Civil	NC	34	31				
?	Dean Morgan	2018	DUI	A	Criminal	PA	35					
?	Nick Clifford	2018	DUI	A	Criminal	NC	36					
Latyr Ndaiye	Sara Klemm	2019	Post-conviction	A	Criminal	MD	37	32			3	
Nathan Fernham	Locke Milholland	2019	Child custody	A	Criminal	NC	38	33	18			
Anne Fail	Danny Glover Jr.	2019	DUI	A	Criminal	Federal	39	34	19			
Jon Harkins	Todd Conormon	2019	DUI	A	Criminal	Federal	40	35				
Audrey Locklear	Jim Doermann	2019	DUI	A	Criminal	NC	41	36				
Densel Dancy	Joseph Arbour	2019	Murder	A	Criminal	NC	42	37	20		4	
Anthony Arnett	Brad Ferguson	2019	Assault	A	Criminal	NC	43	38	21		5	
?	Shira Hedgepeth	2019	Child custody	A	Civil	Tribal	44					
Sherrie Merritt	Mandy Vivelo	2019	Medical malpractice	P	Civil	NC	45	39		1		
Seth Tracy	Sharon Suh	2019	Personal injury	A	Civil	NC	46	40				
Tamarcus Lofton	Selen Vining	2019	Personal injury	A	Civil	NC	47	41	22			
Morgan Carson	Jack Bayliss	2019	Personal injury	A	Civil	NC	48	42	23			
?	Steven Wright	2019	Drug possession	NA	Criminal	NC	49					
Christina Berkoben	Michael Greer	2019	Personal injury	A	Civil	NC	50	43				
Ronald Nash	Michael Levine	2019	Personal injury	P	Civil	NC	51	44		2		
Kevin Jernigan	Craig Myers	2019	Personal injury	A	Civil	TX	52	45	24	3		
Richard Ray	Michael Greer	2019	Personal injury	A	Civil	NC	53	46				
Eric Taylor	Jeremy Smith	2019	DUI	A	Criminal	NC	54	47	25, 26, 27			
Stephen Duriseau	Craig Myers	2020	DUI	P	Civil	TX	55	48				
Mariah Woods	Brooke Mangum	2020	Cause of death	P	Criminal	NC	56	49				
James Williamson	Mark Davis	2020	Personal injury	A	Civil	NC	57	50	28			
?	Rachel Smith	2020	DUI	A	Criminal	NC	58					
Daniel Harris	Alton Reeder	2020	Assault	A	Criminal	NC	59	51	29			
Michelle Ketchens	Keith Metz	2020	DUI	A	Criminal	NC	60	52				

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Akelia Hypolite	Natasha Crawford	2020	Assault	A	Criminal	GA	61	53				
Janet Carter David Cosby	Janelle Wendorf	2020	Personal injury	A	Civil	NC	62	54	30			
Carson Davis Justice Hewitt	Sarah Ellerbe	2020	Personal injury	A	Civil	NC	63	55		4		
Mathew Upchurch	Joe Ivey	2020	Child Custody	A	Civil	NC	64	56				
?	Dorthy Lewis	2020	DUI	A	Criminal	NC	65					
Logan Hopper	?	2020	Cause of death	P	Civil	TN	66					
Alden Whitehead	Jeremy Smith	2020	Murder	A	Criminal	NC	67	57				
Siobhan McCauliffe	Raquel Fox	2020	DUI	A	Criminal	CA	68					
Deonte Spearman	Michael Cohen	2020	Personal injury	A	Civil	NC	69	58				
Theodore Robbins	Stephen Teague	2020	Personal injury	A	Civil	NC	70	59				
Trevor Stiaszny	Julie Hammerman	2020	Employment	A	Civil	Federal	71	60				
Mary Chrutchfield	Cynthia Everson	2020	Personal injury	A	Civil	NC	72	61				
Barbra Raily	David Mohrmann	2020	Personal Injury	A	Civil	Federal	73	62				
Erika Starling	Patrick Williams	2020	Child custody	A	Civil	NC	74	63	31			
Ramon Reguero	?	2020	Poisoning	S	Criminal	NC	75	64				
Tracy Kane	?	2020	Poisoning	A,S	Criminal	VA	76	65				
Kelly Pace	?	2020	Poisoning	A	Criminal	NC	77					
John Whitson	Mark Rabil	2020	Post-conviction	P	Criminal	NC	78	66				
?	Josh Simmons	2020	Child custody	A	Civil	NC	79	67				
Matthew Evans	Casey Cogburn	2020	Cause of death	P	Civil	NC	80	68				
Me'chele Morrison	Ashley Bartolucci	2020	Personal injury	A	Civil	NC	81	69				
Zachary Castro	Craig Myers	2021	Personal injury	A	Civil	TX	82	70	32			
Raheem Jackson	Cecilia Oseguera	2021	Probation	A	Criminal	Federal	83	71				
Carl Farris	Nicolle Phair	2021	DUI	A	Criminal	NC	84	72				
Matthew Doxey	Scott Wligora	2021	Cause of death	P	Criminal	NC	85	73				
Charles Plunkett Jr.	Carlos Mahoney	2021	Personal injury	A	Civil	NC	86	74	33		6	
Nicholas Grant	Eddie Thomas	2021	DUI	A	Criminal	NC	87	75	34			
?	Johnna Herron	2021	DUI	A	Criminal	NC	88					
Britton Smith	George Hunt	2021	DUI	A	Criminal	NC	89	76				
Kerry Richardson	Randolph James	2021	Employment	A	Civil	NC	90	77				
?	Amily McCool	2021	DUI	A	Criminal	NC	91	78				
?	Deborah Davis	2021	Cause of death	P	Civil	SC	92					
?	Aden Wilkie	2021	DUI	A	Criminal	Federal	93					
?	Vanessa Puhak	2021	Child custody	A	Civil	NC	94					

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Evaluatee	Attorney/client	Year	Type	Drug test	Hearing	Jurisdiction	Consultation	Case review	Letter of Opinion or Affidavit	Deposition Testimony	Courtroom Testimony	Trial Consultation
?	Richard Costanza	2021	DUI	A	Criminal	NC	95					
Jennifer Kirk	?	2021	Child Custody	A	Civil	NC	96					
John Rogers	Craig Myers	2021	Personal injury	A	Civil	TX	97	79				
Emmanuel Simeon	Aaron Wellman	2021	DUI	A	Criminal	NC	98	80	35			
Jeffrey Coffey	Robert Karney	2021	Personal injury	A	Civil	NC	99	81				
Truman Staples	?	2021	Probation	A	Criminal	KY	100					
L. C. Jones	Craig Myers	2021	Personal injury	A	Civil	TX	101	82	36			
Michael Bates	Katie Sanders	2021	DWI	A	Criminal	NC	102	83				1
?	Eric Eller	2021	DWI	A	Criminal	NC	103					
Robert Shields	Eli Timberg	2021	DWI	A	Criminal	NC	104					
Dominic Cardone	Pro se	2021	DWI	A	Criminal	NC	105	84	37			2
Cody Bagwell	?	2021	DWI	A	Criminal	NC	106					
?	Carol Kendrick	2021	DWI	A	Criminal	NC	107					
Evangelos Manginas	Jeremy Kosin	2021	Personal injury	A	Civil	NC	108	85				
Terence Walker	Jeremy Kosin	2021	Personal injury	A	Civil	NC	109	86	38			
?	Mary Mendini	2021	DWI	A	Criminal	NC	110					
William Bayliss	Jack Baylis	2021	DWI	A	Criminal	NC	111					
Corey Philemon	Paul Dickinson	2021	Personal injury	A	Civil	NC	112	87				
Christine Benson	Rebecca Blakeslee	2021	Poisoning	A	Criminal	IL	113	88				
Dillion ?	?	2021	DWI	A	Criminal	NC	114					
Deysi Martinez	Dane Peddicord	2021	Murder	P	Criminal	NC	115	89				
Scott Sasek	Christine Mumma	2021	Post-conviction	S	Criminal	NC	116					
Benjamin Goddard	Jake Minick	2021	DWI	A	Mock trial	NC	117	90				
Meaghan Williman	Jake Minick	2021	DWI	A	Mock trial	NC	118	91			7	
John Hyatt	Grey Powell	2021	DWI	A	Criminal	NC	119	92	39			3
?	Meredith Cairo	2021	DWI	A	Criminal	NC	120					
Ebonee Johnson	Cate Frederick	2021	DWI	A	Criminal	NC	121					
?	Chas Post	2021	DWI	A	Criminal	NC	122					
Tyronne Johnson	Marcus Hill	2021	DWI	A	Criminal	NC	123	93				
Oscar ?	Marcus Hill	2021	DWI	A	Criminal	NC	124					4
Philip Carlson	Kevin Rust	2021	Personal injury	A	Civil	NC	125					
Jesse Bram	?	2021	Employment	A	Criminal	Federal	126					
Zechariah Lemmon	Marcus Hill	2021	DWI	A	Criminal	NC	127	94				
Totals							**127**	**94**	**39**	**4**	**7**	**4**

Drug test: A = Antemortem, P = Postmortem, S = Substance

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Handout 9

Dr. Barbara Wolf

Report

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October 18, 2021

Julie E. Bridenstine, Esq.
North Carolina Innocence Inquiry Commission
P.O. Box 2448
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RE: Whitson, Jonathan Russell Jr. (deceased)
State of North Carolina *v.* John Pritchard--11 CRS 304-305, Yancey County

Dear Ms. Bridenstine:

As you requested, I have reviewed the materials that you forwarded to me pertaining to the death of Jonathan Russell Whitson Jr. These materials include:

1. Report of the postmortem examination performed on the body of Jonathan Whitson by Brent D. Hall, M.D., Pathology Associated of Boone (case # AP-11-5) and associated documents and diagrams

2. Report of Investigation of Medical Examiner

3. Report of postmortem toxicologic studies performed by the Office of the Chief Medical Examiner, Chapel Hill, NC

4. Autopsy photographs

5. Microscopic slides (13) prepared from autopsy tissues

6. Medical Examiner's Certificate of Death and Supplemental Report of Cause of Death

7. Medical record of Jonathan Whitson from Mission Hospital, Asheville, NC

8. Investigative reports and associated documents from the Yancey County Sheriff's Office and Investigation Notes of Chief Deputy Thomas L. Farmer

9. Buncombe County Sheriff's Office Booking Report, Release Order and Inmate Property Record/Receipt

10. Madison County Jail records

11. Affidavit of Christena L. Roberts, M.D.

12. Handwritten letter from John Pritchard to Dr. Roberts

13. Expert Reports of Jerri L. McLemore, M.D. and George S. Behonick, Ph.D., D-ABFT

14. Deposition transcript of Dr. Hall and exhibits

15. Transcript of Trial, State of North Carolina *vs.* John Pritchard

16. Documents titled FSR reviews of Yancy County Sheriff's Office File, Trial Transcript and SBI File

Background

Jonathan Russell Whitson Jr. was 29 years old at the time of his death on March 6, 2011. He was found dead at the home of his step-grandmother, Christine Angel and family members, where he had spent the previous day and night. He had a past history of intravenous drug abuse and a previous hospital admission for cellulitis secondary to intravenous drug abuse. In her trial testimony Ms. Angel said that she also knew that he had asthma, a blood clot and a "hole in his heart." Mr. Whitson went to bed on the living room couch on the evening of March 5, 2011 after speaking with Ms. Angel before she went to bed at approximately 9:00 p.m., according to her trial testimony. Ms. Angel's son, Nathan Angel, who was staying at his mother's house, awoke at approximately 4:00 to 4:30 a.m. on the morning of March 6, 2011 and heard Mr. Whitson snoring loudly. He again heard snoring at 8:00 a.m. The following morning Ms. Angel heard Mr. Whitson snoring before leaving for the grocery store with her husband. They returned at approximately 10:30 and observed him still on the couch and snoring. He was found deceased by Ms. Angel's grandson, Christian, who had been asked to wake up Mr. Whitson. A 911 call was recorded at 11:33 a.m. Mr. Whitson was pronounced dead at the scene. Two syringes with residue were found in his coat pocket.

A postmortem examination was performed by Brent D. Hall, M.D. The external examination of the body revealed abrasions of the right thumb and both upper legs, a 2.0 cm ulcer of the left heel and needle marks in the left antecubital fossa and on the left forearm, although these findings were not documented photographically. The autopsy findings included severe pulmonary edema and congestion (lung weights: right1040 g, left 900 g), acute bronchial pneumonia described as moderate, mild pulmonary emphysema and mild cardiomegaly (heart weight 420 g) with left ventricular hypertrophy. The cause of death was initially certified as pending. Postmortem toxicology studies reposted "trace" morphine in the femoral blood, morphine "present" in aortic blood and a urine concentration of morphine of 15 mg/L. The aortic blood also contained ethanol at the concentration of 40 mg/dL and nicotine was also present. The

Supplemental Report of Cause of Death listed the cause of death as morphine toxicity and the manner of death was accidental.

Mr. Whitson had been released from the Madison County Jail on Friday, March 4, 2011 after serving a sentence for driving without a license and was transferred to the Buncombe County Jail, from which he was released at approximately 7:40 p.m. that day. He called his cousin, Floyd Ayers, at approximately 11:07 p.m. and said that he was walking and asked Mr. Ayers to pick him up. Mr. Ayers dropped him off at the Angel residence at approximately 12:45 p.m. He described Mr. Whitson as looking healthy and having good color. In her statement, Stephanie Whitson, Mr. Whitson's girlfriend, said that she came to the residence at approximately 3:00 p.m. on the afternoon of March 5, 2011 and that Jonathan Pritchard came later that afternoon. At some point Mr. Pritchard and Mr. Whitson left the residence. Ms. Whitson stated that when they returned Mr. Whitson showed her ten 30 mg morphine tablets, one of which he gave to Nathan Angel. Over the course of the afternoon and evening of March 5, 2011 Stephanie indicated that Mr. Whitson crushed and melted the remaining pills and injected them both multiple times, the last time being approximately 7:30 p.m. There were approximately 6 syringes worth of the liquid left on a spoon under the bathroom sink. She left the residence at approximately 9:50 p.m. Subsequent laboratory testing of the two syringes recovered from Mr. Whitson's coat revealed no controlled substances. The spoon was not found by law enforcement.

My Opinions and the Bases and Reasons Thereof

My opinions in this matter are based on my review of the above-listed materials, as well as my training and experience in medicine and in the subspecialty of forensic pathology.

The interpretation of drug concentrations and the determination of the cause of death of an individual who dies with drugs in his or her system is sometimes not straightforward but can necessitate the consideration of the scene and circumstances, the decedent's medical history and other potential natural or unnatural causes of death found at autopsy. There are many factors that can affect the reaction of an individual's body to a drug, including pre-existing natural disease processes, some of which can affect the body's ability to metabolize the drug, and the person's history of use of the drug. Some drugs, such as morphine, when used repeatedly over a period of time can result in the user's development of tolerance, a diminished response to the drug necessitating the use of larger doses to produce the same physiologic responses. An individual taking a drug after a period of abstinence may be more susceptible to adverse effects of the drug than he or she would have been prior to the period of abstinence.

In my review of the trial transcript and the July 30, 2021 deposition transcript of the autopsy pathologist, Brent Hall, M.D. I encountered some opinions given with which I respectfully disagree. Most notably, Dr. Hall stated that Mr. Whitson's urine concentration of 15 mg/L indicates "a lethal level of morphine." Likewise, in his trial testimony Dr. Hall stated that, in urine "the cut off point for toxicity resulting in death is

14 milligrams per liter." This not accurate statement. The detection of a drug in an individual's urine can support the finding of the drug in the blood, but the concentration in urine cannot be extrapolated to correlate with a blood concentration pertaining to potential impairment or lethality. The concentration of a drug in the urine is dependent is in part a reflection of the amount of water in the urine, i.e., whether it is concentrated or dilute based on the liquid consumption of the individual.

Dr. Hall also opined that it is common to for an individual to have pneumonia in cases of opiate toxicity and that the pneumonia seen in Mr. Whiston's autopsy was a consequence of the opiate toxicity. I also respectfully disagree with this opinion. In the autopsies of thousands of individuals who have died of opiate toxicity, a common finding has been pulmonary congestion and edema. Dr. Hall testified that pulmonary edema serves as a medium for the growth of organisms. In the case of Mr. Whitson, I agree that the lungs showed acute pneumonia with features of aspiration. Additionally, the lungs and pulmonary hilar lymph nodes showed giant cell formation in response to polarizable foreign material, which would be consistent with the body's reaction to components of crushed pills injected into the blood stream. However, it is my opinion this would not have developed in the short time interval between the March 5, 2021 afternoon and evening injections of the crushed morphine pills and Mr. Whitson's death. In my opinion, the acute pneumonia and granulomatous reaction to foreign material constitute a condition that was in place before the time between his injection of the crushed morphine pills and his death.

However, in spite of the exception that I would take to Dr. Hall's above stated opinions, I agree with Dr. McLemore's opinion that morphine toxicity contributed to Mr. Whiston's death. The finding of only a "trace" of morphine in his blood at autopsy can be attributed to the metabolism of the drug in the interval between its use and death. The circumstances of his death, occurring with the first use of morphine following abstinence due to his incarceration, as well as the observations of his heavy snoring, are typical for a death due to drug toxicity. Additionally, I would include the pneumonia as an independent factor in his death. I would certify the cause of death as morphine toxicity and acute pneumonia, or, alternatively, I would certify the cause of death as morphine toxicity on Part I of the death certificate and list acute pneumonia as a contributory cause of death (Part II of the death certificate).

Morphine is an opiate that acts as a depressant of the central nervous system. It is used clinically as an analgesic for the treatment of pain. Its use is contraindicated in patients with breathing problems such as asthma because it induces respiratory depression, reducing respiratory rate and prolonging expiration time. In the case of Mr. Whitson, the degree of pneumonia seen in the histologic slides would have impaired his breathing and acted synergistically with the respiratory depression produced by the morphine, ultimately leading to his death. Although the source of the ethanol in his system is unknown, if Mr. Whitson did also consume alcohol, the blood concentration would have been significantly higher hours earlier. Because ethanol is also a central nervous system depressant, this may have been an additional contributing factor in his death.

My Qualifications

I am a physician, licensed to practice medicine in the state of Florida. I also hold inactive licenses in the states of Massachusetts, New York, and New Jersey. I am currently employed as the District Medical Examiner for Florida's District 5, serving Lake, Sumter, Marion, Hernando and Citrus Counties and the Interim District Medical Examiner for District 24, serving Seminole County. I am Board Certified by the American Board of Pathology in the specialties of anatomic pathology, hematopathology and in forensic pathology. I have previously served as the Director of the Divisions of Anatomic Pathology and Hematopathology in the Department of Pathology and Laboratory Medicine at the Albany Medical Center, and I was an adjunct full Professor of Pathology at the Albany Medical College. Between 1991 and 2001 I also served up to 20 counties in upstate New York as a coroner's pathologist. I resigned from the directorship position at Albany Medical Center in 1996 to pursue full time forensic pathology. In 1997 I took the position of Chief Medical Examiner for Rensselaer County, New York, and in 1999 I became the Director of Forensic Medicine for the Medicolegal Investigation Unit of the New York State Police. I relocated to Palm Beach County, Florida in 2001 where I served as the Deputy Chief Medical Examiner and then to the District 21 Medical Examiner's Office in 2004, prior to assuming the leadership position in the District 5 office in November of 2007. I also currently serve as the Chairperson of the Inspection and Accreditation Committee of the National Association of Medical Examiners and as a faculty member of the National District Attorneys' Association.

As part of my work as a forensic pathologist I perform postmortem examinations in cases where death was sudden and unexpected. Additionally, I also on occasion conduct reviews of cases for the purpose of providing expert forensic pathology opinion. I have provided testimony in both civil and criminal matters in trials, hearings and depositions in excess of 500 proceedings in many states. I also have testified before the United States Congress (Helsinki Commission) pertaining to my work in the examination of the remains of victims found in mass graves in Bosnia and Croatia.

As a forensic pathologist, my expertise includes the evaluation of injuries to the body and the determination of the cause and manner of death. In my career to date I have performed in excess of 10,000 autopsies, including numerous autopsies in cases of drug-related deaths.

Please feel free to contact me if I can be of further assistance.

Sincerely,

Barbara C. Wolf, M.D.
Forensic Pathologist

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November 8, 2021

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Raleigh, NC 27602

RE: Whitson, Jonathan Russell Jr. (deceased)
State of North Carolina *v.* John Pritchard--11 CRS 304-305, Yancey County
Supplemental Report

Dear Ms. Bridenstine:

Because I am a full-time practicing chief medical examiner, the vast majority of my testimonies are for the state in homicide cases, since the prosecution typically calls the medical examiner to introduce the autopsy findings. In the occasional criminal cases in which I have testified as a consultant, I have testified on behalf of both the prosecution and the defense. I have never been excluded as an expert.

For purposes of reviewing this case on behalf of the North Carolina Innocence Inquiry Commission, preparation of my report and testimony not requiring travel, I am billing at the state rate of $320.00 per hour. I have submitted an invoice totaling $5,280.00 for work performed to date.

Please feel free to contact me if I can be of further assistance.

Sincerely,

Barbara C. Wolf, M.D.
Forensic Pathologist

Handout 10

Dr. Barbara Wolf CV

CURRICULUM VITAE

Barbara C. Wolf, M.D.

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Leesburg, FL 34748

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EDUCATION

College/Medical School:	Boston University Six Year Program in Liberal Arts and Medical Education, Boston University School of Medicine, Boston, MA 1978 A.B., 1980 M.D.

POSTGRADUATE TRAINING

Residency:	Anatomic Pathology, Mallory Institute of Pathology and Boston Veterans Administration Hospital, Boston, MA 1980-1982
	Anatomic Pathology, New England Deaconess Hospital, Boston, MA and Lahey Clinic Medical Center, Burlington, MA 1982-1984
	Clinical Pathology (Hematology), New England Deaconess Hospital, Boston, MA 4/1984-6/1984

Fellowship:	Hematopathology, Mallory Institute of Pathology, under the direction of Dr. Richard S. Neiman, 1984-1985

LICENSURE

State of Florida (# ME 83748)
Commonwealth of Massachusetts (# 53067-inactive)
State of New York (#1821841-inactive)
State of New Jersey (#61810-inactive)

CERTIFICATIONS

American Board of Pathology, Forensic Pathology,
May 31, 1994

American Board of Pathology, Hematology,
May 26, 1987

American Board of Pathology, Anatomic Pathology,
November 17, 1984

National Board of Medical Examiners,
July 1981

PROFESSIONAL POSITIONS

Oct. 2018-present	Interim District Medical Examiner, District 24, State of Florida, serving Seminole County
July, 2011-present	District Medical Examiner, District 5, State of Florida
Oct. 2008-July, 2011	Interim District Medical Examiner, District 5, State of Florida
2007-present	Chief Medical Examiner, District 5, State of Florida, serving Marion, Lake, Sumter, Hernando and Citrus counties
Nov. 2004-Oct. 2007	Associate Medical Examiner, District 21, State of Florida, serving Lee, Hendry and Glades Counties

Oct. 2001-Oct. 2004	Deputy Chief Medical Examiner, District 15, State of Florida, serving Palm Beach County
1999-2001	Director of Forensic Medicine, Medicolegal Investigation Unit, New York State Police
1997-2001	Chief Medical Examiner, Rensselaer County, NY
1991-2001	Coroner's Pathologist, Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Herkimer, Montgomery, Oneida, Orange, Saratoga, Schenectady, Schohaire, St. Lawrence, Ulster, Warren and Washington Counties
1996-1998	Staff Pathologist, Albany Medical Center (part-time), Albany, NY
1991-1996	Director of Department of Anatomic Pathology, Albany Medical Center, Albany, NY
1990-1995	Director of Hematopathology Division and Hematopathology Fellowship Program, Albany Medical Center, Albany, NY
1992-1993	Director, Autopsy Service, Albany Medical Center, Albany, NY
1990	Director of Hematopathology Division, Mallory Institute of Pathology, Boston, MA
1989	Assistant Director, Mallory Institute of Pathology, in charge of educational activities
1986-1989	Staff Pathologist, Mallory Institute of Pathology and Research Pathologist, New England Deaconess Hospital, Boston, MA
1985-1986	Staff Pathologist, New England Deaconess Hospital, Boston, MA

ACADEMIC APPOINTMENTS

2010-present	Adjunct Professor of Pathology, University of Central Florida College of Medicine, Orlando, FL
1998-2001	Adjunct Professor of Pathology and Laboratory Medicine, Albany Medical College, Albany, NY
1996-1998	Professor of Pathology and Laboratory Medicine, Albany Medical College, Albany, NY
1990-1996	Associate Professor of Pathology and Laboratory Medicine, Albany Medical College, Albany, NY
1990	Associate Professor of Pathology, Boston University School of Medicine, Boston, MA
1986-1990	Assistant Professor of Pathology, Boston University School of Medicine, Boston, MA
1985-1986	Instructor in Pathology, Harvard Medical School, Boston, MA
1984-1986	Instructor in Pathology and Biology of Disease, Boston University School of Medicine, Boston, MA
1982-1984	Clinical Fellow in Pathology, Harvard Medical School, Boston, MA
1980-1982	Instructor in Pathology and Biology of Disease, Boston University School of Medicine, Boston, MA

SCIENTIFIC APPOINTMENTS AND COMMITTEES

2017-present	Board of Directors, National Association of Medical Examiners

2017-present	National Association of Medical Examiners International Relations Committee
2016-present	Chair, National Association of Medical Examiners Inspection and Accreditation Committee
2016-present	National Association of Medical Examiners Strategic Planning Committee
2015-present	Florida Medical Examiners Commission
2015-present	Florida Sheriff's Association Cold Case Advisory Commission
2015	Co-Chair, National Association of Medical Examiners Standards, Inspection and Accreditation Committee
2015	National Association of Medical Examiners Nominating Committee
2015	President, Florida Association of Medical Examiners
2013-2015	President Elect, Florida Association of Medical Examiners
2012-present	Staff member, International Firearms Specialist Academy
2012-2014	Florida Chapter, American Professional Society on the Abuse of Children
2012-2014	Co-Chair, Florida State Child Abuse Death Review Committee
2011-present	Chair, Forensic Medicine Committee, Florida Division, International Association for Identification
2011-present	National Association of Medical Examiners, Inspection and Accreditation Committee
2011-present	National Association of Medical Examiners Certified Accreditation Inspector
2011-2014	Florida Coalition Against Domestic Violence
2008-present	District 5 Child Death Review Team, FL

2008-present	Faculty Member, National District Attorneys Association
2008-present	Instructor, Practical Homicide Investigation ®
2005-present	Consultant, Royal Barbados Police Force
2005-2007	District 21 Child Death Review Team, FL
2004-2014	Florida State Child Abuse Death Review Committee
2004	Palm Beach County Fetal and Infant Mortality Review Team, FL
2004	Palm Beach County Child Fatality Review Team, FL
2001-present	Consultant in Forensic Pathology, Medicolegal Investigation Unit, New York State Police
1993-2001	Albany County Task Force on Child and Sexual Abuse, Albany, NY
1998-2001	Warren and Washington Counties Child Death Review Committee, NY
1994-2001	Albany County Child Death Review Committee, Albany, NY
1997-2001	Montgomery County Child Death Review Committee, NY
1998-2001	Dutchess County Child Death Review Committee, NY
1991-1995	Pathology Chair, Eastern Cooperative Oncology Group
1989-1991	Pathology Co-chair, Eastern Cooperative Oncology Group
1987-1995	Director, Pathology Coordinating Office and Central Histology Laboratory, Eastern Cooperative Oncology Group
1991-1995	Faculty Senate, Albany Medical Center, Albany, NY
1991-1995	Academic Governing Council, Albany Medical Center, Albany, NY

1991-1995	Operating Room Committee, Albany Medical Center, Albany, NY
1991-1995	Executive Committee, Albany Medical Center, Albany, NY
1991-1995	Infection Control Committee, Albany Medical Center, Albany, NY
1991-1994	Chair, Surgical Review Committee, Albany Medical Center
1987-1989	Pathology Chair, National Gastrointestinal Cancer Consortium
1986-1990	Review Pathologist, National Surgical Adjuvant Project for Breast and Bowel Cancer
1986-1989	Chair, Head and Neck Pathology Subcommittee, Eastern Cooperative Oncology Group
1985-1995	Hematopathology Subcommittee, Eastern Cooperative Oncology Group
1989-1990	Quality Assurance Committee, Mallory Institute of Pathology, Boston, MA
1987-1990	Tumor Committee, Boston City Hospital, Boston, MA

GOVERNMENT APPOINTMENTS

1993-2001	New York State Commission on Quality of Care for the Mentally Disabled Medical Review Board
1994-2001	New York State Commission on Correction Medical Review Board
2015-present	Florida Medical Examiners Commission

HOSPITAL APPOINTMENTS

1990-1998	Pathologist, Albany Medical Center, Albany, NY
1987-1990	Associate Scientist, Research Staff, New England Deaconess Hospital, Boston, MA
1986-1990	Pathologist, Mallory Institute of Pathology, Boston City and University Hospitals, Boston, MA
1985-1986	Pathologist, New England Deaconess Hospital, Boston, MA
1985-1986	Pathologist, New England Baptist Hospital, Boston, MA

RESEARCH ACTIVITIES AND GRANTS

1982-1983	American Cancer Society Regular Clinical Fellowship
1984-1986	American Cancer Society Junior Faculty Fellowship
1986	Aid for Cancer Research Award
1986	Biochemical Research Support Grant, "Non-Hodgkin's Lymphomas of the Gastrointestinal Tract", NIH
1986-1990	NIH NCI POI CA4470405 "The Pathology of Colorectal Cancer" (Glenn Steele, Jr., M.D., Principal Investigator) 6.1.875.31.90
1986-1995	NCI CA 2111514 "The Eastern Cooperative Oncology Group" (Douglass Tormey, M.D., Ph.D., Principal Investigator)
1991-1995	NIH NCI R01 CA5551801 "AIDS Related Lymphomas Clinical and Biologic Studies" (Leo Gordon, M.D., Principal Investigator) 7.16.917.15.94

STUDY SECTIONS

1992	NIH/NCI Specialized Programs of Research Excellence in Breast Cancer
1993	NIH/NCI RFA for Breast Cancer Tumor Registry

EDITORIAL REVIEW BOARDS

1989	Human Pathology (guest editor)
1989-1994	American Journal of Clinical Pathology
2003-2015	American Journal of Forensic Medicine and Pathology
2004-2006	Journal of Forensic Sciences (guest editor)
2007-present	Journal of Forensic Sciences

VISITING PROFESSORSHIPS

November, 1990	Hartford Hospital, Hartford, CT
October, 1992	Melrose-Wakefield Hospital, Melrose, MA
October, 1992	Nassau County Medical Center, NY
April, 1994	Bay State Medical Center, Springfield, MA

AWARDS AND HONORS

1974	Presidential Scholar
College:	National Merit Scholarship, 1974
	Graduation with Honors (Summa Cum Laude), 1978
Medical School:	Elizabeth K. Moyer Award for Excellence in Anatomy, 1977
	Graduation with Honors (Magna Cum Laude), 1980
	Dean Eleanor Tyler Memorial Award for Excellence in Six Year Program in Liberal Arts and Medical Education, 1980
	American Medical Women's Association Achievement Award, 1980
2007-2010, 2015	Consumer Research Council America's Top Pathologists (Forensic Pathology)
2017	National Association of Medical Examiners STAR Award (Service, Time, Attitude & Respect)
2019	National Association of Medical Examiners Setting the Standards Award

PROFESSIONAL SOCIETIES

1978-present	Phi Beta Kappa
1979-present	Alpha Omega Alpha
1988-1995	Society for Hematopathology
1987-present	American Society of Clinical Pathologists

1988-present	College of American Pathologists
1986-1995	New England Society of Pathologists
1987-1998	US/Canadian Academy of Pathology
1989-1998	Arthur Purdy Stout Society of Surgical Pathologists
1990-1995	European Association for Hematopathology
1991-present	Association of Directors of Anatomic and Surgical Pathology (Emeritus member since 1995)
1991-1995	New England Cancer Society
1992-1995	American Society of Clinical Oncology
1994-2001	New York State Association of County Coroners and Medical Examiners
1994-present	National Associations of Medical Examiners (Fellow since 2008)
1993-present	American Academy of Forensic Sciences (Fellow since 2004)
2004-present	International Association for Identification
2001-present	Florida Association of Medical Examiners
2006-present	Florida Medical Association
2007-2019	Lake-Sumter Medical Society
2008-2019	Marion County Medical Society
2010-present	American Professional Society on the Abuse of Children
2010-present	Florida Chapter, American Professional Society on the Abuse of Children
2018-present	Seminole County Medical Society

WORKSHOPS AND INVITED LECTURES

1990-1995	Course Director, United States/Canadian Academy of Pathology short course, “Disorders of the Spleen”.
1991	Propp/Olson Symposium, Albany Medical College, “New Immunohistologic and Molecular Techniques in the Diagnosis of Lymphoproliferative Disorders”, Albany, NY
1992	National Society for Histotechnology, “Topics in Forensic Pathology”, Albany, NY
1992-1995	Workshop Director, American Society of Clinical Pathologists Meeting, “Application of DNA Ploidy and Cell Cycle Analysis in Surgical Pathology”
1993	New York State Association of County Coroners and Medical Examiners, “Acquired Immunodeficiency Syndrome,” Lake Placid, NY
1993	New York State Association of County Coroners and Medical Examiners, “Medicolegal Investigation of Child Abuse”
1993	New York State Association of Public Health Laboratories, “Disorders of the Spleen”
1993	New York State Police Academy Major Crimes Seminar, “Child Abuse and Sex Related Deaths,” Albany, NY
1993-1997	Moderator of Child Abuse seminar required for licensure for New York State physicians
1994	New York State Police Academy Sex Offense Seminar, “Sex Related Deaths,” Albany, NY
1994	New York State Association of County Coroners and Medical Examiners, “Transportation Fatalities”
1994	Marist College Symposium on Forensic Sciences, “Child Abuse” and “Traffic Fatalities,” Poughkeepsie, NY

1994	State University of New York, University of Albany, "Forensic Pathology," Albany, NY
1995	Crime Scene and Evidence Technician Course, Capital Region Police Departments, Albany, NY
1995	Annual Tri-State International Association for Identification Educational Conference and Training Seminar, Albany, NY
1995, 1997	Course Director, United States/Canadian Academy of Pathology short course, "Forensic Sciences and the Pathologist"
1995	United States/Canadian Academy of Pathology Specialty Conference, Forensic Medicine: Past and Future; DNA profiling, Toronto, Canada
1995	New Jersey Medical Examiner Office "AIDS-Related Deaths," Newark, NJ
1995	Colby College Forensic Sciences Seminar, "Forensic Serology," Waterville, ME
1995	Evidence Collection/Forensics Regional Information Sharing Conference, "The Changing Role of the Medical Examiner at the Scene," Albany, NY
1995	New York State Police Henry F. Williams Homicide Seminar, "DNA in Criminal Investigations," Albany, NY
1995	Conference Co-Director, Illinois County Coroners' Association
1995	Quinnipiac School of Law, "Forensic Evidence in Sexual Assaults and Other Crimes," New Haven, CT
1995	Commission on Security and Cooperation in Europe (U.S. Congress Helsinki Commission), "Mass Graves and Other Atrocities in Bosnia," Washington, DC
1996	University of New Haven Forensic Science Program Arnold Markle Symposium, "Post-mortem Changes and Time of Death," New Haven, CT

1996	Conference Co-Director, Illinois County Coroners' Association
1996	New York State Association of County Coroners and Medical Examiners, "Time of Death, Exhumations and DNA"
1996	State University of New York Conference Telemedicine Reality and Virtual Realty II, "New Developments in the Forensic Sciences," Syracuse, NY
1996	New York State Attorney General's Inspectors, "Investigation of Deaths and Injuries," Albany, NY
1996	New York State Division of Criminal Justice Service Crime Scene Course, "Death Investigation," Albany, NY
1996	Philadelphia Center for Legal Education Conferences on Expert Witnesses, Bermuda
1996	Florida Inspector General's Training Workshop, "Forensic Pathology,", Orlando FL
1997	Crime Scene and Evidence Technician Course, Capital Region Police Departments, Albany, NY
1997	Marist College Basic Crime Scene Evidence Technician Course "Forensic Pathology Overview" and "Time of Death," Poughkeepsie, NY
1997	Washington County Mandated Reporter's Conference, "Child Abuse", NY
1997-2001	Capital District Forensic Officers' Group Course, "Death Investigation and DNA," Albany, NY
1997	Massachusetts Academy of Trial Attorneys, "The Use of Expert Witnesses," Boston, MA
1997	Indiana State Coroner's Association Seminar Lecturer, Evansville, IN
1998	New York State Police Major Crimes Seminar, "Forensic Pathology,", Albany NY

1998	National Association of Criminal Defense Lawyers, "Forensic Pathology: New Tools for the Defense," Santa Monica, CA
1998	Annual Tri-State International Association for Identification Educational Conference and Training Seminar, Albany, NY
1998	New York State Attorney General's Inspectors, "Investigation of Deaths and Injuries," Albany, NY
1998	Crime Scene and Evidence Technician Course, Capital Region Police Departments, Albany, NY
1998	SEAK National Expert Witness and Litigation Seminar, "Collection and Control of Trace Evidence," Hyannis, MA
1998	New York State Defender's Association Annual Conference, "Forensic Pathology: New Tools for the Defense," Corning, NY
1998-2003	New York State Police Henry F. Williams Homicide Seminar, "Child Deaths," Albany, NY
1998	MAGLOCLEN Information Sharing Conference, "The Changing Role of Forensic Science", Albany, NY
1998	New York State Correctional Health Care Symposium, "The Sudden In-Custody Death Syndrome," Saratoga, NY
1999	New York State Sexual Assault Nurse Examiner Association Symposium, "Patterns of Injury," Albany, NY
1999	New York State Association of County Coroners and Medical Examiners Spring Conference, "The Crime Scene and Trace Evidence," Saranac Lake, NY
1999	Indiana State Coroners' Association Conference, "Child Abuse," Evansville, IN
1999	New York Prosecutors Training Institute Seminar, "Use of the Medical Examiner to Enhance Domestic Violence Prosecution," Syracuse, NY

1999	New York State Association of County Coroners and Medical Examiners Fall Conference, “Gunshot Wounds,” Albany, NY
2000	Warren & Washington Counties Multidisciplinary Team Conference, “Child Abuse Injuries and Photographic Documentation,” Glens Falls, NY
2001	2000 New York State Association of County Coroners and Medical Examiners Fall Conference, “Kendall Francois; The Story of a Serial Killer,” Queensbury, NY
2001	Practical Homicide Investigation Advanced Course, “Forensic Pathology,” Columbus, OH
2002	Henry C. Lee Symposium, “Sex-Related Homicides,” New Orleans, LA
2002	Asian Association of Chiefs of Police Conference, “The Abused and Battered Child,” New Orleans, LA
2006-2008	Seminole County Child Protection Conference, “The Forensic Pathology of Child Abuse,” Orlando, FL
2007-2010	Course Director, United States/Canadian Academy of Pathology short course, “Fundamentals of Forensic Pathology; A Case-Based Approach”
2007	Seminole County Kids’ House, “Sudden Unexplained Infant Death Investigation,” Jacksonville, FL
2007	Florida Department of Law Enforcement Crimes Against Children, “The Forensic Pathology of Child Abuse,” Fort Myers, FL
2007	Jacksonville Naval Air Station, “Child Abuse; Physical Injuries and Sudden Unexplained Infant Death Investigation,” Jacksonville, FL
2007	Florida Department of Law Enforcement Crimes Against Children, “The Forensic Pathology of Child Abuse,” Pensacola, FL

2008	Practical Homicide Investigation Advanced Course "Forensic Pathology," "Domestic Violence Homicides" and "The Medicolegal Investigation of Child Homicides," Spartanburg, SC
2008	Florida Department of Law Enforcement Crimes Against Children, "Physical Abuse of Children" and "Sudden, Unexplained Infant Death Investigation," Tampa, FL
2008	National District Attorneys Association Prosecuting Homicide Cases Course, "The Multidisciplinary Investigation of Unnatural Deaths," Orlando, FL
2008	Florida Department of Law Enforcement Crimes Against Children, "Physical Abuse of Children" and "Sudden, Unexplained Infant Death Investigation," Daytona Beach, FL
2008	Seminole County Kids' House, "Sudden Unexplained Infant Death Investigation," Jacksonville, FL
2008	Florida Department of Law Enforcement Crimes Against Children, "Physical Abuse of Children" and "Sudden, Unexplained Infant Death Investigation," Melbourne, FL
2008	Bay Area Trauma Symposium, "Medical and Law Enforcement Collaboration in Child Homicide Investigation," Tampa, FL
2008	Practical Homicide Investigation Advanced Course "Forensic Pathology", "Domestic Violence Homicides" and "The Medicolegal Investigation of Child Homicides," Houston, TX
2008	Florida Children's Advocacy Center Multidisciplinary Conference on Child Abuse, "The Forensic Pathology of Child Abuse" and "Sudden, Unexplained Infant Death Investigation," Orlando, FL
2008	National District Attorneys Association Annual National Multidisciplinary Conference on Domestic Violence, "Domestic Violence Homicides," San Diego, CA

2008	Hodges University, “Fundamentals of Forensic Pathology,” Fort Myers, FL
2009	Practical Homicide Investigation for First Responders, “Patterns of Injury,” “Domestic Violence Homicides”, and “Sudden Unexplained Infant Death Investigation,” Ocala, FL
2009	National District Attorneys Association Prosecuting Homicide Cases Course, “Injury Causation in Homicide Cases,” Houston, TX
2009	“Child Injury and Death Scene Re-enactment and Scene Reconstruction”, Miami-Dade Medical Examiner Department, Miami, FL
2009	National District Attorneys Association Annual National Multidisciplinary Conference on Domestic Violence, “Domestic Violence Homicides,” San Antonio, TX
2009	“Child Injury and Death Scene Re-enactment and Scene Reconstruction,” Florida Department of Law Enforcement, Tallahassee, FL
2009	Lake-Sumter Medical Society, “Medicolegal Death Investigation and Death Certification in Florida,” Lake County, FL
2009	Florida Homicide Investigators’ Association Conference, “Homicide Investigation: Forensic Pathology,” Lake Mary, FL
2009	National District Attorneys Association Forensic Evidence Course, “Forensic Evidence: Wound Analysis and Autopsy” and “Forensic Identification: Defendants’ Manipulation of the Crime Scene,” San Diego, CA
2009	Marion County Medical Society, “Medicolegal Death Investigation and Death Certification in Florida,” Ocala, FL
2010	Workshop Co-Director, American Academy of Forensic Sciences annual meeting, “Determining the Manner of Death in Equivocal Death Investigations: Homicide, Suicide, Accident or Natural?”

2010	National District Attorneys Association Prosecuting Homicide Cases Course, “Injury Causation in Homicide Cases” and “Equivocal Death Investigation,” Orlando, FL
2010	American Professional Society on the Abuse of Children Annual Colloquium, “The Medicolegal Investigation of Child Abuse,” New Orleans, LA
2010	National District Attorneys Association Trial Advocacy Conference, Fairbanks, AL
2010	Alaska Department of Law Annual Conference, “Injury Causation in Domestic Violence Cases” and “Equivocal Death Investigation,” Girdwood, AL
2010	National Advocacy Center Arson and Explosives Course, “The Medicolegal Investigation of Fire Deaths,” Columbia, SC
2010	Florida Division of the International Association for Identification, “Sudden Unexpected Infant Death Investigation” St. Petersburg, FL
2010	National District Attorneys Association Twentieth Annual National Multidisciplinary Conference on Domestic Violence, “Establishing Medical Proof: Injury Causation in Domestic Violence Homicides,” Washington, DC
2010	Practical Homicide Investigation Advanced Course, “Patterns of Injury”, “Sudden Unexplained Infant Death investigation” and “The Medicolegal Investigation of Child Homicides,” Ocean Springs, MS
2010	National District Attorneys Association Forensic Evidence Course, “Forensic Evidence: Wound Analysis and Autopsy” and “The Investigation and Prosecution of Child Homicides,” San Antonio, TX
2010	South Carolina Criminal Justice Academy, “Establishing Medical Proof: Injury Causation in Domestic Violence Homicide Cases,” Columbia, SC

2011	South Carolina Division of the International Association for Identification, “Sudden Unexpected Infant Death Investigation” and “Physical Abuse of Children,” Columbia, SC
2011	National District Attorneys Association Prosecuting Homicide Cases Course, “Injury Causation in Homicide Cases,” San Francisco, CA
2011	National District Attorneys Association Career Prosecutors Course, “Mechanisms of Injury,” Charleston, SC
2011	Lake-Sumter Children’s Advocacy Center,” The Forensic Pathology of Child Abuse,” Leesburg, FL
2011	Lake-Sumter Medical Society, “Medicolegal Death Investigation and Death Certification in Florida,” Lake County, FL
2011	National District Attorneys Association Career Prosecutors Course, “Injury Causation in Homicide Cases” and “Staged Murders: What’s Wrong with this Crime Scene?,” Tucson, AZ
2012	Central Florida Community College, “Forensic Pathology for Law Enforcement,” Ocala, FL
2012	Lake-Sumter Children’s Advocacy Center, “Child Neglect and Sudden Unexpected Infant Death Investigation,” Leesburg, FL
2012	American Academy of Forensic Sciences annual meeting, workshop faculty, “Sex-Related Homicide and Death Investigation: Practical and Clinical Perspectives—Significance of Pornography, Sexual Deviance, Autoerotic Fatalities, Signature and MO, Serial Murder Investigation, as well as the Increase in African American Serial Killers Involved in These Events,” Atlanta, GA
2012	National District Attorneys Association Forensic Evidence Course, “Forensic Evidence: Wound Analysis in Homicide Cases” and “Evaluating Suspicious Deaths,” San Francisco, CA

2012	National District Attorneys Association Career Prosecutors Course, “Mechanisms of Death: Injury Causation and Analysis,” San Diego, CA
2012	National District Attorneys Association Forensic Evidence Course, “Wound Analysis: Homicide” and “Evaluating Suspicious Deaths,” Portland, OR
2012	South Carolina Solicitors’ Association Conference, “The Medicolegal Investigation of Unnatural Deaths,” Myrtle Beach, SC
2012	Florida Professional Society on the Abuse of Children Symposium on Neglect, the Forgotten Danger to Children, “Overview of Child Abuse and Neglect Deaths: Findings from the State Child Abuse Death Review Committee,” Tampa, FL
2012	National District Attorneys Association Prosecuting Homicide Cases Course, “Death Causation in Homicide Cases” and “Evaluating Child Deaths,” San Francisco, CA
2013	American Academy of Forensic Sciences annual meeting, workshop co-director, “Practical Homicide and Medicolegal Death Investigation: Practical and Clinical Perspectives Regarding the Homicide Investigation and the Medical Examiner’s Determination in Various Modalities of Death Including Child Deaths and Suicide,” Washington, DC
2013	National District Attorneys Association Forensic Evidence Course, “The Medicolegal Investigation of Fire and Explosion Deaths,” San Diego, CA
2013	Practical Homicide Investigation Advanced Course “Gunshot Wounds”, “Domestic Violence Homicides”, “The Investigation of Child Homicides” and “Asphyxial Deaths,” Coral Springs, FL
2013	National District Attorneys Association Prosecuting Homicide Cases Course, “Death Causation in Homicide Cases” and “Evaluating Child Deaths,” Seattle, WA

2013	National District Attorneys Association Prosecuting Sexual Assaults and Related Crimes Course, “Causes of Death in Sexual Assault Homicides” and “Evaluating Child Deaths,” Denver, CO
2013	Florida Department of Law Enforcement, “Evaluating Child Deaths: Sudden Unexpected Infant Death and Physical Abuse Investigations,” Tampa, FL
2013	National District Attorneys Association Forensic Evidence Course, “Death Causation in Homicide Cases” and “Evaluating Suspicious Deaths,” Los Angeles, CA
2014	Florida Emergency Medical Services Advisory Council, “Sudden Unexpected Infant Death Investigation,” Daytona Beach, FL
2014	National District Attorneys Association Prosecuting Homicides Course, “Death Causation in Homicide Cases” and “Serial Murders: Dispelling the Myth of the Profile of the Serial Killer,” San Francisco, CA
2014	National District Attorneys Association Career Prosecutors Course, “Injury Causation: Working With Your Medical Examiner,” San Diego, CA
2014	National District Attorneys Association Prosecuting Sexual Assaults and Related Crimes Course, “Causes of Death: Sexual Assault Homicides” and “Sexual Serial Killers,” Scottsdale, AZ
2014	National District Attorneys Association Domestic Violence: The Team Approach, “Death Causation in Domestic Violence Homicide Cases,” Ellicott City, MD
2014	National District Attorneys Association Forensic Evidence Course, “Wound Analysis in Homicide Cases” and “Evaluating Equivocal Death Scenes,” Coronado, CA
2015	National District Attorneys Association Prosecuting Homicide Cases Course, “Death Causation in Homicide Cases” and “Child Homicides,” New Orleans, LA

2015	American Academy of Forensic Sciences annual meeting, workshop co-director, “Practical Homicide Investigation: Offender-ManipulatedHomicide Scenes Relating to Equivocal Deaths and Stages Crine Scenes,” Orlando, FL
2015	National District Attorneys Association Special Offenses: Domestic Violence and Sexual Assault for the Prosecution Team Multidisciplinary Training, “Injury Causation in Domestic Violence and Sexual Assault,” Detroit, MI
2015	National District Attorneys Association Career Prosecutors Course, “Injury Causation: Working With Your Medical Examiner,” San Diego, CA
2015	National District Attorneys Association Prosecuting Sexual Assaults and Related Crimes Course, “Causes of Death in Sexual Assault Homicides” and “Sexual Serial Killers,” Seattle, WA
2015	National District Attorneys Association Forensic Evidence Course, “Wound Analysis in Homicide Cases” and “Staged Crime Scenes,” Savannah, GA
2016	American Academy of Forensic Sciences annual meeting, workshop co-director, “Practical Homicide Investigation: An Evaluation of Homicides Involving Child Victims, Child Offenders, and Equivocal Death Investigations,” Las Vegas, NV
2016	Naval Justice School Litigating Complex Cases course, “Forensic Pathology,” Newport, RI
2016	National District Attorneys Association Prosecuting Homicide Cases Course, “Cause of Death in Homicide Cases” and “Uncovering Staged Crime Scenes,” Phoenix, AZ
2016	National District Attorneys Association Course Protecting the Defenseless: Abuse Against Elders and Vulnerable Adults, “The Medicolegal Investigation of Elder Abuse,” Tampa, FL

2016	National District Attorneys Association Course Inside the Mind of a Killer, “Cause of Death in Homicide Cases” and “Uncovering Staged Crime Scenes,” Memphis, TN
2016	National Homicide Investigators Association Annual Course, “Updates in Medicolegal Death Investigation” and “Staged Crime Scenes,” Lake Mary, FL
2016	National District Attorneys Association Forensic Evidence Course, “Wound Analysis in Homicide Cases” and “Staged Crime Scenes,” Santa Fe, NM
2017	American Academy of Forensic Sciences annual meeting workshop faculty, “Sex-Related Homicide and Death Investigations: Practical and Clinical Perspectives—The Significance of Pornography, Sexual Deviance, Autoerotic Fatalities, Signature and Modus Operandi (M.O.) in Serial Murder Investigation and Criminal Investigative Analysis,” New Orleans, LA
2017	National District Attorneys Association Prosecuting Homicide Cases Course, “Cause of Death in Homicide Cases” and “Sexual Homicides,” Bellevue, WA
2017	National District Attorneys Association Prosecuting Sexual Assaults and Related Crimes Course, “Causes of Death: Sexual Assault Homicides,” Long Beach, CA
2017	National District Attorneys Association Prosecuting Homicide Cases Course, “The Medicolegal Investigation of Homicides in the Era of Crime TV Course,” St. Petersburg, FL
2017	National District Attorneys Association Special Offenses: Domestic Violence and Sexual Assault for the Prosecution Team Multidisciplinary Training, “Injury Causation in Domestic Violence Cases,” Little Rock, Arkansas
2017	National Homicide Investigators Association Annual Course, “Updates in Medicolegal Death Investigation,” Lake Mary, FL

2017	Palm Beach County Bar Association Course "The of Role of the Medical Examiner in Wrongful Death Cases: An Insider's Perspective," West Palm Beach, FL
2017	National District Attorneys Association Forensic Evidence Course, "Wound Analysis in Homicide Cases" and "Staged Crime Scenes," Phoenix, AZ
2018	National District Attorneys Association Investigating and Prosecuting Human Sex Trade and Labor Trafficking Cases Course, "Causes of Death: Sexual Assault Homicides," Miami, FL
2018	National District Attorneys Association Prosecuting Homicide Cases Course, "Cause of Death in Homicide Cases" and "Arson Homicides," Louisville, KY
2018	Florida Association of Medical Examiners 45th Annual Conference, "Anticipating Challenges to Forensic Evidence and Courtroom Testimony," Howey-in-the-Hills, FL
2018	National District Attorneys Association National Multidisciplinary Conference on Domestic Violence, "Cause of Death in Domestic Violence Homicides," Long Beach, CA
2019	National District Attorneys Association Prosecuting Homicide Cases Course Inside the Mind of a Killer, "Causes of death in Homicide: Part I—Adult Victims" and "Part II—Child Victims," Scottsdale, AZ
2019	National District Attorneys Association Prosecuting Sexual Assaults and Related Violent Crimes Course, "Through the Medical Eye: Sexual Assaults and Sex-Related Homicides of Adults and Children," Minneapolis, MN
2019	National District Attorneys Association National Multidisciplinary Conference on Domestic Violence, "Working With Your Medical Experts—Part I—Overview and Injury Causation—Blunt and Sharp Force Injuries" and "Part II—Injury Causation—Asphyxial Deaths and Firearm Injuries," Mesa, AZ

2019	2019 Annual Meeting of the National Association of Medical Examiners. Guszecki AC, Aiken S, Wolf BC, Arunkumar P, Mitchell R. "ISO17020:2012 Accreditation and NAME Accreditation: Our Experiences and Removing the misconceptions," Kansas City, MO
2019	National District Attorneys Association Forensic Evidence Course, 'Death Investigation Part I—The Autopsy, Science and Medicine: Cause of Death in Adult Victims" and "Death Investigation Part II—The Scene: Equivocal Deaths and Stages Crime Scenes, " New Orleans, LA

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62. Bayer LA, Wolf BC, Warren MW. The transgender consideration: the importance of reassessing unidentified human skeletal remains in order to provide new investigative directions. Proceedings of the 2017 Scientific Meeting of the American Academy of Forensic Sciences, 2017.

63. Wolf BC, Shaw K, Harding BE. Determination of intent: accident, suicide or homicide? The utilization of social behavioral science within the medicolegal death investigation process. Proceedings of the 2018 Scientific Meeting of the American Academy of Forensic Sciences, 2018.

Handout 11

Dr. George Behonick

Report

ENCLOSURE 1

Independent Report to The North Carolina Innocence Inquiry Commission

By George S. Behonick, Ph.D., F-ABFT

Re: State v. John Pritchard-11 CRS 304-305 (Yancey County)

List of Materials and Documents Reviewed

1. North Carolina Office of The Chief Medical Examiner Toxicology Laboratory Standing Operating Procedures (SOPs)

- 102- Basic Drug Detection by Gas Chromatography
- 130- Opiate Extraction Using SPE for Quantification by Gas Chromatography/Mass Spectrometry
- LC201- Multi-class Drug Screen Using Protein Precipitation for Detection by Liquid Chromatography/Ion Trap Mass Spectrometry/(LC/MS)
- NC-OCME-VOLATILES: Quantification of Volatile Hydrocarbons by Gas Chromatography/Flame Ionization Detection

2. Documents from the NC Office of The Chief Medical Examiner

3. Documents from the Watauga Medical Center (autopsy report)

4. Yancey County Sheriff's Office File

5. NC State Bureau of Investigation File

6. Trial Transcript

7. Documents from the Madison County Jail (decedent period of incarceration January 6, 2011 to March 4, 2011)

8. Documents from the Buncombe County Jail (decedent period of incarceration on/about March 4, 2011)

9. Unsigned draft affidavit of Dr. Christena Roberts

10. Letter from John Pritchard to Dr. Roberts

11. Deposition transcript of Dr. Brent Hall with Exhibits

12. Medical records of decedent Jonathan Whitson

ENCLOSOURE 2

AMENDED (November 8, 2021-Part III, page 4, date of telephone conversation with Dr. Winecker corrected to September 20, 2021)

Independent Report to The North Carolina Innocence Inquiry Commission

By George S. Behonick, Ph.D., F-ABFT

Re: State v. John Pritchard-11 CRS 304-305 (Yancey County)

Part I : Case History Summary

This report focuses on the activities and whereabouts of decedent Jonathan Russell Whitson, Jr. (DOB 1/20/1982), and the circumstances immediate to his being pronounced dead on March 6, 2011. In August 2010 and December 2010, Mr. Whitson's past medical and social history was remarkable for seeking treatment for intravenous abuse of Oxycontin®, and medical treatment of cellulitis in the left antecubital fossa secondary to intravenous drug injection.Mr. Whitson, twenty nine years old, secured release from the Buncombe County, NC jail on March 4, 2011. His release from Buncombe County followed a longer period of incarceration at another facility (Madison County, NC). Mr. Whitson made telephone contact with Floyd Joseph Ayers, his first cousin, late in the evening of March 4, 2011 to request a ride to the residence of Christine Angel. Ms. Angel is identified to be the step-grandmother to Mr. Whitson. Ms. Angel indicated Mr. Whitson arrived at her residence at approximately 0100 hours, March 5, 2011. Later that day, Ms. Stephanie Whitson came to the residence. She was informed by Mr. Whitson that Mr. John Pritchard was expected at the residence later in the afternoon. Shortly after his arrival to the residence, Mr. Pritchard and Mr. Whitson left the residence for a brief period of time to go to a store. Afterward, Ms. Whitson stated she was shown a number of 30 milligram morphine tablets by Mr. Whitson. She stated Mr. Whitson injected both himself and her with a number of morphine tablets that were melted down, while seated in a vehicle owned by Ms. Whitson's father. Both drove to another location, where Mr. Whitson again injected Ms. Whitson and himself. After returning Mr. Whitson to the residence of Ms. Angel at approximately 1800 hours, Ms. Whitson departed briefly to meet a friend at a fast food restaurant. She returned to the residence and stated that Mr. Whitson injected additional morphine (three times) to both himself and her. Ms. Whitson departed the residence at approximately 2150 hours, and asserts never having spoken to the decedent again. In court testimony, Christine Angel stated Mr. Whitson went to bed right after Ms. Whitson departed the residence. Ms. Angel awoke in the early morning (0600-0700 hours) of March 6, 2021 to find Mr. Whitson on the couch and snoring. She and her husband left for a brief time to go grocery shopping. Upon returning, they saw Mr.

Whitson remaining on the couch and still snoring. Ms. Angel prepared breakfast for the family members present, and all then ate with the exception of Mr. Whitson. Ms. Angel stated that Nathan Angel, the decedent's stepfather, instructed his son, Christian, to wake Mr. Whitson. It was then that they discovered Mr. Whitson to be deceased. The Yancey County Emergency Operations Center was notified of the death at approximately 1133 hours. Sergeant L.R. Higgins, Yancey County Sheriff's Office, arrived on scene at approximately 1140 hours. The decedent was found to be lying supine on a couch, legs straight, and covered by a blue blanket. The decedent's body was photographed, and Dr. Brent Hall, Medical Examiner at Watuga Medical Center was notified telephonically of the death. Further, Ms. Angel reported finding items in the decedent's coat pocket identified as syringes. These items were photographed, secured and cataloged as evidence. The decedent was transported to Watuga Medical Center. The next day, March 7, 2011, an autopsy was conducted by Dr. Hall. The remarkable findings from the autopsy included: Pulmonary edema and congestion (severe), acute bronchial pneumonia (moderate), pulmonary emphysema (mild) and cardiomegaly (mild), with left ventricular hypertrophy. External examination of the body demonstrated needle marks to be present in the left antecubital fossa and left forearm. Aorta blood, femoral vessel blood, urine and a sample of liver tissue were submitted to the Office of The Chief Medical Examiner Toxicology Laboratory, Raleigh, NC for postmortem toxicological analyses (see Part II Postmortem Analytical Toxicology). Initially, the Medical Examiner's Certificate of Death classified Mr. Whitson's cause of death as pending; afterward, with receipt of the final toxicology report, the cause of death was amended to morphine toxicity with a manner of death accident.

Part II: Postmortem Analytical Toxicology

The following postmortem specimens were accessioned into the Office of The Chief Medical Examiner Toxicology Laboratory, Raleigh, NC from Dr. Brent Hall on March 9, 2011: 6.0 milliliters (mL) of blood obtained from a femoral vessel, 16.0 mL of blood obtained from the aorta, 5.0 mL of urine collected from the urinary bladder, and a sample of liver tissue (no specimen amount/volume noted).

Analysis for volatile compounds (ethanol, methanol, isopropanol and acetone) was achieved by dual column Headspace-Gas Chromatography Flame Ionization Detection (HSGC-FID). The Limit of Detection (LOD) and Limit of Quantitation (LOQ) for ethanol by this testing is 20 milligrams per deciliter (mg/100 mL or mg/deciliter, mg/dL). The equivalent expression for 20 mg/dL is 0.020 grams per 100 mL (0.020 g/100 mL or 0.020% weight by volume). Testing for volatile compounds was performed in the specimen of blood obtained from the aorta and revealed an ethanol concentration of 40 mg/dL, or 0.040%.

The analysis for a comprehensive class of drugs was performed by Liquid Chromatography/Ion Trap Mass Spectrometry (LC/MS) following protein precipitation of the blood specimen with acetonitrile. After precipitation by the organic solvent, and evaporation under nitrogen, the specimen was analyzed by LC/MS with presumptive identifications of drugs

or drug metabolites by relative retention times and mass spectra. Morphine and nicotine were determined to be present in the aorta blood specimen; the cut off concentration for morphine as a target analyte by this method is 10 ng/mL. Notably, no other opiate/opioid drugs (including oxymorphone, with a cut off concentration 5 ng/mL), or organic basic drugs, benzodiazepine class drugs, or cocaine/cocaine metabolite were detected by this method.

Confirmatory and quantitative analysis for morphine was conducted by Gas Chromatography/Mass Spectrometry (GC/MS). This testing was conducted in the blood specimen collected from a femoral blood vessel. The dynamic calibration range for morphine by this method is 50 – 1,000 ng/mL; meanwhile, the calibration range for oxymorphone by this method is 25-500 ng/mL. Morphine was determined to be present in a 'trace' amount in the femoral blood specimen. No other opiates/opioids (including oxymorphone) were detected by this method.

Part III: Interpretation of Postmortem Toxicology Data

Ethanol 40 mg/dL (0.040%) - aorta blood: The likely reasons for detecting ethanol in postmortem blood are two-fold. Primarily, the finding is indicative of ethanol ingestion/consumption by a decedent; secondarily, it may represent a by-product of the decomposition of a cadaver. Bacteria, especially the enteric bacteria of the gut, proliferate rapidly in a postmortem state. In the presence of sugar and other substrates, bacterial metabolism results in the neo-formation of alcohol/ethanol. Depending on the postmortem interval (PMI), which is the elapsed time from death to blood collection at autopsy or examination, together with the physical and environmental conditions peculiar to the postmortem setting, substantial amounts of ethanol may be produced (~ 0.05% or 50 mg/dL). The investigative details and circumstances of this case are not suggestive of postmortem decomposition being a factor in the concentration of ethanol detected in blood sampled from the aorta. The neo-formation of alcohol is mitigated by a minimal PMI, proper specimen collection at autopsy using appropriate preservatives (sodium fluoride and potassium oxalate fortified collection vials), and maintaining the cadaver in a cooler prior to autopsy. With respect to consumption of an alcohol-containing beverage, a "standard drink" is defined as containing a standard amount of alcohol per serving; specifically, one twelve ounce beer, or four ounces of table wine, or one shot of 80-proof (40% volume by volume alcohol) liquor all contain approximately the same amount of alcohol. For further reference, one standard drink raises the blood alcohol concentration by 0.025% for a hundred and fifty pound male.

Morphine 'trace' – femoral blood: The morphine reported in this case represents *free morphine*, as opposed *to total morphine*. 'Trace' nomenclature in describing findings in a postmortem blood specimen is a semi-quantitative expression. This implies that the concentration of morphine detected is less than the lowest calibration point which defines the dynamic, linear range of the test method. Specifically, this lowest point or Lower Limit of Quantitation (LLOQ) for the North Carolina Office of The Chief Medical Examiner Toxicology

Laboratory opiate analytical method is 50 ng/mL; therefore, it can be inferred that morphine was detected in the femoral blood specimen at a concentration less than 50 ng/mL. To report a finding as such, the result must confirm to the acceptable criteria necessary for making a positive identification (satisfactorily meeting criteria such as retention time and mass spectral data defining the Limit of Detection, or LOD) by the GC/MS method. Dr. Ruth Winecker, Chief Toxicologist of the North Carolina Office of The Chief Medical Examiner Forensic Toxicology Laboratory in 2011, confirmed this reporting convention as being the standing procedure in place at that time during a phone conversation with me on September 20, 2021. As a 2011 case, the raw data for this analysis is unavailable for review; the records retention policy, in accordance with American Board of Forensic Toxicology accreditation standards, is five years.

Morphine 15 mg/L (15,000 ng/mL) – urine: The morphine result reported for the urine concentration represents *free morphine*; this being a laboratory analytical practice in place at the toxicology laboratory in 2011 and confirmed telephonically by Dr. Winecker. In human beings, the majority of administered morphine is inactivated by metabolism to morphine-3-glucuronide (M-3-G). More than 80% of a dose of morphine is eliminated in the 72 hour urine, with the majority as M-3-G. Only about 10% of a dose of morphine is accounted for as *free morphine* in urine [1].

Part IV: Opinions and Conclusions

- Despite the lack of affirmative evidence or statements related by witnesses addressing the decedent's apparent use of alcohol in the 24 hour period spanning March 5-6, 2011, the toxicology finding of 40 mg/dL is indicative of consumption/ingestion at some point in time before death. The average rate of alcohol elimination by human beings is 0.015% per hour, or 15 mg/dL per hour [2]. It is impossible to estimate what the decedent's blood alcohol concentration was for a given time point in the 24 hour period of March 5-6, 2011. Lack of information precludes making such an estimate; specifically, the time when drinking began and ended is unknown, the type of alcohol consumed (e.g. beer, wine, distilled spirits) is unknown, and an approximate amount of alcohol consumed (e.g. number of drinks) is unknown.
- The detection of alcohol and morphine in blood indicate the presence of two central nervous system (CNS) drugs in the decedent which may have implications as to the overall pharmacologic effects and toxicities experienced by the decedent [3]. The two substances produce CNS depressive effects by slightly different mechanisms (mu or μ receptor interactions by an opiate such as morphine, and GABA-A receptor interactions by alcohol). In an additive fashion, morphine and alcohol combine to enhance CNS depression. Respiratory depression may be a consequence of combined morphine and alcohol intoxication.
- Opiates and opioids depress the ventilator response by acting centrally on the medullary respiratory center to diminish sensitivity to elevations of carbon dioxide concentrations;

opioids also blunt the ventilator response to hypoxemia (reduced oxygen concentrations in blood). Opioids depress all aspects of respiration, which results in irregular and periodic breathing, ultimately leading to apnea (cessation of breathing). Morphine toxicity is manifested by an irregular breathing pattern with shallow breathing and hypercarbia (increased concentrations of carbon dioxide in blood), followed by hypoxia (reduced oxygen concentration in blood), bradypnea (reduced rate of respirations), then apnea [4].

- Drugs detected in urine assist in establishing exposure, or use, by an individual. In comparison to blood as a test matrix, urine affords a longer window of detectability. Generally, drugs are apparent and are able to be detected in blood in time periods defined by hours whereas urine can detect drug use that not only is associated with acute use (e.g. hours just prior to death), but to also reveal exposure that may have occurred several days beforehand. Furthermore, urine drug findings cannot infer impairment, toxicity or lethality in an individual; that is, drug or active drug metabolites have been excreted from the blood into urine and are no longer able to exert a pharmacological effect at a target site such as a receptor or organ system. Drug detection in urine in a postmortem setting can corroborate findings in blood.
- Understanding the possible origins for morphine in postmortem blood is essential to correct interpretation. When morphine is detected in postmortem blood there are three likely possibilities as a source. First, it may be derived from its own pharmaceutical form (e.g. MSContin®, Kadian®, Avinza®). Secondly, it can represent a metabolite of the drug codeine. Finally, morphine is a metabolite of heroin. Discerning the source of morphine in large part is based on case and decedent history and circumstances (e.g. prescription history, scene evidence, etc.); furthermore, as a metabolite of a codeine-containing drug (e.g. Tylenol III®), only a small amount of morphine, relative to codeine concentration, would be expected. It is not typical to see morphine as metabolite of codeine when the parent drug codeine itself is not present. Finally, although morphine and/or codeine can be detected in cases of heroin use, other evidence (e.g. detection of 6-acetylmorphine or 6-AM in blood or urine, physical evidence at a death scene, and decedent history) is necessary in drawing the conclusion of heroin use by a decedent.
- Oxymorphone was not detected in either the blood or urine of decedent Johnathan Whitson by either LC/MS or GC/MS methods. Mention is made of this since a witness related to law enforcement that the drug Opana® (oxymorphone hydrochloride) **may** have been implicated in Mr. Whitson's death (Review of Yancey County Sheriff's Department Files, Bates 000033).
- Tolerance is defined as reduced responsiveness to a drug, also known as desensitization. Practically, it is characterized by a need to increase the dose of a drug to achieve a particular desired effect (e.g. analgesia or pain relief for a chronic pain patient, or the euphoria or "high" associated with a drug such as heroin). It may complicate certification of cause of death when a decedent was known to be on long term or chronic opioid

therapy. Tolerance may impart better ability for an individual to withstand the toxic effects of a drug that are normally associated with higher doses. Nevertheless, tolerance to respiratory depression is quickly lost during periods of abstinence/withdrawal from a drug. Substantial reduction in tolerance to the respiratory depressive effects of a drug occurs in individuals who then begin using a drug following a period of withdrawal/abstinence [4]. Chronic opioid users may die from the respiratory effects of a drug when they consume what is a 'typical' dose for them following a period of abstinence or withdrawal. This is a scenario which frequently plays out when an individual is released from being incarcerated in prison or jail, or from an extended period of inpatient hospitalization/ rehabilitation. Users return to previous drug habits and to self-administering usual doses to only then suffer the consequences of lost or diminished tolerance to that drug.

- It is beyond the scope of expertise for a toxicologist to opine as to the absolute cause of death of an individual; however, this does not limit a toxicologist from addressing the toxicological impact of any substance found in the toxicological analyses of specimens from a postmortem case [5].

Part V: References

[1] Baselt, R.C. (2020) Morphine. *In*: Disposition of Toxic Drugs and Chemicals in Man, 12th edition, pp. 1428-1431, Biomedical Publications, Seal Beach, CA

[2] Levine, B. (2010) Alcohol. *In*: Principles of Forensic Toxicology, 3rd edition, Chapter 11, pp.175-190, AACC Press, Washington, DC

[3] Davis, G.G. (2013) Recommendations for the investigation, diagnosis, and certification of deaths related to opioid drugs. Academic Forensic Pathology, 3 (1): 62-76

[4] Dolinak, D. (2013) *In*: Forensic Toxicology: A Physiologic Perspective, pp. 221 and 246-250, Academic Forensic Pathology Inc., Calgary, CA

[5] ANSI/ASB Best Practice Recommendation 037 (2019) Guidelines for opinions and testimony in forensic toxicology. AAFS Standards Board, LLC, Colorado Springs, CO

George S. Behonick, Ph.D., F-ABFT

AXIS
FORENSIC TOXICOLOGY

November 8, 2021

The North Carolina Innocence Inquiry Commission

ATTN: Ms. Julie Bridenstine, Staff Attorney

P.O. Box 2448

Raleigh, NC 27602

RE: State v. John Pritchard-11 CRS 304-305 (Yancey County)/Record of Expert Witness Testimonies

Dear Ms. Bridenstein:

Herein please find my response to your questions posed in your electronic mail message of November 4, 2021. With respect to my record of testimonies as an expert witness, please be aware that effective July 2016 Axis Forensic Toxicology became incorporated and purchased the Forensic Toxicology Business Unit from American Institute of Toxicology (a/k/a AIT Laboratories). I began my tenure as a toxicologist with AIT Laboratories in November 2009. Beginning in August 2011 to the present, I testified as an expert in forensic toxicology in a total of 53 cases. Of this number, testimony was rendered in 19 states and 10 federal courts. During this period of time, I was deposed as an expert in forensic toxicology in 24 cases. A record of court testimonies and depositions is available upon request. Prior to 2011, in my work experience as a forensic toxicologist I have also rendered testimony while serving in positions in Massachusetts and Virginia; however, I did not formally tally, or maintain a record of these testimonies. I can categorically state to you that I have never failed to qualify as an expert witness in forensic toxicology, nor have I ever been excluded from a case as an expert in forensic toxicology.

With respect to specifics as to the proportion of cases I have testified as an expert in forensic toxicology on behalf of the plaintiff or defense, a reasonable approximation is 75-80% as a witness for the plaintiff or state. The relative proportion is dictated by the clientele make-up of Axis Forensic Toxicology, the majority of the laboratory's client base is built upon medical examiner and coroner jurisdictions, and the criminal litigations which emanate from the death investigations by these agencies are primarily driven as state or federal prosecutions. Finally, I receive no compensation for rendered witness testimony or consultations; I am a salaried employee of Axis Forensic Toxicology and financial compensation for expert testimony, and associated expenses incurred for testimony are based upon a professional fee schedule maintained and administered by Axis. Payment for such services is made directly to Axis Forensic Toxicology, Inc.

Sincerely,

George S. Behonick, Ph.D., F-ABFT

Director, Chief Toxicologists

P.O. Box 681513
Indianapolis, IN 46268

Phone: (317) 715-0448
Fax: (317) 481-8872

Handout 12

Dr. George Behonick CV

CURRICULUM VITAE

As of October 2021

George S. Behonick BS, MS, Ph.D., F-ABFT

Axis Forensic Toxicology

P.O. Box 681513

Indianapolis, Indiana 46241

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Email: gbehonick@axisfortox .com

CURRENT POSITION

Director, Chief Toxicologist-Axis Forensic Toxicology, Indianapolis, IN

(Effective July 2016 Axis Forensic Toxicology became incorporated and purchased the Forensic Toxicology Unit from American Institute of Toxicology, Inc., aka AIT Laboratories)

- Ensures compliance to ABFT/ISO17025(ANAB), CAP and CLIA accreditation standards
- Approval authority to all technical standing operating procedures (SOPs)
- Provides oversight to and approval authority for the validation and re-validation procedures of analytical methods
- Scientific technical advisor to laboratory executive and business management groups
- Reviews/certifies forensic toxicology reports
- Provides expert scientific testimony in criminal/civil litigations and depositions
- Compiles written scientific opinions and interpretation to clients
- Consults with medical examiners, coroners, law enforcement and prosecuting/defense attorneys and other stakeholders

PRIOR ACADEMIC APPOINTMENT (2005-09)

Assistant Professor of Pathology

Department of Pathology

University of Massachusetts Medical School

Worcester, MA

EDUCATION

High School: Pope John XXIII Regional High School 1971-75, Sparta NJ (Diploma)

EDUCATION (Cont.)

Preparatory School: Admiral Farragut Academy Naval Preparatory School 1975-76, Pine Beach, NJ (Postgraduate Certificate)

Undergraduate: The Citadel 1976-80, Charleston, SC (BS)

Graduate: Hahnemann University 1980-83, Philadelphia, PA (MS)

Graduate: St. John's University 1992-1997, Jamaica, NY (Ph.D.)

Postdoctoral: Research Associate, National Research Council/National Academy of Sciences, U.S. Army Medical Research Institute of Chemical Defense (USAMRICD), Edgewood Area-Aberdeen Proving Ground, MD, 1997-98

OTHER TRAINING

The care and use of laboratory animals (short course), Renaissance Research Associates August 1997, USAMRICD, Edgewood Area-Aberdeen Proving Ground, MD

Fundamentals of alcohol testing and interpretation, SOFT Annual Meeting Workshop, Salt Lake City, UT, October 1997

American Red Cross adult CPR course, USAMRICD, Edgewood Area-Aberdeen Proving Ground, MD, November 1997

Drug testing and forensic analyses seminar, Hewlett Packard-Wilmington, DE, March 1998

Liquid chromatography electrochemical detection (LCEC) and chromatography control and data acquisition workshop, Bioanalytical Systems, Inc. -Neptune, NJ, April 1998

Postmortem pediatric forensic toxicology: Issues in childhood poisoning, American Academy of Forensic Sciences Workshop, Orlando, FL, February 1999

Marijuana: A forensic symposium, American Academy of Forensic Sciences Workshop, Orlando, FL, February 1999

Intoxilyzer 5000 Breath Alcohol Operator Course, Division of Forensic Science-Richmond, VA, December 1999

Benzodiazepines: Pharmacology and analytical challenges, SOFT Annual Meeting Workshop, Milwaukee , WI, October 2000

"Observations and Facts": The September 11, 2001World Trade Center Attacks, National Medical Services, Willow Grove, PA, June 2002

Agilent GC-MSD ChemStation and Instrument Operation (Course No. H4043A), Richmond , VA, July 2002

Statistics and Method Validation: FBI Laboratory Symposium on Forensic Toxicology, Joint SOFT/TIAFT Meeting, Washington, DC, August 30-September 3, 2004

OTHER TRAINING (Cont.)

Poisons and Poisoners-What a toxicologist needs to know, FBI Laboratory Symposium on Forensic Toxicology, Joint SOFT/TIAFT Meeting, Washington, DC, August 30-September 3, 2004

SOFT/AAFS guidelines & forensic toxicology laboratory accreditation, FBI Laboratory Symposium on Forensic Toxicology, Joint SOFT/TIAFT Meeting, Washington, DC, August 30-September 3, 2004

The postmortem "blood drug screen", SOFT Annual Meeting Workshop, Nashville, TN, October 2005

Postmortem toxicology interpretation, SOFT Annual Meeting Workshop, Nashville, TN, October 2005

Method validation and measurement of uncertainty for dummies...and smarties too, SOFT Annual Meeting Workshop, Austin, TX, October 2006

CE committee: How does your QA/QC program measure up? SOFT Annual Meeting Workshop, Austin, TX, October 2006

Benzodiazepines: The basics and beyond, SOFT Annual Meeting Workshop, Durham, NC, October 2007

LC-MS in the 21 st century, SOFT Annual Meeting Workshop, Durham, NC, October 2007

Preparing for ISO 17025 accreditation-what you need to know, SOFT Annual Meeting Workshop, Phoenix, AZ, October 2008

Pain management and addiction, SOFT Annual Meeting Workshop, Phoenix, AZ, October 2008

Crawford Motions: The right to confrontation & how recent rulings may affect forensic laboratory management and expert testimony, SOFT Annual Meeting Workshop, Oklahoma City, OK ,October 2009

Envenomations: Toxins, anti-venoms & clinical course, SOFT Annual Meeting Workshop, Oklahoma City, OK, October 2009

Autopsy hair collection-just pull it, SOFT Annual Meeting Workshop, Oklahoma City, OK, October 2009

Use of pharmacogenetics in personalized pain management, SOFT Annual Meeting Workshop, Richmond, VA, October 2010

A stroll through the cannabinoid field: Pharmacology, therapeutics and untoward effects, SOFT Annual Meeting Workshop, Richmond, VA, October 2010

Beyond the numbers: An objective approach to forensic toxicological interpretation, American Academy of Forensic Sciences 65th Annual Scientific Meeting Workshop (#6), Washington, DC, February 2013

Ohio's assertive approach to scheduling opioids and fentanyl analogs, American Academy of Forensic Sciences 70th Annual Scientific Meeting Workshop (#5), Seattle, WA, February 2018

Fentalogs: Chemistry, pharmacology, and toxicology of illicit fentanyl and emerging opioids, American Academy of Forensic Sciences 70th Annual Scientific Meeting Workshop (#20), Seattle, WA, February 2018

Cannabis impaired driving, SOFT Annual Meeting Workshop (SOFTember Virtual Meeting), September 2020

OTHER TRAINING (Cont.)

GC-MS and LC-MS/MS method development-a step by step guide, SOFT Annual Meeting Workshop (SOFTember Virtual Meeting), September 2020

A new realm of novel psychoactive substance (NPS) opioids and NPS benzodiazepines –analytical and interpretive considerations, American Academy of Forensic Sciences 73rd Annual Scientific Virtual Meeting-Workshop (#11), February 2021

Strategies for screening of NPS in forensic toxicology, SOFT Annual Meeting Workshop, Nashville, TN, September 2021

MILITARY SERVICE

Commission: United States Army, May 17, 1980

Branch: Medical Service Corps

Active Duty: October 1982-December 1992, Honorable Discharge, rank CPT

Reserve Duty: January-October 1993, Honorable Discharge, rank CPT(P)

POSITIONS HELD/WORK EXPERIENCE

July 2016 – Present: Director, Chief Toxicologist, Axis Forensic Toxicology

November 2009-July 2016: Toxicologist, AIT Laboratories, Indianapolis, IN

January 2005-November 2009: Director, Forensic Toxicology UMass Memorial Medical Center Department of Hospital Laboratories and Assistant Professor, Department of Pathology, University of Massachusetts Medical School, Worcester, MA

2001-December 2004: Forensic Toxicologist, Commonwealth of Virginia Department of Criminal Justice Services, Division of Forensic Science-Western Laboratory, Roanoke, VA

1998-2001: Forensic Scientist, Commonwealth of Virginia Department of Criminal Justice Services, Division of Forensic Science-Western Laboratory, Roanoke, VA

1997-1998: NRC Postdoctoral Research Associate, U.S. Army Medical Research Institute of Chemical Defense, Edgewood Area-Aberdeen Proving Ground, MD

1993-1996: Teaching fellow, Department of Pharmaceutical Sciences, College of Pharmacy and Allied Health Professions, St. John's University, Jamaica, NY

1991-1992: Personnel counselor, U.S. Army Health Professional Support Agency, Washington, DC with duty at Fort Totten, NY

1989-1991: Chief , Special Chemistry, 10th Medical Laboratory, Landstuhl, Germany

March 1989-May 1989: U.S. Army Combined Arms Services Staff School, Fort Leavenworth, KS

1988 -1989: U.S. Army Medical Department Officers' Advanced Course, Fort Sam Houston, TX

POSITIONS HELD/WORK EXPERIENCE (Cont.)

1986-1988: Chief, Pathology Service, Fox Army Community Hospital, Redstone Arsenal, AL

1985 -1986: Officer- In- Charge, Emergency Procedures (STAT} Laboratory, Dwight David

Eisenhower Army Medical Center, Fort Gordon, GA

1984-1985: Medical Service Corps Clinical Laboratory Officers' Course, Walter Reed Army Medical Center, Washington, DC

1983 -1984: Medical Platoon Leader, 5th Battalion, 16th Infantry, 1st Infantry Division (Mechanized), Fort Riley, KS

October 1982-December 1982: U.S. Army Medical Department Officers' Basic Course, Fort Sam Houston

HONORS AND AWARDS

National Honor Society, Pope John XXIII Regional High School, Sparta, NJ

Magna Cum Laude, Admiral Farragut Academy, Pine Beach, NJ

Dean's List-7 Semesters, The Citadel

Gold Stars (High Honors), The Citadel

Army Service Ribbon

Army Achievement Medal

Army Commendation Medal with two oak leaf clusters

Army Meritorious Service Medal

National Defense Service Ribbon

Expert Field Medical Badge

Outstanding Young Men of America, 1990

Beta Beta Beta Biological Honor Society, The Citadel chapter

Rho Chi Honor Society, St. John's University chapter

June K. Jones Scholarship-American Academy of Forensic Sciences Toxicology Section, 1996

Society of Forensic Toxicologists Educational Research Award, 1996

NRC/National Academy of Sciences Research Associateship, 1997

Cambridge Who's Who Registry of Executives, Professionals and Entrepreneurs, 2009-2010

SCHOLARSHIPS

United States Army-The Citadel

Spirit of '76 Scholarship-The Citadel

Teaching Fellowship-St. John's

PROFESSIONAL CERTIFICATIONS

F-ABFT, Fellow-American Board of Forensic Toxicology (ABFT Certificate No. 1021, September 2004), re-qualification effective January 1, 2020 through December 31, 2024

New York State Department of Health Certificate of Qualification, Laboratory Director with qualification in the categories of Forensic Toxicology and Therapeutic Substance Monitoring/Quantitative Toxicology, expiration September 2023

PROFESSIONAL AFFILIATIONS

American Academy of Forensic Sciences-Toxicology Section

Society of Forensic Toxicologists

TEACHING EXPERIENCE

1993-1996: Biopharmaceutical chemistry laboratory (3 semesters), Human Anatomy and Physiology laboratory (4 semesters, 2 summer sessions), College of Pharmacy and Allied Health Professions, St. John's University

2006-2009: Resident and Fellow Rotation Forensic Toxicology, Massachusetts Office of the Medical Examiner (Forensic Medicine Fellowship training) and University of Massachusetts Medical School Department of Pathology Residency Training, Worcester, MA

2013-Present: Forensic Medicine Fellow Toxicology Laboratory Rotation training

FUNDED RESEARCH

National Institutes of Health (NIH)/National Institute on Drug Abuse (NIDA), grant# 1 R03 DA019047-01Al, Opioid mortality in southwestern Virginia , co-investigator, August 5, 2005-November 2007

SCIENTIFIC PUBLICATIONS AND PRESENTATIONS

Chapters

Baskin, S.I. and Behonick, G.S. Cardiac toxicology *In:* General and Applied Toxicology, Vol. 2 (2nd ed.), eds. Ballantyne, B., Marrs, T. and Syversen, T. Macmillian Reference Ltd, London and Grove's Dictionaries Inc., pp. 803-826 (1999)

Journal Articles (Peer Reviewed)-19

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Beyond the Numbers: An objective approach to forensic toxicological interpretation (Presenter/Faculty), *The Role of Tolerance in Toxicological Interpretation.* American Academy of Forensic Sciences 65th Annual Meeting (Workshop #6), Washington, DC (2013)

Handout 13

Dr. Christopher Holstege

Report

Medical Toxicology

November 15, 2021

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Re: Whitson, Jonathan Russell Jr. (deceased)

Dear Ms. Bridenstine,

The following review and synopsis was written by me at your request. I was initially contacted about the Whitson case by faculty within the University of Virginia's Institute of Law, Psychiatry, and Public Policy after you contacted them requesting assistance. I have also attached my current resume. In brief, I am a University of Virginia Professor within the School of Medicine, Chief of the Division of Medical Toxicology, and Director of the Blue Ridge Poison Center. I clinically provide care for poisoned patients presenting to University of Virginia Health, provide call coverage for the poison center, and serve as a practicing member of the emergency medicine faculty. I have numerous ongoing research projects in clinical, basic science and epidemiologic arenas with over 200 publications in medical journals, periodicals, and books. I have edited or authored 10 books and am the lead editor of the book entitled *Criminal Poisoning – Clinical and Forensic Perspectives*. I am a Diplomate of both the American Board of Medical Toxicology and the American Board of Emergency Medicine.

I have testified in court as an expert in four past murder cases (Essa, Ferrante, Merlino, Vatter). I have never been excluded as an expert. For the four cases above, I was retained by the prosecution as an expert. I have served as a consultant to the FBI's Critical Incident Response Group. Due to time commitments at the University of Virginia, I am exceedingly selective on the cases I decide to personally review as an expert. By agreement, the Commission has agreed to reimburse for time away from my duties at a rate of $320 per hour.

I reviewed the records provided by you and your team regarding Jonathan Russell Whitson, Jr. The records sent to me are contained in the following files:

- 102 - Basic Drug Detection by Gas Chromatography.pdf
- 130 - Opiate Extraction using SPE for Quantification.pdf
- 2020.02.06 FSR Review of Yancey County Sheriff's Office File.pdf
- 2021.03.30 Subpoenaed records from Buncombe County Sheriffs Office.pdf
- 2021.04.09 Response from HSHP re Subpoena to Madison Co SO.pdf
- 2021.04.28 FSR re Review of SBI File.pdf
- 2021.07.30 Dr. Brent Hall Deposition.pdf
- 2021.09.06 Report by Dr. McLemore.pdf
- Affidavit - Dr Cat Roberts re Pritchard 12-20[5050] edits.docx
- Combined Files from YCSO.pdf
- Combined Madison County Jail Records.pdf
- Combined SBI File.pdf
- Exhibit 1 - Dr. Hall Deposition Subpoena.pdf
- Exhibit 2 - Dr. Hall CV from Court File.pdf
- Exhibit 3 - Watauga Medical Center Autopsy Documents.pdf
- Exhibit 4 - OCME Autopsy Documents.pdf
- Exhibit 5 - Documents from Dr. Hall.pdf
- Exhibit 6 - YCSO Higgins Report.pdf
- Exhibit 7 - Dr. Hall Trial Testimony.pdf
- Exhibit 8 - Toxicology Report via Email to Dr. Hall.pdf
- Exhibit 9 - YCSO Farmer Report.pdf
- Exhibit 10 - The Patient Safety League Dr. Hall Articles.pdf
- Exhibit 11 - Dr. Hall Interim Non-Practice Agreement.pdf
- Exhibit 12 - Dr. Hall Consent Order.pdf
- Exhibit 13 - Dr. Hall Order Dissolving Interim Non-Practice Agreement.pdf
- LC201 - Multi-Class Drug Screen using Protein Precipitation for Detection.pdf
- Letter from Pritchard to Dr. Roberts.docx
- Mission Hospital Medical Records.pdf
- NC OCME VOLATILES Quantification of Volatile Hydrocarbons.pdf
- 2021.03.09 FSR re Review of Trial Transcript.pdf
- 2021.04.07 Subpoenaed Files from Watauga M.E. Office.pdf
- 2021.04.12 Subpoenaed Records from Office of Chief Medical Examiner.pdf
- 2021.10.04 Signed Report by Dr. Behonick.pdf
- 2021.10.18 Signed Report by Dr. Wolf.pdf
- Transcript - State V. Pritchard - April 14, 2014 - Volume 1 of 1 (2).pdf

On March 6th, 2011, Jonathan Russell Whitson, Jr. was found dead in a home. Mr. Whitson had a documented history of opioid abuse with intravenous injection of substances. He also had a history of complications associated with his opioid abuse, specifically abscess formation and cellulitis requiring hospitalization. The Mission Hospital Medical Records (Mission Hospital Medical Records.pdf) reviewed demonstrated the following:

History and Physical – 12-27-2010
Dictator: Jennifer L Love, MD
Chief complaint: Left arm pain
HISTORY OF PRESENT ILLNESS: Mr. Whitson is a 28-year-old man with no prior medical history who presented to the emergency department today after experiencing 1 week of arm pain, erythema and swelling. Ten days ago a friend injected morphine into his left antecubltal space. Approximately 2 days after the injection, he noticed some erythema and pain in that area. Symptoms progressed over the next week. A couple of days ago he started experiencing fevers and chills. His girlfriend then prompted him to come to the emergency department. He does admit to prior IV drug use, "but I'm not a druggie." He has not been taking anything or doing anything to his left arm or try to make it better.
SOCIAL HISTORY: The patient smokes a pack of cigarettes a day and has done so for about 8 years. He denies alcohol. He admits to occasional IV drug use.
PHYSICAL EXAM: EXTREMITIES: The left antecubital space is erythematous and indurated; it is tender to touch; there is no fluctuance, no purulent drainage.
LABORATORY DATA White count 13 with a left shift... CT scan of the elbow with contrast shows probable small subcutaneous abscess in the antecubital region with associated cellulitis and venous thrombosis. It measures 8 mm, but difficult to accurately define. The elbow joint is normal with no joint effusion. There is thrombosis of the superficial draining veins.
ASSESSMENT AND PLAN: Left arm cellulitis with superficial vein thrombosis: The patient will be admitted to a medical bed. Blood cultures have been sent. We will continue him on clindamycin IV.

Discharge Instructions – 12-30-2010
DIAGNOSIS: Left antecubital cellulitis after street injection; tobacco; abuse IV narcotic abuse.
clindamycin (clindamycin), 300 mg, Oral, Four times a day, 14 Days

ER Report – 08-18-2010
Dictator: Allen W Lalor, MD
Chief complaint: Requesting detoxification
History: He has been injecting IV OxycoContin 3 times a day. He started abusing drugs he was 15…He does not take other street drugs. He is wanting to get off the drugs and wanting to get on Suboxone and get into a narcotic treatment facility…He has no

abscesses or area of inflammation over his antecubital fossae. He denies suicidal or homicidal ideation.
Blood alcohol is 0. Urine drug screen is positive for opiates.
The gentleman became more and more impatient and seemingly manipulative. The girlfriend asked if we could give the medication to her, and she would give it to him and tell him it was something else. I told her we could not ethically do that. He voiced to Stirling that he wanted to go to a methadone clinic….
Dictator: Mary S Barlow, NP
This is a 28-year-old male who presents to our emergency department and notes that he has been using OxyContin intermittently since the age of 15, He describes a slow ascension into the use of street OxyContin beginning with Percocet at that age. The patient tells me that for the last 6 months he has taken approximately 250 mg of this per day. He injects it intravenously.

Mr. Whitson was discharged from the hospital on 12-30-2010. He was subsequently incarcerated on 01-06-2011 in the Madison County Jail. The Combined Madison County Jail Records.pdf file documented the following:

Date Booked - 01-06-2011 18:16
Medical Questionnaire Information:
- *Does the inmate use alcohol? No*
- *Does the inmate appear to be under the influence of drugs or alcohol? No*
- *Does the inmate appear to have any withdrawal symptoms? No*
- *Is the inmate presently taking medication for other? No*

Items "returned" 3/4/2011 18:26

Mr. Whitson was prescribed clindamycin (300 mg oral, four times a day for 14 days) on 12-30-2010 when discharged from the Mission Hospital for his abscess and cellulitis. However, on 01-06-2011 (~ 1week after his hospital discharge), the records from the jail do not note his need to continue the clindamycin when he was incarcerated and he did not complete his antibiotic course for his arm abscess as instructed on discharge from the hospital.

In regards to the files pertaining to Mr. Whitson's death provided to me, the following records and notes were viewed as pertinent to this case:

2021.04.28 FSR re Review of SBI File.pdf

Case Identification Report dated 2/12/2013

NOTES: Synopsis: On 3/6/2011, Jonathan Whitson (Whitson) was found dead at a residence in Yancey County. Autopsy reports indicates that Whitson died from morphine toxicity. The SBI was requested to assist with interviews regarding this investigation.

Defendant/Suspect Disposition and Closing Report

NOTES: Remarks: On 3/6/2011, Whitson was found dead at a residence in Yancey County. Whitson's death was caused by Morphine toxicity. SBI assistance was requested to assist with interviews.

Tammy Mae Joann Ayers Interview dated 9/26/2011

Ayers was interviewed by SA Vines and Deputy Higgins at the Yancey County Sheriff's Office Annex. Ayers said she was at residence of Nathan Angel (Angel) day before Whitson's death. When she arrived, Angel and Stephanie Whitson (Stephanie) were there. Robbie Silver may have been there. Whitson was leaving as she arrived with Pritchard in a silver truck (she believed). Ayers stayed at residence while Whitson was gone. Ayers asked Angel if Whitson was going to score 30s (reference to morphine). Angel said he was. As she was driving away, Whitson and Pritchard were returning. Ayers did not speak to either. Ayers spoke to Stephanie, Whitson's girlfriend. Stephanie said Whitson got 30s from Pritchard and that she and Whitson did four to five of the pills at Angel's and Whitson had the remaining pills. Ayers said Angel had gotten pills for her in the past from Pritchard, but she never bought them directly from Pritchard. Robbie Brown told her that she knew Pritchard sold the morphine to Whitson. Most of the pills were given to Whitson on credit or were fronted to Whitson. Ayers thought Pritchard got his pills from Tennessee. Angel told Ayers during the funeral visitation that if Stephanie would not have had any money, then Whitson would not have bought the pills.

Predication Interview dated 9/26/2011.pdf

Handwritten Notes, Emails, and Investigative Documents Submitted by Vines dated 2/15/2012

Attached to the report is a copy of the handwritten notes, emails, and investigative documents submitted by Vines for 9/26/2011 through 2/15/2012. -Tammy Ayers interview: notes indicate Whitson was gone with Pritchard for around 30 minutes. Truck described as two-door Toyota. Notes say something about "10" in reference to pills? Robbie Brown told her most of the pills given to Whitson were given on credit or fronted. -Robbie Brown interview: store they went to was Riddles; Aaron Collins lived with Pritchard; saw Pritchard give two pills to Whitson around Christmas—they first met in the fall of 2010

Combined Files from YCSO.pdf

Incident/Investigation Report Narrative

On 03/06/2011 at approximately 11:33 a call was received by the Yancey County Emergency Operations Center. The Emergency Operations Center then relayed the call information to the Yancey County Sheriff's Office, which consisted of a white male being found deceased at 410 English Branch Road. Upon arrival to the scene at approximately 11:40 the residence was

entered and the deceased, who was observed to be Jonathan Russell Whitson Junior was found to be lying on the living room couch. The deceased who was twenty nine years of age was observed to be lying flat on his back with his legs straight out covered by a blue blanket. The reporting person and an occupant of the residence Christine Angel was then contacted. Christine Angel along with her husband Wade Angel, son Nathan Angel, and grandsons Christian and James Angel were all noted as being present at the residence during the time in which the death occurred. Christine Angel who was a step-grandmother to the deceased stated that Whitson had been incarcerated and just recently released. Angel also stated that Whitson had arrived to her residence on 03/05/2011 at approximately 01:00. Angel stated that Whitson's girlfriend Stephanie Whitson had come to the residence on 03/05/2011 at approximately 14:3. Angel stated that the two had left the residence together returning approximately an hour and a half later. Angel stated that upon returning to her residence that Stephanie Whitson stayed until approximately 21:30 before leaving. Angel stated that the deceased then prepared to go to sleep on the living room couch.

Angel stated that she woke on 03/06/2011 at approximately 09:00 and Jonathan was still asleep on the couch snoring loudly. Angel stated that she and her husband Wade left the residence traveling to Burnsville to Sav-Mor supermarket returning at approximately 10:30. Angel stated that upon their return Jonathan was still asleep on the couch and still snoring. Angel stated that she then cooked and that everyone but Jonathan ate. Angel stated that her son Nathan, who was the deceased's stepfather, then told his son Christian to wake Jonathan up. Angel stated that it was then that they discovered Jonathan was deceased. Upon completion of the statement obtained from Christian Angel the body of the deceased was photographed. Medical Examiner Brent Hall of Watauga Medical Center was contacted by telephone and made aware of the death at which time he agreed to receive the body for autopsy. The deceased's mother Ann Annette Green, who had arrived to the residence, requested to use Yancey Funeral Services for burial. Yancey Funeral Services was then contacted-and requested to be en-route to the residence to transport the body. Yancey Funeral Service assistants John Paul Kirk and Scottie Mathis arrived to the residence at approximately 13:18. Christine Angel then revealed that she had discovered items in Jonathan's coat pocket. Upon observing the inside coat pocket a syringe was located and upon a search of the contents of the pocket an additional syringe was located as well. The items were then photographed and seized as evidence. Yancey Funeral Services then took custody of the body and transported the deceased to Watauga Medical Center.

Combined SBI File.pdf

CASE IDENTIFICATION REPORT
Yancey SH/Sgt. R. Higgins/Same as RO/LA. On 03/06/2011, Jonathan Russell Whitson was found dead at a residence in Yancey County. Autopsy reports indicates that Whitson died from Morphine Toxicity. The SBI was requested to assist with interviews regarding this investigation.

Tammy Mae Joann Ayers, W/F/DOB: 07/24/1977 (Witness)

Tammy Mae Joann Ayers was interviewed on Monday, September 26, 2011, beginning at approximately 10:30 a.m. by Special Agent (SA) C. E. Vines and Deputy R. Higgins of the Yancey County Sheriff's Office. The interview was conducted at the Yancey County Sheriff's Office Annex. Ayers was interviewed regarding the death of Jonathan Russell Whitson. Ayers stated she was at the residence of Nathan Angel the day prior to Whitson's death. Ayers said when she arrived, Nathan Angel and Stephanie Whitson were there and Robbie Silver may have been there. Ayers stated Jonathan Whitson was leaving as she arrived. Whitson was leaving with John Pritchard in what Ayers believes was a silver truck. Ayers said the truck may be a two-door Toyota. Ayers stayed at the residence while Whitson was gone. Ayers asked Angel if Whitson was going to score 30s, referring to Morphine. Angel said he was. Ayers said as she was driving away, Whitson and Pritchard were returning, but Ayers did not speak to either one of them. The following day, Ayers spoke with Stephanie Whitson. Stephanie was the girlfriend of Whitson. Stephanie told Ayers that Whitson got ten 30s from Pritchard and that she and Whitson did about four or five of the pills at Angel's. Stephanie further told Ayers when she left, Whitson had the remaining pills. Ayers stated Angel had gotten pills for her in the past from Pritchard, but stated she had never bought from Pritchard directly. Ayers further stated Robbie Brown told her that she knew Pritchard sold the Morphine to Whitson and added that most of the pills were given to Whitson on credit or were fronted to Whitson. Ayers thinks Pritchard gets his pills from Tennessee. Angel told Ayers during the funeral visitation that if Stephanie would not have had any money, then Whitson would not have bought the pills. The interview concluded at approximately 11:00 a.m.

<u>Robbie Jean Brown, W/F/DOB: 02/23/1957 (Witness)</u>

Robbie Jean Brown was interviewed on Monday, September 26, 2011, beginning at approximately 3:12 p.m. by Special Agent (SA) C. E. Vines Jr. and Sergeant R. Higgins of the Yancey County Sheriff's Office. The interview was conducted at the Yancey County Sheriff's Office Annex. Brown was interviewed regarding the death of Jonathan Russell Whitson. No other person was present at the time of the interview. Brown is the girlfriend/fiancée of John Pritchard. Brown told SA Vines that Pritchard gave Whitson eight pills the day prior to the death of Whitson. Brown stated she was told by Pritchard that he went to the residence of Nathan Angel, AKA: "Fruit," to pick up Brown's son, Aaron Collins, and Whitson. Pritchard told Brown he took the pair to the store, then took Collins back to Collins' residence. Pritchard told Brown at some point he gave Whitson eight Morphine pills and took Whitson back to the residence of Angel. Brown stated she knows Whitson has gotten Morphine from Pritchard in the past and personally saw Pritchard give Whitson two pills around Christmas of 2010. Pritchard and Whitson first met in the fall of 2010 and that occasion at Christmas was the only time she ever saw anything. Brown added Whitson did yard work for her around the house. According to Brown, Pritchard keeps his pills locked in a lockbox in his house and when the two lived together Pritchard received 15 mg Morphine from the VA Hospital in Asheville. Brown stated Pritchard has been and is worried about Whitson's death and is very worried that he gave Whitson the Morphine that killed him. The interview concluded at approximately 4:00 p.m.

John Herbert Pritchard, W/M/DOB: 09/07/1951 (Suspect)

John Herbert Pritchard was interviewed on Thursday, December 1, 2011, beginning at approximately 11:40 a.m., by Assistant Special Agent in Charge (ASAC) C. E. Vines and R. Higgins of the Yancey County Sheriff's Office. The interview was conducted at the Burnsville Police Department. Pritchard was interviewed regarding the death of Jonathan Russell Whitson. Pritchard was in custody at the time of the interview and was advised of his rights prior to any questions being asked. Pritchard advised he would not make any statements and had an attorney.

SYNOPSIS:

On Tuesday, September 27, 2011, Assistant Special Agent in Charge (ASAC) C. E. Vines Jr. was contacted by Sergeant R. Higgins of the Yancey County Sheriff's Office. Sergeant Higgins advised that on March 6, 2011, the Yancey County Sheriff's Office responded to a residence in Yancey County regarding an overdose death. The SBI was requested to assist with interviews on a limited basis. Jonathan Russell Whitson was found dead at the residence. Whitson was autopsied, and autopsy results indicated Whitson died from Morphine toxicity. Tammy Ayers was interviewed by ASAC Vines and Sergeant Higgins. Ayers stated she was at the residence of Nathan Angel the day prior to Whitson's death. Ayers said when she arrived, Nathan Angel and Stephanie Whitson were there and Robbie Silver may have been there. Ayers stated Jonathan Whitson was leaving as she arrived. Whitson was leaving with John Pritchard in what Ayers believes was a silver truck. Ayers said the truck may be a two door Toyota. Ayers stayed at the residence while Whitson was gone. Ayers asked Angel if Whitson was going to score 30s, referring to Morphine. Angel said he was. Ayers said as she was driving away, Whitson and Pritchard were returning, but Ayers did not speak to either one of them. The following day, Ayers spoke with Stephanie Whitson. Stephanie was the girlfriend of Whitson. Stephanie told Ayers Whitson got ten 30s from Pritchard, and that she and Whitson did about four or five of the pills at Angel's. Stephanie further told Ayers when she left, Whitson had the remaining pills. Ayers stated Angel had gotten pills for her in the past from Pritchard but stated she has never bought from Pritchard directly. Ayers further stated Robbie Brown told her she knew Pritchard sold the Morphine to Whitson and added that most of the pills were given to Whitson on credit or were fronted to Whitson. Ayers believes Pritchard gets his pills from Tennessee. Angel told Ayers during the funeral visitation, if Stephanie would not have had any money then Whitson would not have bought the pills. Robbie Jean Brown was interviewed by ASAC Vines and Higgins. Brown is the girlfriend/fiancée of John Pritchard. Brown told ASAC Vines Pritchard gave Whitson eight pills the day prior to the death of Whitson. Brown stated she was told by Pritchard that he went to the residence of Nathan Angel, also known as "Fruit," to pick up Brown's son, Aaron Collins, and Whitson. Pritchard told Brown he took the pair to the store then took Collins back to Collins' residence. Pritchard told Brown at some point, he gave Whitson eight Morphine pills and took Whitson back to the residence of Angel. Brown stated she knows Whitson has gotten Morphine from Pritchard in the past and personally saw Pritchard give Whitson two pills around Christmas of 2010. Pritchard and Whitson first met in the fall of 2010, and that occasion at Christmas was the only time she ever saw anything. Brown added Whitson did yard work for

her around the house. According to Brown, Pritchard keeps his pills locked in a lock box in his house, and when the two lived together, Pritchard received 15 mg of Morphine from the VA Hospital in Asheville. Brown stated Pritchard has been and is worried about Whitson's death and is very worried that he gave Whitson the Morphine that killed him. ASAC Vines and Higgins attempted to interview John Herbert Pritchard on December 1, 2011. Pritchard declined the interview, and advised ASAC Vines and Higgins he had an attorney. This case is pending court.

Exhibit 9 - YCSO Farmer Report.pdf

Sgt. Higgins stated that at approximately 11:33 a.m. on Sunday March 6, 2011 Christine Higgins Angel had called Yancey County 911 and reported that Jonathan Whitson was at her residence on a couch in the living room and was not breathing.

Sgt. Higgins stated that he upon his arrival he observed Whitson in fact deceased laying on the couch in the living room.

Sgt. Higgins stated that he had been advised that Jonathan Whitson had arrived at the Angel residence around noon on Saturday March 5, 2011 after being released from the Buncombe County Jail on Friday evening March 4, 2011. Chief Deputy Farmer learned that Jonathon Whitson had been in the Madison County Jail where he had served a 60 day sentence prior to being released on March 4, 2011to authorities in Buncombe County who had a warrant for his arrest for previous matters.

Sgt. Higgins stated that he had learned that Stephanie Whitson had arrived at the Angel residence soon after he arrived home on Saturday March 5, 2011 and the two of them had left together but returned later in the evening of Saturday March 5, 2011 at approximately 10:00 p.m.

Sgt. Higgins did stated that he had recovered two used syringes in the coat pocket of a coat that belonged to Whitson that was present at the scene near his body. Sgt. Higgins stated that he had collected the syringes.

At approximately 6:00 p.m. on Sunday March 6, 2011 Sgt. Higgins and Chief Deputy Farmer met at the Yancey County Sheriff's Department and Higgins advised that he had completed an interview with Stephanie Whitson in regard to her time spent with Jonathan Whitson on Saturday March 5, 2011.

During the interview Whitson admitted that she and Jonathan Whitson had spent several hours together on Saturday March 5, 2011 at the residence of Christine Angel and away from the residence of Christine Angel. In addition Stephanie Whitson admitted that she and Jonathan Whitson had used prescription drugs together and admitted that they had both "shot up" morphine drugs.

Sgt. Higgins stated that Stephanie Whitson advised him that on Saturday March 5, 2011 while she was present with Jonathan Whitson at the residence of Christine Angel she and Jonathan had a conversation about John Pritchard. Stephanie Whitson stated that Jonathan Whitson told her that he had talked with John Pritchard and that "Johnnie" (Pritchard) had told him (Jonathan Whitson) that he was coming up "Marion Mountain" and would call him when he got home. According to Stephanie Whitson this meant that John Pritchard was on his way home to Turtle Trot Drive with Morphine and he would call Jonathan Whitson when he arrived and arrange a delivery of Morphine to Jonathan Whitson.

Stephanie Whitson stated that John Pritchard did not call Jonathan Whitson but showed up at the residence of Christine Angel instead. Stephanie Whitson stated that she visually observed John Pritchard arrive at the Angel residence driving his silver colored Ford Ranger pickup truck, Stephanie Whitson stated that that Jonathan Whitson got inside the Ford Ranger truck with Pritchard and Pritchard drove away from the residence. Stephanie Whitson stated that after Jonathan Whitson was gone with John Pritchard for approximately 15 minutes they returned to the residence of Christine Angel and Jonathan Whitson got out of the truck and came back inside the house where she was at. Stephanie Whitson stated that Nathan "Fruit" Angel went out and met with John Pritchard for a few minutes and she has no knowledge what they discussed.

Stephanie Whitson told Sgt. Higgins that when Jonathan Whitson arrived back into the house where she was at he showed her ten (10) dosage units of 30 mg Morphine pills in his possession. Stephanie Whitson told Sgt. Higgins that according to Jonathan Whitson he had received the Morphine 30 mg pill> from John Pritchard while they were together during the time they had left the residence of Christine Angel on March 5, 2011. Stephanie Whitson told Sgt. Higgins that Jonathan Whitson told her that John Pritchard had given him the ten dosage units of Morphine 30 rag tablets because he knew Jonathan had been in jail and had not had anything in a while nor did he have any money. Stephanie Whitson also stated to Sgt. Higgins that Jonathan Whitson told her that John Pritchard had told him that he (Whitson) could purchase the Morphine pills from him for $ 8.00 a pill in the future and then turn around and sell them fro $ 15.00 a pill if he decided to do that. Stephanie Whitson did admit to Sgt. Higgins that she had been with Jonathan Whitson on many previous occasions while Jonathan Whitson was purchasing Morphine 30 mg pills from John Pritchard. Stephanie Whitson stated that she knew for a fact that Pritchard was the person Jonathan Whitson obtained prescription drugs from on past recent occasions. Stephanie Whitson also told Sgt. Higgins that she recalled a conversation that she had With Jonathan Whitson on a prior occasion when Jonathan Whitson told her that John Pritchard had a doctor in South Carolina who was prescribing him Morphine and that Pritchard was traveling to South Carolina to get the prescriptions from the doctor and getting the prescriptions filled in South Carolina as well.

On Tuesday March 8, 2011 I Chief Deputy Thomas L. Farmer received a copy of the Jail Medical Records for Jonathan Whitson while he was incarcerated at the Madison County Jail. The records stated that Jonathan Whitson did not have any medical issues while in custody in

Madison County and was not prescribed any medication while he was there and was not taking any medication while he was there.

Exhibit 3 - Watauga Medical Center Autopsy Documents.pdf

FINAL ANATOMIC DIAGNOSIS:
Pulmonary edema and congestion, severe
Acute bronchial pneumonia, moderate
Pulmonary emphysema, mild
Cardlomegaly, mild, with left ventricular hypertrophy

CAUSE OF DEATH:
Morphine toxicity

EVIDENCE OF INJURY:
Abrasions of both upper legs measuring up to 2.8 cm in greatest diameter are present. There is a 0.5 cm abrasion of the right thumb. A 2.0 cm ulcer of the left heel is also identified. Needle marks are present in the left antecubital fossa and left forearm.

ADDITIONAL PROCEDURES:
Radiographs: None
Microbiology: None
Chemistry:
Glucose - <20.0 mg/dL
Chloride – 114.0 mmol/L
Potassium – 12.2 mmol/L
Sodium – 158 mmol/L
UREA nitrogen – 16 mg/dL
Calcium – 6.6 mg/dL

INTERNAL EXAMINATION:

Body Cavities: Unremarkable
Cardiovascular system: Heart waght-420 grams. The coronary arteries display normal anatomic distribution and are free of significant atherosclerotic change. Sections of the heart demonstrate mild concentric left ventricular hypertrophy. The cardiac valves, cardac chambers and myocardium are otherwise unremarkable. The aorta is unremarkable.
Neck: The thyroid is of the usual size and configuration. The hyoid bone and thyroid cartilage are intact The larynx and trachea are unremarkable.
Respiratory tract: Lungs: Right weight-1040 grams: left weight-900 grams. Sectioning demonstrates marked edema and congestion. Mild emphysematous change is also identified. The lower trachea and major bronchi are unremarkable.

Gastrointestinal tract: The gastrointestinal tract is intact throughout its length. The stomach contains about 200 cc of partially digested food among which are recognizable bits of white meat. Unusual odor is not detected. The appendix is present. The large bowel contains a small amount of semisolid stool.
Liver: 1760 grams. Glisson's capsule is intact. Sectioning demonstrates unremarkable hepatic parenchyma. The extrahepatic biliary system is patent. The gallbladder contains liquid bile.
Pancreas: Unremarkable.
Spleen: 210 grams. Unremarkable.
Adrenals: Unremarkable.
Urinary tract: Kidneys: Right weight-180 grams; left weight-160 grams. The capsules strip with ease to reveal smooth cortical surfaces. Sectioning shows good corticomedullary differentiation. Bladder: The bladder contains about 10 cc of straw colored urine. The bladder mucosa is unremarkable.
Reproductive tract: Unremarkable
Musculoskeletal system: Unremarkable.
Immunologic system: Unremarkable.
Head: Scalp: Intact. Skull: Intact. Brain: Weight-1260 grams. The meninges are thin, delicate and without evidence of hemorrhage or exudate. Sectioning demonstrates unremarkable parenchyma. The blood vessels at the base of the brain are unremarkable.

MICROSCOPIC: Heart: Sections of the heart show mild myelocyte hypertrophy. Lungs: The lungs demonstrate marked edema and congestion. Moderate acute bronchial pneumonia is present. Perihilar lymph nodes contain granulomas with birefringent material. Liver: No pathologic diagnosis. Kidney: No pathologic diagnosis. Brain: No pathologic diagnosis.

SUMMARY AND INTERPRETATION:
Mr. Whitson was a 29 year old found dead in bed 3-6-11. Autopsy was requested by the Yancey County Sheriff's Department. Autopsy demonstrated marked pulmonary edema and congestion with a moderate degree of acute bronchial pneumonia. Mild pulmonary emphysema was also present. The heart was mildly enlarged with left ventricular hypertrophy. An ethanol level performed on aortic blood obtained at the time of autopsy was 40.0 mg/dL (0.04% of Breathalyzer scale). Additional toxicology performed on aortic blood demonstrated the following: Benzodiazepines, none detected; cocaine, none detected; morphine, present; nicotine, present; other opiates/opioids, none detected; other organic bases, none detected. A trace of morphine was present in the femoral blood. Morphine was present in the urine at concentration of 15.0 mg/L.

The case of death in this case was morphine toxicity.

Exhibit 4 - OCME Autopsy Documents.pdf

SPECIMENS received from Brent D. Hall on 09-mar-2011
S110004482: 6.0 ml Blood

CONDITION: Postmortem
SOURCE: Femoral Vessel
OBTAINED: 07-mar-2011
Morphine – Trace
04/04/2011

S110004483: 16.0 ml Blood
CONDITION: Postmortem
SOURCE: Aorta
OBTAINED: 07-mar-2011
Benzodiazepines None Detected LCMS
Cocaine None Detected LCMS
Ethanol 40 mg/dL
Morphine Present LCMS
Nicotine Present
Other Opiates/Opioids None Detected
LCMS Other Organic Bases None Detected
04/04/2011

S110004484: 5.0 ml Urine
CONDITION: Postmortem
SOURCE: Urinary Bladder
OBTAINED: 07-mar-2011
Morphine 15 mg/L
04/04/2011

Exhibit 7 - Dr. Hall Trial Testimony.pdf

Q. So you found pulmonary edema and acute bronchial phenomena in the lungs?
A. Yes, those were findings related to the morphine toxicity. In addition morphine was 14 measured in the blood as well as the urine.
Q. What were the findings there?
A. The test that is done on the aortic blood is a screening test to find out what drugs are present in the decedent. That screening test was positive for morphine. Then the blood - there is an attempt to quantitate how much of certain drugs are present. That is typically performed in blood that is removed from peripheral blood vessel, either the femoral vessels or the subclavian vessel. And there was a trace of morphine found there. In the urine however there was 15 milligrams per liter of morphine there. Morphine is a drug that is metabolized in the liver and excreted through the kidneys into the urine. The cut off point for toxicity resulting in death is 14 milligrams per liter. As I said Mr. Whitson had a level of 15 milligrams per liter in his urine.

Q. At the time you performed the autopsy, or before did you have an opportunity to inspect or view any of the needles that were used, as it has been testified to, the morphine into this deceased body?
A. I never saw any of the needles.
Q. Are you aware that those have been tested by the lab now, and are you aware of what the results of those tests are?
A. Not prior to this morning, I was not aware.
Q. Are you aware now that the lab results are that there was simply a residue amount, but there was no finding of any controlled substance in those syringes, are you aware of that now?
A. Yes sir
Q. Is it your understanding that that is how at least the deceased girlfriend has described these substances were introduced into Mr. Whitson's body?
A. Yes sir.
Q. Did you have an opportunity to inspect the spoon that was used to crush and melt the morphine, draw out the liquid, to inject the morphine into the deceased body? Did you ever have a chance to look at that?
A. No sir.
Q. And you have no personal knowledge of your own how these drugs were ingested into Jonathan Whitson's body, do you?
A. No sir, there was a finding of needle marks on the left arm, but the morphine could have got there by injection or it could have been taken orally. I have no way of knowing.
Q. So it could have been as Ms. Whitson described, or it could have happened another way, you could have taken it orally and it would have been in his system just as if he would have injected it, right?
A. Yes sir.
Q. Then again, you don't know of your own personal knowledge when these were introduced into his body, whether they were crushed or not crushed or melted, put in a syringe, or taken in any other way, do you?
A. That is correct.
Q. So nothing about your autopsy would allow you to determine the method or manner in which these drugs were taken?
A. Again, other than the fact that there were track marks on the arm, and I noted no residual pills in the gastric contents.
Q. And therefore you wouldn't know what time they were taken, would you?
A. That is correct
Q. You wouldn't know if that is something you did, whether it be earlier in the day on March 5th, or something he did much later in the day of March 5th. You have no way of knowing the time and the manner in which those pills were taken?
A. That is correct.

Letter from Pritchard to Dr. Roberts.docx

…I believe that this gentleman died of other illnesses than "overdose". It was alleged that the deceased and his ex-girlfriend inject 210 mg of morphine between them. First injection of 3 – 30 mg tablets around 4:30, then 4 – 30 mg tablets at 9:45 that night on the 5th of March, 2011. Which the alleged cause overdose around 10:30 am the next morning which is impossible. Also, I was taking generic 30 mg morphine sulfate tablets not the original 30 mg with m Box on them…Also victim had an uncared for abscess on his left arm larger than the upper part of my leg, he was shooting drugs into his arm. The deceased was running high fever when detained in Madison County Detention Center where they gave him know medicine to alleviate his pain when he asked for a ride to the BP Station in Yancey City on March 5th, 2011.

2021.07.30 Dr. Brent Hall Deposition.pdf

Transcript of the audio recording of the deposition of Dr. Brent Dwayne Hall on July 30, 2021.

This case involved the second-degree murder, delivery of Schedule II controlled substance, possession with intent to sell, manufacture or deliver Schedule II controlled substance, and maintaining a vehicle, dwelling, or place for controlled substances. All of these charges occurred on March 5th, 2011, to March 6th, 2011. And the victim in this case was Jonathan Whitson.

All documents were destroyed in a flood.

p. 36 – typically a vitreous sample is obtained
p. 36 – typically a femoral blood sample is obtained
p. 37 – a central blood sample, typically from the heart or aorta, is also obtained
p. 38 – Q. What happened to those notes? A. They were all destroyed by water.
p. 51 - …if you go over on the left arm, it's got a question mark, needle marks. Then in the inguinal area, it's got abrasions up to 2.8 centimeters…Q.
p. 51-52 - Do you have any idea what could have caused symmetrical abrasions like that? A. No ma'am.
p. 52 – Q. What did the ulcer on the left heel look like? A. I can't remember any detail.
p. 52 -53 – Q. Does the question mark - -could it possibly mean that you weren't sure if they were needle marks or not? A. Probably signifies some degree of ambiguity.
p. 53 – Q. It looked to me on the body diagram that you had found multiple marks on his left arm. Because it looks like you have two lines going on each side of his arm. Is that accurate? A. I would agree.
p. 53 – Q. And it also looks lie you're indicating that there were marks on the other side of his arm, down towards the wrist? A. The dorsal aspect of the forearm. Yes, Ma'am.
p. 55 – A. Okay. Mr. Whitson was a 29 year old released from jail in Madison County 3/4/11. On 3/5/11 he is alleged to have taken morphine with his girlfriend. The next morning he was found dead in bed. Autopsy was requested by the Yancey County Sheriff's Department. Q. Where did

you get this information? A. Well again, I don't remember. But in all likelihood from the investigating officers.
p. 58 – Q. And why didn't you take photographs of the injuries that you noted on Mr. Whitson's body diagram? A. I don't remember. Q. Was it your practice to take photographs of injuries that you noted on a body during an autopsy? A. Yes, ma'am.
p. 59 - Q. You noted that quote, sections of the heart demonstrate mild concentric ventricular hypertrophy, end quote. What does that mean? A. It means that his left ventricle was slightly enlarged.

p. 60-65 – Q. You noted that quote, sections of the heart demonstrate mild concentric ventricular hypertrophy, end quote. What does that mean? A. It means that his left ventricle was slightly enlarged. Q. What causes that? A. A number of things can cause it. You know, it just means there's -- one cause would be increased stress on the heart, either from hypertension or other processes. It could be congenital in nature. He could have a hypertrophic cardiomyopathy. Q. And what is that? A. It's a congenital enlargement of the heart. Q. Could that be related to cause of death? A. In some cases. Yes, ma'am. Q. How does it contribute to death? A. It can lead to cardiac arrhythmias. Q. How do you know if someone had cardiac arrhythmias when you are doing an autopsy? A. Well, you know, the -- in most autopsies, the final mechanism for cause of death is some sort of cardiac arrhythmia. You know, if there's -- you can take sections of the conduction system and look for abnormalities in the conduction system. Or you can do -- I'm not sure this was available in 2011. But now you can do DNA analysis to look for congenital anomalies. Q. Did you do that in this case? Did you look for conduction system? A. No. Q. Did you do DNA testing? A. None is noted. Q. Do you know if Mr. Whitson had a cardiac arrhythmia? A. Well, as I said, in most cases, the actual final mechanism of death is a cardiac arrhythmia. So in all likelihood he had one in the agonal stages. Q. Okay. Is there a way to know for sure if someone had one or not? A. Well, other than them having an EKG strip, no. Q. So it is possible that his mild concentric left ventricular hypertrophy contributed to death in this case? A. It may have been a contributing factor. Yes, ma'am. Q. Could it have caused the death? A. Not in my opinion. Q. And why is that? A. Because the morphine in his system, in my opinion, was the cause of death. Q. You also note under this section under the respiratory tracts, lung section, quote, Sectioning demonstrates marked edema and congestion, mild emphysematous change is also identified in the lower trachea, and major bronchi are unremarkable, end quote. What is marked edema and congestion in the lungs? A. Well, in layman's terms, it would be water on the lung. Q. What causes that? A. Well, for instance, in a drug overdose, the -- especially with morphine, the -- it's a respiratory depressant. It acts on the primitive area of the brain. And so the body is not oxygenating well. And so the lungs do what they can do to help oxygenate the body. So the capillaries, the alveolar spaces in the lungs will open up, the capillaries in the lungs will open up as much as they can. And when the capillaries open up, the endothelial cells which line the capillaries get really stretched. And their connections to one another get really stretched. And plasma leaks from the bloodstream into the lung parenchyma. And that's what causes the edema. The congestion is blood vessels dilating really big to try to help with oxygenation. Q. Can something other than drugs cause marked edema and congestion in the lungs? A. Yes, ma'am. Q. What other things can cause that condition? A. Heart attack. Q.

Anything else? A. Yes, ma'am. There's a litany of things. Q. What are some examples? A. Well, if a person is smothered or strangulated. Anything that's going to impair oxygenation of the body can cause this. Q. Could an illness cause marked edema and congestion in the lungs? A. Sure. Q. So a virus can cause it? A. Virus can cause it. Yes, ma'am. Q. Can bacteria cause it? A. Yes, ma'am. Q. Is it something that you typically see in pneumonia? A. You can see that in pneumonia. You can. Yes, ma'am. Q. What is mild emphysematous change? A. Emphysematous. Q. Sorry. I'm going to pronounce all these medical terms wrong. And I apologize. A. No. That's fine. Q. So please correct me. A. Okay. That just means that his alveolar spaces were somewhat dilated. Q. What causes that? A. Most commonly, smoking. Q. Can anything other than smoking cause it? A. Sure. Q. What else? A. Well, pneumoconiosis. Exposure to toxic chemicals, exposure to toxic metals, that sort of thing. Q. And what did the mild emphysematous change indicate to you? A. That he was probably a smoker. Q. What did you see when you looked at Mr. Whitson's lungs during the internal examination? A. Well, just what was noted there in the autopsy report. Q. Was there anything that you could have done during the internal examination in this autopsy that you did not do? A. Well, I mean, there's lots of things you could have done. Q. Can you give me some examples? A. Well, I mean, could have taken injections for culture. And I could have examined his testicles. You know, I could have taken the spinal cord. But at the time of autopsy, I saw no reason to do those procedures.

p. 73 Q. Can the birefringent material be something other than talc? A. Yes, ma'am. Q. What other kinds of things? A. Well, it could be other types of crystal material. You know, again, there's a litany of things that it could be. And the only way to know for sure that it's talc will be to do special studies on the birefringent material.

p. 88-89 – Why do they test both the blood and the urine for morphine? A. Well, in this case, the testing of the blood was inconclusive. So that's the reason they went to testing the urine. That would be my assumption. Q. What was inconclusive? A. The testing of the blood. Q. What does the fact that Mr. Whitson had 15 milligrams per liter in his urine, what does that indicate to you? A. That indicates a lethal level of morphine. Q. Did you say lethal? A. Lethal. Yes, ma'am. Q. When does morphine become lethal in the urine? A. Well, based on the literature, it's about 14 milligrams per liter. 1Q. What literature are you relying on? A. The -- primarily the textbooks that all pathologists have used. It's a textbook by Baselt that's called Distribution [sic] of Toxic Chemicals in Man, or4 something like that. Don't hold me exactly to that. Q. Do you know when that came out? A. Well, there's been several editions. Q. What does trace morphine mean from the femoral vessel? A. Well again, Ms. Winecker could probably answer that better than I. But to me, that indicates that there was not enough to quantitate.

Affidavit - Dr Cat Roberts re Pritchard 12-20[5050] edits.pdf

Dr. Hall testified at trial that the cause of Mr. Whitson's death was morphine toxicity. In my opinion, the death of Mr. Whitson cannot be attributed to acute morphine toxicity because there is no evidence, from the autopsy report, toxicology reports from the OCME, or clinical presentation to support that conclusion.

It appears that although only a trace level of morphine was found in the blood, the death was called morphine toxicity by Dr. Hall because there was morphine in the urine. Dr. Hall testified that the cut off level for toxicity in the urine was 14 mg/L and since there was 15 mg/L in the urine that was a toxic level. Dr. Hall did not apply the correct methodology in arriving at his conclusions. A value in urine cannot be interpreted in isolation. For the cause of death to be called a death by acute toxicity of morphine, there must be an appreciable level of morphine in the blood, which is not the case here.

Morphine levels in the blood must be interpreted using literature to determine what represents in general: therapeutic, supratherapeutic and toxic levels. That level then is interpreted with the clinical information such as the person's tolerance and the decedent's clinical presentation in the time preceding their death.

As shown by the toxicology report, no opiates (morphine is an opiate) were detected by the LCMS screen of the aorta blood. A quantification was performed the on femoral blood that showed "trace" amounts of morphine.

As morphine is a respiratory and central nervous system depressant the clinical presentation of acute toxicity would include somnolence, unable to be awakened, snoring and labored breathing, comatose, followed by death.

a. *Mr. Whitson allegedly crushed, melted and injected three (3) pills into two (2) syringes and injected himself with one (1) of them and injected his friend with the other.*
b. *Over the next approximately 5.5 hours six (6) more pills were crushed and injected between them.*
c. *No is no evidence that Mr. Whitson was stuporous during this timeframe. In fact, they were "hanging out" and driving in a vehicle. His grandmother reported to police that once he went to bed that night around 10:00 pm he got up three (3) times to go to the bathroom and each time he popped his head in her bedroom door and told her he loved her.*
d. *Clearly, he was not comatose if he was up walking and talking.*

It may be possible that Dr. Hall opined enough time had passed to metabolize the morphine out of the blood. Liquid morphine used for surgical patients is designed to have a very short half-life, approximately 2-3 hours. The half-life of a drug is the amount of time that it takes for the body to eliminate half of the concentration in the blood.

a. *In this case the morphine pills that were allegedly crushed, melted and injected were sustained release morphine pills. The half-life of sustained release morphine pills the when ingested is approximately 16-18 hours. This reviewer is not aware of literature studying the half-life of a sustained release pill when it is crushed, melted and injected.*

At autopsy one can find a situation where low levels of an opiate like morphine or heroin can cause acute toxicity by direct cardiotoxicity. In this situation a person who lost their tolerance to a drug tries to inject the same amount as they had built up to prior to a drug absence. In these cases, the decedent is often found with the syringe still in their arm or nearby. The victim is often slumped over or witnessed by others to be "passed out", unarousable and snoring loudly.

a. *This scenario clearly doesn't match the clinical presentation of Mr. Whitson that evening.*

In my opinion, Dr. Hall also did not completely explore competing causes of death. No blood, lung or viral cultures were performed at the time of autopsy to rule out a bacterial or viral underlying medical condition. This would be especially important as Mr. Pritchard reported that when Mr. Whitson was released from jail, he had a fever and he had a large abscess of his left arm. There is no documentation in the autopsy of an abscess. To independently evaluate this possible mechanism of death I would need to review the autopsy photographs and Mr. Whitson's jail medical records.

The autopsy did document an ulceration of the left heel. There is no description provided of the stage of the ulceration (depth, presence of purulent exudate). No culture swab was performed on the heel ulceration to rule out infection. As noted above no blood cultures were performed to rule out sepsis as a cause of death.

Autopsy did find that Mr. Whitson had "moderate" acute bronchial pneumonia. The extent of the pneumonia was not documented further. I would need to review the original or recut microscopic slides from the lungs to independently evaluate the extent of the pneumonia. Acute bronchial pneumonia can be a primary cause of death. The presence of chronic lung disease could be a contributing factor. Changes consistent with pulmonary emphysema were described in the autopsy report.

Based on the information available to me at this time with the limitations of the autopsy performed, the cause of death would be better listed as acute bronchial pneumonia with pulmonary emphysema as a contributing factor. The manner of death would therefore be listed as "Natural".

In order to arrive at a more definitive opinion as to Mr. Whitson's cause of death, I would need copies of or access to the following information:

a. *All jail records, including medical, psychiatric, psychological and prescription records for Mr. Whitson during his incarceration in the months before he died from the jails in Madison and Buncombe counties.*
b. *All autopsy photographs of Mr. Whitson.*
c. *Any and all other law enforcement or medical examiner photographs of Mr. Whitson after his death.*
d. *The original file for the medical examiner, Dr. Hall, in this case, including any notes, documents, correspondence or reports relating to the death investigation of Mr. Whitson.*

e. All law enforcement reports concerning the death investigation of Mr. Whitson.
f. Access to either the original microscope slides from autopsy or recuts of those slides.

If I had been called as a witness to testify at the trial of this case, I would have testified to the opinions given in this affidavit. Alternatively, if I were not called as a trial witness, I would have provided the information discussed above to the trial attorney for use during cross-examination of Dr. Hall or other State's witnesses.

2021.10.04 Signed Report by Dr. Behonick.pdf

The following postmortem specimens were accessioned into the Office of The Chief Medical Examiner Toxicology Laboratory, Raleigh, NC from Dr. Brent Hall on March 9,2011: 6.0 milliliters (mL) of blood obtained from a femoral vessel, 16.0 mL of blood obtained from the aorta, 5.0 mL of urine collected from the urinary bladder, and a sample of liver tissue (no specimen amount/volume noted). Analysis for volatile compounds (ethanol, methanol, isopropanol and acetone) was achieved by dual column Headspace-Gas Chromatography Flame lonization Detection (HSGC FID). The Limit of Detection (LCD) and Limit of Quantitation (LOQ) for ethanol by this testing is 20 milligrams per deciliter (mg/100 mL or mg/deciliter, mg/dL). The equivalent expression for 20 mg/dL is 0.020 grams per 100 mL (0.020 g/100 mL or 0.020% weight by volume). Testing for volatile compounds was performed in the specimen of blood obtained from the aorta and revealed an ethanol concentration of 40 mg/dL, or 0.040%. The analysis for a comprehensive class of drugs was performed by Liquid Chromatography/Ion Trap Mass Spectrometry (LC/MS) following protein precipitation of the blood specimen with acetonitrile. After precipitation by the organic solvent, and evaporation under nitrogen, the specimen was analyzed by LC/MS with presumptive identifications of drugs or drug metabolites by relative retention times and mass spectra. Morphine and nicotine were determined to be present in the aorta blood specimen; the cut off concentration for morphine as a target analyte by this method is 10 ng/mL. Notably, no other opiate/opioid drugs (including oxymorphone, with a cut off concentration 5 ng/mL), or organic basic drugs, benzodiazepine class drugs, or cocaine/cocaine metabolite were detected by this method. Confirmatory and quantitative analysis for morphine was conducted by Gas Chromatography/Mass Spectrometry (GC/MS). This testing was conducted in the blood specimen collected from a femoral blood vessel. The dynamic calibration range for morphine by this method is 50 -1,000 ng/mL; meanwhile, the calibration range for oxymorphone by this method is 25-500 ng/mL. Morphine was determined to be present in a 'trace' amount in the femoral blood specimen. No other opiates/opioids (including oxymorphone) were detected by this method.

Morphine 'trace' - femoral blood: The morphine reported in this case represents free morphine, as opposed to total morphine. 'Trace' nomenclature in describing findings in a postmortem blood specimen is a semi-quantitative expression. This implies that the concentration of morphine detected is less than the lowest calibration point which defines the dynamic, linear range of the

test method. Specifically, this lowest point or Lower Limit of Quantitation (LLOQ) for the North Carolina Office of The Chief Medical Examiner Toxicology Laboratory opiate analytical method is 50 ng/mL; therefore, it can be inferred that morphine was detected in the femoral blood specimen at a concentration less than 50 ng/mL.

Morphine 15 mg/L (15,000 ng/mL) - urine: The morphine result reported for the urine concentration represents free morphine', this being a laboratory analytical practice in place at the toxicology laboratory in 2011 and confirmed telephonically by Dr. Winecker. In human beings, the majority of administered morphine is inactivated by metabolism to morphme-3-glucuronide (M-3-G). More than 80% of a dose of morphine is eliminated in the 72 hour urine, with the majority as M-3-G. Only about 10% of a dose of morphine is accounted for as free morphine in urine [1].

2021.10.18 Signed Report by Dr. Wolf.pdf
I encountered some opinions given with which I respectfully disagree. Most notably, Dr. Hall stated that Mr. Whitson's urine concentration of 15 mg/L indicates "a lethal level of morphine." Likewise, in his trial testimony Dr. Hall stated that in urine "the cut-off point for toxicity resulting in death is 14 milligrams per liter." This is not accurate statement. The detection of a drug in an individual's urine can support the finding of the drug in the blood, but the concentration in urine cannot be extrapolated to correlate with a blood concentration pertaining to potential impairment or lethality. The concentration of a drug in the urine is dependent in part a reflection of the amount of water in the urine, i.e., whether it is concentrated or dilute based on the liquid consumption of the individual.

SUMMARY:

In the practice of Medical Toxicology, the history pertaining to our patients who use/misuse various substances is notoriously unreliable.

In this case, we have a few objective findings to try to discern the cause of death. The 6.0 ml of postmortem blood from the femoral vessel obtained on March 7th, 2011 revealed "trace" morphine. Per Dr. Behonick:

> ***'Trace' nomenclature in describing findings in a postmortem blood specimen is a semi-quantitative expression. This implies that the concentration of morphine detected is less than the lowest calibration point which defines the dynamic, linear range of the test method. Specifically, this lowest point or Lower Limit of Quantitation (LLOQ) for the North Carolina Office of The Chief Medical Examiner Toxicology Laboratory opiate analytical method is 50 ng/mL; therefore, it can be inferred that morphine was detected in the femoral blood specimen at a concentration less than 50 ng/mL.***

Because the level was below the LLOQ, we do not know the exact level at the time the blood was drawn post-mortem. Levels below 50 ng/mL would be considered in the

therapeutic range for pain management and may produce analgesia, but would not be expected to stop respirations, result in aspiration pneumonia, or cause death. To place in context, the United Kingdom established a threshold of 80 ng/mL for morphine in the blood as indicative of impaired driving ability.[1]

There was also blood obtained from the aorta on March 7th, 2011. This sample revealed an ethanol level of 40 mg/dL and both morphine and nicotine present on LCMS. This ethanol level is equivalent to what we would expect for a blood ethanol level following the consumption of two standard alcoholic beverages. It is unclear when the victim consumed ethanol based on the history. Ethanol can have an additive sedative effect with morphine. The patient is a smoker, which explains the nicotine. The finding of morphine confirms the history of misuse, but this report does not inform of the exact level.

The 5.0 ml of urine obtained on March 7th, 2011, revealed a morphine level of 15 mg/L. Dr. Wolf noted in her report dated October 18, 2021:

> ***I encountered some opinions given with which I respectfully disagree. Most notably, Dr. Hall stated that Mr. Whitson's urine concentration of 15 mg/L indicates "a lethal level of morphine." Likewise, in his trial testimony Dr. Hall stated that in urine "the cut-off point for toxicity resulting in death is 14 milligrams per liter." This is not accurate statement. The detection of a drug in an individual's urine can support the finding of the drug in the blood, but the concentration in urine cannot be extrapolated to correlate with a blood concentration pertaining to potential impairment or lethality. The concentration of a drug in the urine is dependent in part a reflection of the amount of water in the urine, i.e., whether it is concentrated or dilute based on the liquid consumption of the individual.***

I agree with Dr. Wolf. A significant error made in the 2014 trial was the testimony of Dr. Hall. A urine morphine level indicates past exposure which is consistent with the history in this case. However, the urine level cannot be used to determine the degree of intoxication or lethality. The blood level is used for the purpose, not the urine level.

The most significant problem that I have with attributing morphine as the cause of death in this case is that there is not a detectable blood morphine level reported. I agree with Dr. Roberts:

> ***For the cause of death to be called a death by acute toxicity of morphine, there must be an appreciable level of morphine in the blood, which is not the case here.***

[1] Specified controlled drugs and specified limits for the purposes of section 5A of the Road Traffic Act 1988. ROAD TRAFFIC, ENGLAND AND WALES The Drug Driving (Specified Limits) (England and Wales) Regulations 2014 (https://www.legislation.gov.uk/ukdsi/2014/9780111117422/data.pdf)

A "trace" level only tells us the level was below 50 ng/mL. If the patient died due to morphine, even with the additive effects of ethanol, I would expect the level to be measurable above 50 ng/mL. Morphine has an elimination half-life of 1.3-6.7 hours.[2] At the time of death, the metabolism and excretion of morphine ceases. Opioids, such as morphine, at higher levels can depress respirations and lead to the loss of the gag reflex, resulting in aspiration pneumonia. In my clinical practice, I care for opioid overdoses on a regular basis with resultant aspiration pneumonia. Mr. Whitson did not have a morphine level above 50 ng/mL and I would not expect him to be comatose and not be able to cough at such a low level (even with "abstinence" from opioids as Dr. Wolf noted). There is no report of the patient coughing or being in respiratory distress from the witnesses. Only snoring is described by the witnesses present. Snoring can be associated with opioid toxicity (or any other sedative toxicity), but many who snore are not opioid toxic.

As a professor in the University of Virginia School of Medicine, I warn my students, residents, fellows, and faculty when I teach that they must be careful in attributing presenting symptoms in those that abuse substances solely to the patient's substance use/misuse. The substance abusing population can develop many other medical problems either related or unrelated to their substance abuse. In this case, there are many questions we cannot gain answers to from the available records. We do not know the exact morphine blood level (only that it was "trace"), there is no picture of the arm to refute the concern of a large abscess (especially in the context of Mr. Whitson not completing his antibiotic course), there are no cultures to determine if the Mr. Whitson was septic, and we do not know if there are other drugs/substances in his system that were not tested for at the time of his post-mortem. Based on the limited data that we have in this case, I simply cannot state that morphine is the direct cause of his death, especially with a blood level that is "trace".

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Christopher P. Holstege, M.D
Chief, Division of Medical Toxicology
Director, UVA Health Blue Ridge Poison Center
Professor, Departments of Emergency Medicine & Pediatrics
University of Virginia School of Medicine
Email: ch2xf@virginia.edu

[2] Baselt RC. Morphine. Disposition of Toxic Drug and Chemicals in Man. 12th Edition.

Handout 14

Dr. Christopher Holstege CV

CURRICULUM VITAE

CHRISTOPHER P. HOLSTEGE, MD

I. PERSONAL DATA

Date of Birth: December 2, 1965
Married: Angela J. Holstege, 1989
Children: Erik, Elijah, Benjamin, Samuel, Noah, Annalee

Business Address P.O. Box	University of Virginia School of Medicine P.O. Box 800774 Charlottesville, Virginia 22908-0774
Business Address Physical	Room 4601, 1222 Jefferson Park Avenue Charlottesville, Virginia 22903
Home Address	3644 Worcester Place Keswick, Virginia 22947-9185
Office Phone	1 (434) 924-5185
Office E-mail	ch2xf@virginia.edu
Emergency Phone (24/7)	1 (800) 451-1428
Cellular Phone	1 (434) 566-1246

II. CURRENT POSITIONS

Chief
Division of Medical Toxicology
Center of Clinical Toxicology
University of Virginia School of Medicine
August, 1999 – Present

Medical Director
Blue Ridge Poison Center
University of Virginia Health
August, 1999 – Present

Professor with Tenure
Departments of Emergency Medicine & Pediatrics
University of Virginia School of Medicine
June, 2014 – Present

Executive Director
Department of Student Health & Wellness
University of Virginia
August 2013 – present

Adjunct Professor of Clinical Pediatrics
Department of Pediatrics
Eastern Virginia Medical School
November, 2010 – Present

Clinical Affiliate Professor
Department of Pharmacy Practice
Appalachian College of Pharmacy
September, 2008 – Present

Managing Director
Blue Ridge Poison Center
University of Virginia Health
July 2001 – Present

III. EDUCATION

1993	Doctor of Medicine	School of Medicine Wayne State University Detroit, Michigan
1988	Bachelor of Science in Chemistry	Calvin College Grand Rapids, Michigan

IV. POST-GRADUATE EDUCATION

2007	Leadership in Academic Medicine	Darden School of Business University of Virginia Charlottesville, Virginia
1998	Medical Toxicology Fellowship	School of Medicine Indiana University Indianapolis, Indiana
1996	Emergency Medicine Residency	Butterworth Hospital (Spectrum) Michigan State University Affiliate Grand Rapids, Michigan

V. PREVIOUS ACADEMIC APPOINTMENTS

July 2013 – July 2015	Associate Medical Toxicology Fellowship Director University of Virginia School of Medicine Charlottesville, Virginia
May 2005 – June 2014	Associate Professor Departments of Emergency Medicine & Pediatrics University of Virginia School of Medicine Charlottesville, Virginia
July 2009 – July 2013	Medical Toxicology Fellowship Director University of Virginia School of Medicine Charlottesville, Virginia
July 2002 – July 2009	Associate Medical Toxicology Fellowship Director University of Virginia School of Medicine Charlottesville, Virginia
February 2002 – July 2002	Medical Toxicology Fellowship Director University of Virginia School of Medicine Charlottesville, Virginia
August 1999 – May 2005	Assistant Professor Departments of Emergency Medicine & Pediatrics University of Virginia School of Medicine Charlottesville, Virginia
July 1998 – July 1999	Assistant Professor Department of Emergency Medicine Associate Medical Director

	Virginia Poison Center Virginia Commonwealth University Richmond, Virginia
July 1996 – June 1998	Clinical Instructor (part time) Emergency Medicine Residency Clarian Health – Methodist Hospital Campus Indiana University School of Medicine Indianapolis, Indiana

VI. OTHER EMPLOYMENT PERTAINING TO CURRENT PROFESSIONAL APPOINTMENTS

February, 2004 – July 2018	Chief Medical Advisor Lead-Safe Virginia Virginia Department of Health Richmond, Virginia
January 2003 – July 2005	Co-Medical Director Hyperbaric Medicine University of Virginia Health System Charlottesville, Virginia
July 1996 – June 1998	Staff Physician (part time) Emergency Department Kokomo Hospital Kokomo, Indiana
July 1995 – June 1996	Staff Physician (part time) Emergency Department Three Rivers Area Hospital Three Rivers, Michigan
July 1995-June 1996	Flight Physician (part time) Aeromed Butterworth Hospital Grand Rapids, Michigan

VII. CERTIFICATION AND LICENSURE

A. Certification

Diplomat of the Subspecialty of Medical Toxicology – 1999 & 2008, 2018 #960277
Diplomat of the American Board of Emergency Medicine – 1997, 2007, 2017 #960277
Diplomat of the National Board of Medical Examiners - 1994 #960277
Advanced Hazmat Life Support Provider/Instructor - 2012
Advanced Cardiac Life Support (recertification) - 2018
Certification in Hyperbaric Medicine - 1997

B. Licensure

Virginia Medical License	#0101058141	
South Carolina Medical License	#23543	
Drug Enforcement Agency	Expiration 2022	X-Waiver obtained 2019

VIII. HONORS AND AWARDS

- The Raven Award (2021) – The Raven Society confers an award each year to recognize excellence in service and contribution to the University of Virginia. This is the highest honor that the Society can bestow on an individual. The Award is reserved to honor a student, faculty, administrator, or alumni of the University who have widely and sympathetically shared, supported, and advanced the function of this institution.
- American Red Cross Christopher E. Lee Humanitarian Spirit Hero (2021). Presented each year to a community member who exemplifies a humanitarian spirit and servant leadership.
- Hoos Building Bridges Award (2019) – University of Virginia presidential award acknowledges and celebrates those who are working on projects that bridge across different areas of the University.
- Inductee, University of Virginia's Raven Society - The oldest and most prestigious honorary society at the University of Virginia. 2016.
- Fellow, Academy of Wilderness Medicine, Wilderness Medical Society. 2015.
- Preceptor of the Year Award, Appalachian College of Pharmacy. 2012.
- Inductee, Academy of Distinguished Educators (Academy for Excellence in Education name change in 2021), University of Virginia School of Medicine. 2010.
- Fellow, American Academy of Clinical Toxicology. 2010.
- Fellow, Institute for Infrastructure & Information Assurance, James Madison University. 2009.
- Fellow, American College of Medical Toxicology. 2004.
- Dean's Award for Clinical Excellence, University of Virginia School of Medicine. 2003.
- National Faculty Teaching Award. American College of Emergency Physicians. 2002.
- Fellow, American College of Emergency Physicians. 2002.
- Attending Teacher of the Year Award, Department of Emergency Medicine, University of Virginia. 2002.
- Attending Teacher of the Year Award, Department of Emergency Medicine, University of Virginia. 2001.
- Fellow, American Academy of Emergency Medicine. 1999.
- Blocksma Award – Resident Researcher of the Year, Butterworth Hospital, Grand Rapids, Michigan, 1996.
- Kent Medical Foundation Award - Premedical Student of the Year, Calvin College. Grand Rapids, Michigan, 1988.

- Analytic Chemistry Student of the Year, Chemistry Department, Calvin College. Grand Rapids, Michigan, 1986.
- Dow Chemical Research Award, Chemistry Department, Calvin College. Grand Rapids, Michigan, 1986.

IX. PROFESSIONAL AFFILIATIONS

- 2021-present Society for Research into Higher Education
- 2017-present European Society for Emergency Medicine
- 2013-present American College Health Association
- 2012-present Academy of Wilderness Medicine
- 2005-present Asia Pacific Association of Medical Toxicology
- 2002-present Wilderness Medical Society
- 2001-present Albemarle County Medical Society
- 2001-present Society of Toxicology
- 1999-present European Association of Poisons Centres & Clinical Toxicologists
- 1999-present Medical Society of Virginia
- 1998-present Virginia College of Emergency Physicians
- 1996-present Society of Academic Emergency Medicine
- 1996-present American Academy of Clinical Toxicology
- 1996-present American Academy of Emergency Medicine
- 1996-present American Association of Poison Control Centers
- 1996-present American College of Medical Toxicology
- 1993-present American College of Emergency Physicians

X. AREAS OF RESEARCH INTEREST

- Higher education – specifically the student population
- Appropriate clinical care of the poisoned patient
- Epidemiology of poisonings & substance use/misuse
- Criminal poisonings
- Wilderness & austere medical care

XI. TEACHING ACTIVITIES

- Engaging Nature for Health and Wellness (KINE 1070-1), University of Virginia School of Education and Human Development.
    - Instructor (2020-present).
    - Wilderness curriculum development.
- Medical Toxicology Student Rotation (#1305), University of Virginia School of Medicine
    - Core Faculty (2001-present)
    - Director (2001-present)
    - Curriculum developed. Elective rotation offered since July of 2001.

- Medical Toxicology Resident Rotation, University of Virginia School of Medicine.
    - Core Faculty (1999-present)
    - Director (1999-2009; 2012-2015)
    - Curriculum developed. Elective rotation offered since August 1999.
- Medical Toxicology Fellowship, University of Virginia School of Medicine.
    - Core Faculty (2002-present)
    - Director (2002, 2009-2013)
    - Curriculum developed. Fellowship approved by GME in 2002.
- Wilderness Medicine Elective (#1307), University of Virginia School of Medicine.
    - Core Faculty (2008-present)
    - Director (2008-2009)
    - Curriculum developed. Elective rotation offered since August 2008.
- Telemedicine Monthly Medical Toxicology Conference Series, University of Virginia Health.
    - Monthly lecture series to small, rural Virginia hospitals. 2002 – 2008.
    - Directed and provided content for talks
- Case Tool Web-Based Medical Toxicology Learning Modules, University of Virginia School of Medicine.
    - Individual cases developed for rotator self-teaching. 2004 – 2007.
- LeadPoison.org, University of Virginia Health.
    - Website dedicated to lead poisoning detection and management 2005-2009.

XII. TEACHING ACTIVITIES OTHER THAN CLASSROOM OR CLINICAL, INCLUDING TEACHING OF UNDERGRADUATE (PRE-BACCALAUREATE), GRADUATE, POST-DOCTORAL STUDENTS AND CONTINUING EDUCATION MEDICAL STUDENTS.

A. Conferences, Grand Rounds, Journal Clubs, etc

See other documents in portfolio for lectures done since 1998.

B. Student/Resident Mentoring

- Emergency Medicine Residents
    - See separate list
- Medical Students
    - See separate list
- Undergraduate Students
    - See separate list
- Grants
    - Engineering in Medicine (2021-2022)
        - Aaron Frey, M.D. (Medical Toxicology Fellows)
    - Engineering in Medicine (2020-2021)
        - Leah Dignan (Ph.D. Candidate Chemistry) & Jennifer Ross, M.D. (Medical Toxicology Fellow)
    - Double Hoo Award (2016-2017)

        - Brett Nobles (undergraduate; College of Arts & Sciences) & Alicia Nobles (Ph.D. Candidate, School of Engineering and Applied Sciences)
    - PhD Dissertation Committee
        - Kris Rawls (2019) - School of Engineering and Applied Science
          Identifying candidate biomarkers of drug-Induced nephrotoxicity
        - Edik Blais (2016) – School of Engineering and Applied Science
          Comparative toxicogenomics analyses of rat and human metabolic networks. Ratcon1: a computational systems biology framework to facilitate preclinical drug development and biomarker discovery
        - Sue Kell (2006) – Curry School of Education
          Incorporating human patient simulation in medical education - Efficacy of a student-center approach in teaching the treatment of venomous snakebites

XIII. OTHER PROFESSIONAL ACTIVITIES (BOARDS, EDITORSHIPS, ETC.)

Conferences Coordinated

- "Criminal Poisoning & Drug-Facilitated Sexual Assault: Forensic, Legal, and Medical Aspects". American College of Medical Toxicology (ACMT) Washington, DC. December 9, 2019.
- Practical Strategies in the Clinical Diagnosis and Management of Childhood Lead Poisoning: A Case-Based Approach. Grant Support Obtained from the Cameron Foundation. Petersburg, Virginia. November 4, 2005.

Member of Editorial Board

- Clinical Toxicology 2006-2008; 2010-present
    - Senior Editorial Board Member 2018 – present

Member of Board of Directors or Board of Trustees

- Chair, Applied Research Institute Advisory Board, 2018-present.
- Chair, Research Strategies Network, 2017-present.
- Member, Board of Directors, Charlottesville Police Foundation, 2014-2017.
- Member, Board of Governors, Colonnade Club, 2011-2015.
- Member, First Aid Science Advisory Board, American Heart Association, 2008-2010.
- Member, Board of Trustees, American Academy of Clinical Toxicology, 2007-2010.

Manuscript Reviewer for Peer Review Journals

- Academic Emergency Medicine
- Annals of Emergency Medicine
- Clinical Toxicology
- Journal of Medical Toxicology
- Wilderness & Environmental Medicine Journal

XIV. CLINICAL ACTIVITIES

1. **Center for Clinical Toxicology**
    - Formally recognized by the UVa Dean of the School of Medicine in 2002.
    - Encompasses the medical toxicology consult service and clinical toxicology clinic.

A. Inpatient

- Medical Toxicology Consult Service Developed
    - 24/7 clinical consult service was instituted in August of 1999
    - Approximately 500 patients are evaluated and managed each year through this service.
    - Currently on call ~10 days per month

B. Outpatient

- Medical Toxicology Clinic Service Developed
    - Formally opened beginning July of 2002.

C. Blue Ridge Poison Center

- Medical Director of poison center since 1999
- Covers 48 hospitals in Virginia with > 6,000 hospital cases per year managed.
- Covers population of ~ 3 million with ~ 25,000 calls per year
- On call for center 24/7/365, with primary call 10 days per month on average
- Oversee annual operating budget ~$1.5 million

2. **Student Health & Wellness**
    - Oversee 5 sections: 1) Medical Services; 2) Counseling and Psychological Services; 3) Student Disability Access Services; 4) Office of Health Promotion; 5) Gordie Center
    - Care for ~23,000 university students with ~ 70,000 visits per year
    - Total of ~200 personnel including faculty & staff
    - Oversee annual operating budget ~$20 million

3. **Emergency Medicine**
    - Faculty member since 1999 practicing within the UVa Department.

XV. SCHOOL, UNIVERSITY, UVA HOSPITALS, DEPARTMENTS, NATIONAL, AND STATE COMMITTEES & COUNCILS

A. School of Medicine

- Academy for Excellence in Education. 2020-present.
- Member, Steering Committee, School of Medicine Strategic Planning Task Force. 2013-2015.
- Member, Liaison Committee on Medical Education. 2013-2014.
    - Chair, Governance Working Group

- Member, General Clinical Research Center Advisory Committee. 2004-2008.

B. University

- COVID-19 Epidemiology Working Group, 2020-present.
- Critical Incident Management Team (CIMT), 2013-present.
- Member, Student Health Insurance Committee, 2013-present.
    - Co-Chair, 2014-present
- Member, Leadership Committee, Department of Student Health & Wellness.
    - Chair, 2013-present
- Member, Education Abroad Risk Management Committee, 2014-present.
- Member, Working Group on Student Travel Policy, 2014-present.
- Member, University Background Check Policy Working Group, 2016-2018
- Member, Vice President of Health Affairs Task Force, 2014-2016.
- Member, Leadership Council on Organizational Excellence, 2013-present.
    - Member, Efficiency & Effectiveness Subgroup, 2019-present
- Member, Student Health Insurance Committee, 2013-present.
    - Chair, 2014-present.
- Member, Honor Faculty Advisory Committee, 2013-2017.
- Member, Provost's Non-Tenure Faculty Task Force, 2013-2015.
- Chair-elect, Chair, & Immediate Past Chair, Faculty Senate. 2012-2015.
- Member (Ex-officio), Academic Affairs Committee, Faculty Senate, 2012-2015.
- Member, Grievance Committee, Faculty Senate, 2012-2015.
- Member, Athletic Advisory Council, 2012-2013.
- Member, Faculty Recruitment, Retention, and Welfare Committee, Faculty Senate. 2008-2014.
    - Chair, 2009-2012.
- Member, Executive Council, Faculty Senate, 2009-2015.
- Member, Faculty Senate, 2007-2015.

C. UVA Health

- COVID-Vax: Advisory Committee. 2020-present.
- Member, Medication Usage, Safety, and Informatics Committee (MUSIC), 2012-2015.
- Deputy Member, Clinical Staff Executive Committee, 2012-present.
- Member, Emerging Diseases Committee, 2006-2009.
- Member, University of Virginia SARS Committee, 2003-2005.
- Member, University of Virginia Small Pox Working Group, 2002-2004.
- Member, Emergency Department Disaster Planning Workgroup, 2001-2005.
- Member, Bioterrorism Non-Pharmaceutical Supply Contingency Task Force, 2001-2002.
- Member, Bioterrorism Preparedness Committee, 2001-2002.

- Member, Community Acquired Pneumonia Committee, 2000-2002.

D. Department

- Member, Program Evaluation Committee (ACGME), Department of Emergency Medicine, 2014 – present.
- Member, Promotion and Tenure Committee, Department of Emergency Medicine, 2005-2008, 2013-present.
    - Chair 2007, 2016-present
- Member, Critical Incident Analysis Group (CIAG), 2008-present.
    - Chair, Critical Incident Analysis Group (CIAG), 2010-present.
- Chair, Research-Grants-Contracts Committee, Department of Emergency Medicine, 2008-2009.
- Member, Search Committee for Emergency Medicine Faculty, 2004-2008.

E. State

- Member. Central VA Overdose Working Group (CVOWG). 2020-present.
- Virginia Higher Education Substance Use Advisory Committee (VHESUAC) Member. 2019-present.
- Chairman, Subcommittee for Screening and Education, LeadSafe Virginia, Virginia Department of Health. 2004-2019.
- Central & Northwest Regional Virginia Disaster Plan Consortium Task Force Member. 2002-2007
- Virginia Hospital & Healthcare Association Hospital Disaster Preparedness Task Force Member. 2002-2007
- Secure Virginia Initiative Health and Medical Forum Member. 2002

F. National

- Member, Wilderness Medical Society Research Committee. 2018 – present.
- Scientific Abstract Reviewer, Wilderness Medical Society Conference. 2019 – present.
- Member, American College Health Association Data Warehouse Committee, 2016-present.
- Chair, Clinical Team Subgroup, American College Health Association Data Warehouse Committee, 2016-2018.
- Member, Advisory Council, Appalachian Center for Wilderness Medicine, 2013-2017.
- Chair, Committee on Ethics, American Academy of Clinical Toxicology. 2010-2013.
- Member, Steering Committee, Appalachian Center for Wilderness Medicine, 2009 – 2013.

- Member, Finance Committee, American Academy of Clinical Toxicology. 2008-2010.
- Chair, Abstract Review Committee, North American Congress of Clinical Toxicology, 2006-2009.
- Member, Toxicology and Environmental Health Information Program Communications Task Group, National Library of Medicine. 2006-2007.
- Abstract Reviewer, North American Congress of Clinical Toxicology. 2005-2006; 2016-present.
- Member, National First Aid Task Force, American Heart Association. 2004-2008.
- Member, American Board of Emergency Medicine, Medical Toxicology Recertification Examination Working Group. 2004.
- Member, Task Force to Develop Code of Ethics for Medical Toxicologists, American College of Medical Toxicologists. 2004-2006.
- Member, WMD Chem-Bioterrorism Committee, American College of Medical Toxicology. 2001-2002.
- Member, American Association of Poison Control Centers, Certification Examination for Specialists in Poison Information Working Group. 2001.
- Member, Education Committee. American Academy of Clinical Toxicology. 2000-2008.
- Member, American Osteopathic Board of Emergency Medicine, Medical Toxicology Exam Working Group. 1999.

G. International

- Abstract Reviewer, International Congress of the European Association of Poisons Centres and Clinical Toxicologists – 2006 - present.

XVI. FINANCIAL RESOURCES (GRANTS AND CONTRACTS)

A. Federal

- *CoVPN 3006. A randomized study to assess the efficacy of SARS-CoV-2 EUA vaccine in preventing SARS-CoV-2 infection and viral shedding in US college students*. Role: Site Co-Principal Investigator. Clinical Trial Sponsored by National Institute of Allergy and Infectious Diseases (NIAID) - National Institutes of Health (NIH) - Department of Health and Human Services (DHHS) - Bethesda, Maryland, USA. Study product provided by ModernaTX, Inc. (Cambridge, MA, USA). IRB-HSR#. 2021. ~$500,000.
- *CARES Act - Poison Center Support & Enhancement Project (Program CFDA: 93.253; Award #: 1 H4CHS37360-01-00; Grant # H4CHS37360).* Award # GB10831. Project # 164660. Role: Principal Investigator. Sponsor: U.S. Health Resources & Services Administration - Department of Health and Human Services. 2020-2021. $36,836.
- *Poison Control Centers Stabilization and Enhancement Grant Program (Program CFDA: 93.253; Award #: 2 H4BHS155281100; Grant #*

H4BHS15528). Award # GB10747. Project # 165255. Role: Principal Investigator. Sponsor: Health Resources and Services Administration - Department of Health and Human Services. 2014-2019. $ 732,237.

- *Poison Control Centers Stabilization and Enhancement Grant Program*. Award 93.253, HRSA-14-016. Role: Principal Investigator. Sponsor: Health Resources and Services Administration - Department of Health and Human Services. 2014-2019. $ 633,380.
- *Characterization of Drinking Water-Related Exposures Reported to AAPCC's National Poison Data System (NPDS).* Award # GF12804. Project # 142836. Role: Site Principle Investigator. Sponsor: Centers for Disease Control & Prevention – American Association of Poison Control Centers. 2013. $22,500.
- *Poison Control Centers Stabilization and Enhancement Grant Program*. Award # 6 H4BHS15528-03-01. Principal Investigator. Sponsor: Health Resources and Services Administration - Department of Health and Human Services. 2009-2014. $863,161.
- *Community Resilience/Shielding - Framework for the National Capital Region.* Contract # SP0600-08-C-5829. Award # GG11116. Project # 004. Role: Principal Investigator. Sponsor: Department of Defense – Defense Energy Support Center. 2008-2011. $2,495,863
- *Phase 1 Breacher Injury Study*. Role: Sub-Investigator. Sponsor: Department of the Navy. 2008-2009. $10,000.
- *Poison Control Centers Stabilization and Enhancement Grant Program*. Award # 6 H4BHS00082-07-01. Role: Principal Investigator. Health Resources and Services Administration - Department of Health and Human Services. 2007-2010. $456,831.
- *Community Shielding Proof of Concept for Mission Assurance: Pilot Study of Fort Belvoir*. Contract # BAL 119822. Role: Sub-Investigator. Sponsor: Department of Defense. *2006*. $8,057.
- *Poison Control Centers Stabilization and Enhancement Grant Program*. Award # 2 H4BMC00082-04-00. Role: Principal Investigator. Sponsor: Health Resources and Services Administration - Department of Health and Human Services. 2004-2007. $495,374.
- *Poison Control Centers Stabilization and Enhancement Grant Program*. Award # 5 H4BMC00082-03-00. Role: Principal Investigator. Sponsor: Health Resources and Services Administration - Department of Health and Human Services. 2001-2004. $420,294

B. State

- *Contract for Virginia Poison Control Network – Blue Ridge Poison Center*. Role: Principal Negotiator. Sponsor: Virginia Department of Health. 2000-present. $8,068,531.
- *Lead Education Grant*. Award # GS11221. Project # 142039. Role: Site Principal Investigator. Sponsor: Virginia Department of Health – CDC. 2012-2013. $29,072.

- *Preventing Unintentional Injuries: Training Care Providers of Senior Citizens to Perform Medication Management and Poison Prevention Education to their Clients*. Role: Principal Investigator. Sponsor: Virginia Department of Health, RFP #704EE087. Preventive Health & Health Services Block Grant, CDC. 2009. $12,043.67
- *Preventing Unintentional Injuries: Preventing Poison Injuries in Adults.* Role: Principal Investigator. Sponsor: Virginia Department of Health, RFP #704EE087. Preventive Health & Health Services Block Grant, CDC. 2009. $12,539.89
- *Preventing Unintentional Injuries: Poison Prevention Train-the-trainer for Senior Care Providers. Role:* Principal Investigator. Sponsor: Virginia Department of Health. Preventive Health & Health Services Block Grant 2B01 DP009055. CDC. 2008. $12,491.01
- *Preventing Unintentional Injuries: Poison Prevention Train-the-trainer for Childcare Providers.* Role: Principal Investigator. Sponsor: Virginia Department of Health. Preventive Health & Health Services Block Grant 2B01 DP009055. CDC. 2008. $11,998.46
- *Lead Education Grant*. Award # GS10993. Project # 134001. Role: Site Principal Investigator. Sponsor: Virginia Department of Health – CDC. 2004-2009. $287,423
- *Contract for Night Poison Center Services with Palmetto Poison Center*. Role: Principal Negotiator. Sponsor: University of South Carolina. 2003-2005. $144,000.

C. Other

- *University of Virginia Initiative on Social and Equitable Indicators of Recidivism*. Award # GI15926. Project # 168381. Role: Principal Investigator. Sponsor: The MITRE Corporation. June 8, 2021 to September 30, 2021. $40,000.
- *Surveillance of the Misuse, Abuse and Diversion of RADARS 8*. Award # GI12350. Project # 129282. Role: UVA Site Principal Investigator. Sponsor: Denver Health & Hospital Authority. July 1, 2007 to present. $457,500.
- *A Phase 2b Randomized Blinded Study to Evaluate SYN023 Compared to Human Rabies Immune Globulin in Post Exposure Prophylaxis of Rabies in Adults with Different Rabies Exposure Risks*. Award # GI15455. Project # 163279. Role: UVA Site Principal Investigator. Sponsor: PPD Investigator Services, LLC; Synermore Holdings Limited. Awarded: February 4, 2020. $12,500 startup plus $24,925 per patient entered.
- *A Portable Microfluidic Detector for Rapid Identification of Infectious Pathogens and Substances of Abuse*. Role: Co-Faculty Sponsor. Center for Engineering in Medicine Seed Grant Program; Sponsor: University of Virginia. $70,297.
- *Stabilized Isoamyl Nitrate (SIAN) Toxicity*. Award #GI15387. Project #162571. Role: Principal Investigator. Sponsor: Emergent Biosolutions, Inc – U.S. Department of Health & Human Services. 2016-2020. $3,245

- *Expertise in the Clinical Toxicology Realm*. Award #GI14630. Project #152716. Role: Principal Investigator. Sponsor: Emergent Countermeasures International, Ltd. 2016-2020. $40,000
- *The Efficacy & Safety of Aracmyn (Black Widow) in Patients with Systemic Latrodectism – Phase 2 & 3*. Award # GI11816. Project # 133616. Role: UVA Site Principle Investigator. Sponsor: Denver Health & Hospital Authority in association & Rare Disease Therapeutics. 2005-2017. $25,620.
- *Health Insurance Literacy Among College Students.* Role: Faculty Sponsor. Sponsor: UVA Double Hoo Research Grant. 2016-2018. $4,000
- *Innovations in Toxicological Education through Mock Patient Cases and Critical Peer-to-Peer Evaluation*. Role: Principal Investigator. Sponsor: UVA Academy of Distinguished Educators. 2014-2015. $15,000.
- *Protein Adduct Concentrations in the United States Population (Adult).* Award # GI13351. Project # 139723. Role: UVa Site Principle Investigator. Sponsor: Rocky Mountain Poison and Drug Center & McNeil. 2011-2012. $63,906
- *Cross reactivity of Veratrum viride with digoxin assays*. Award # GF11847. Project # 129513. Role: Principal Investigator. Sponsor: American Academy of Clinical Toxicology Lampe-Kunkle Memorial Award for Research on Natural Products of Toxicology. 2007. $2,250
- *Poison Center Surveillance of Agricultural Poisonings*. Award # GO10816. Project # 131322. Role: UVa Site Investigator. Sponsor: University of Kentucky Research Foundation - National Institute of Occupational Health and Safety. 2007. $7,198.
- *Glucose uptake sensitivity in cardiac vs. skeletal muscle cells in CCB toxicity*. Award # GF11848. Project # 129515. Role: Principal Investigator. Sponsor: American Academy of Clinical Toxicology Research Award. 2007. $3,250
- *Multicenter Retrospective Review of the Clinical Efficacy and Safety of DigiFab^{TM} in Digoxin Poisoned Patients.* Award # GI11982. Project # 125831. UVa Site Investigator. Sponsor: Denver Health & Hospital Authority. 2006. $4,375.
- *Laboratory Evaluation of the Molecular Basis for Calcium Channel Blocker Induced Hyperglycemia*. Role: Principal Investigator. Sponsor: University of Virginia Department of Emergency Medicine Faculty Research Fund. 2006. $5,000.
- *Studies of the Molecular Basis for Calcium Channel Blocker Induced Hyperglycemia*. Role: Principal Investigator. Sponsor: University of Virginia Department of Emergency Medicine Faculty Research Fund. 2005. $6,900.
- *Practical Strategies in the Clinical Diagnosis and Management of Childhood Lead Poisoning: A Case-Based Approach*. Principal Investigator. Sponsor: Cameron Foundation Grant. 2004. $20,000.
- *Moonshine Contaminants in Virginia*. Role: Principal Investigator. Sponsor: University of Virginia Department of Emergency Medicine Faculty Research Fund. 2002. $3,000.

- *Surveillance of the RADARS 7 by Poison Control Centers: A Pilot Study*. Role: UVa Site Investigator. Sponsor: Denver Health & Hospital Authority in association with Purdue Pharma L.P. 2002. $18,500.

XVII. CURRENT RESEARCH/SCHOLARSHIP

A) Research Programs Developed
- Student Health Office of Research Engagement (SHORE)
  SHORE facilitates the exploration of scientific study pertaining to the student population with the goal to improve student health and wellbeing. The SHORE team assists with enrolling student research participants who are representative of our collegiate populations with the upmost respect for each individual and assuring research projects are managed in full compliance with regulations and guidance. Our inclusive mission facilitates student participation in quality research with the goal of benefitting the student population, higher education, and society as a whole.

B) Past Research Activities
See additional listings

C) Recent Research Activities
- *University of Virginia Student Health Research Database*. Role: Study Principal Investigator. A large prospective collection of data containing electronic medical record data from the university health system (Epic), student health center (Medicat), student information system (SIS), dean's database (SafeGrounds), and disability access center (AIM) with numerous associated IRB approved studies. Sponsor: University of Virginia Division of Student Affairs. IRB-HSR# 17141.
- *Student Health Research Database: Epidemiology and risk markers of common reasons for ED visits among students at University of Virginia*. Role: Study Principal Investigator. Sponsor: University of Virginia Division of Student Affairs. IRB-HSR# 19397.
- *College Health Surveillance Network (CHSN).* Role: Study Principal Investigator. A large prospective collection of data containing EMR data from 33 universities across the country. Sponsor: University of Virginia Division of Student Affairs. IRB-HSR # 18454
- *A Phase 2b Randomized Blinded Study to Evaluate SYN023 Compared to Human Rabies Immune Globulin in Post Exposure Prophylaxis of Rabies in Adults with Different Rabies Exposure Risks*. Role: Site Principle Investigator. Sponsor: Synermore Biologics, Ltd. IRB-HSR # 190039
- *CoVPN 3006. A randomized study to assess the efficacy of SARS-CoV-2 EUA vaccine in preventing SARS-CoV-2 infection and viral shedding in US college students*. Role: Site Co-Principal Investigator. Clinical Trial Sponsored by National Institute of Allergy and Infectious Diseases (NIAID) - National Institutes of Health (NIH) - Department of Health and Human Services (DHHS) - Bethesda, Maryland, USA. Study product provided by ModernaTX, Inc. (Cambridge, MA, USA). IRB-HSR#

- *ToxIC Registry*. Role: Site Principal Investigator. ToxIC is the American College of Medical Toxicology's nation-wide research and collaboration network. Organizationally, ToxIC is divided into 4 Cores: Infrastructure, Registry, Research and Toxicovigilance. Sponsor: American College of Medical Toxicology. IRB-HSR# 15579.
- *Identification of biomarkers in diseased specimens*. Role: sub-investigator. Sponsor: UVA School of Medicine Department of Pathology. IRB-HSR# 13310.
- *Archival data study: sexual harm incident analysis*. Role: sub-investigator. Sponsor: UVA Department of Student Health & Wellness. IRB-SBS# 4260.

XVIII. PAPERS PUBLISHED OR IN PRESS (italics indicate trainee, * indicates corresponding author)

A. Peer Reviewed Journals

1. *Dignan L, Woolf M*; *Ross J*; Baehr C; **Holstege C**; Pravetoni M; Landers J. Membrane-modulated centrifugal microdevice for enzyme-linked immunosorbent assay-based detection of illicit and misused drugs. Analytical Chemistry (submitted)
2. Hayden ME, Burns L, *Farquhar S,* Tanabe KO, Bernheim RG, Baker K, **Holstege CP*.** Using an Exposure Call Center to Help Mitigate COVID-19 on a University Campus. J Am Coll Health. 2021. (accepted, publication pending).
3. Rege S, *Wood M, Ross JA*, **Holstege CP**. Heroin Exposures Reported to a National Real-time Poison Database. International Journal of Mental Health and Addiction. 2021.
4. Hayden ME, Rozycki D, Tanabe KO, Pattie M, Casteen L, Davis S, **Holstege CP*.** COVID-19 Isolation and Quarantine Experience for Residential Students at a Large, 4-year Public University American Journal of Public Health. Am J Public Health. 2021.
5. Tanabe KO, Hayden ME, Rege S, Simmons J, **Holstege, CP***. Risk Factors Associated with Concussions in a College Student Population. Ann Epidemiol 2021;62:77-83.
6. *Ross J*, **Holstege CP**. Comment on Seizure in venlafaxine overdose: a 10-year. retrospective review of the California poison control system. Clin Toxicol 2021;59(9):856–857.
7. Ross J. **Holstege CP**. Comment on "Effects of Acetaminophen on Risk Taking". Soc Cogn Affect Neurosci. 2021;16(5): 537–538.
8. Rege S, *Smith M*, Borek HA, **Holstege CP**. Opioid Exposure Reported to U.S. Poison Centers. Substance Use & Misuse 2021;56(8):1169-1181.
9. *Ross JA*, Borek HA, **Holstege CP***. Toxic Alcohols. Critical Care Clin. 2021;37(3):643-656.
10. Tanabe K, Hayden M, Zunder B, **Holstege CP*.** Identifying Vulnerable Populations at a University during the COVID-19 Pandemic. J Am Coll Health. 2021
11. *Snyder MH, Ross JA*, Rege SV, **Holstege CP**. Comment on Pediatric guanfacine exposures reported to the National Poison Data System, 2000-2016. Clin Toxicol. 2021;59(8):767
12. **Holstege CP**, Ngo DA, Borek H, Ait-Daoud N, Davis S, Rege S**.** Trends and Risk Markers of Student Hazardous Drinking – A Comparative Analysis Using

Longitudinally Linked Datasets in a Public University. J Am Coll Health. 2020; October: 1-8.

13. Rege SV, Borek H, **Holstege CP**. Response to Do Patients Require Emergency Department Interventions After Prehospital Naloxone? J Addict Med. 2020 Aug 12.
14. *Ross JA,* Downs JW, Bazydlo LA, Bordwine PH, Gineste CE, *Kopatic MC,* Rege S, Saady DM, Utah OF, Wyatt SA, Wills BK, Rose SR, **Holstege CP**. Outbreak of Severe Hypoglycemia After Ingestion of a Male Enhancement Supplement—Virginia, August–November 2019 MMWR Morb Mortal Wkly Rep. 2020 Jun 19; 69(24): 740–743.
15. Rege SV, Ngo DA, Ait-Daoud N, *Rizer J, Sharma S,* **Holstege CP**. Epidemiology of pediatric buprenorphine and methadone exposures reported to the U.S. poison centers. Ann Epidemiol 2020 (Jan7)
16. *Kim* J, Ngo DA, Rege S, Tolley W, **Holstege CP.** Impact of instituting hard-waiver on a student health insurance program at a public university. J Am Coll Health. 2019 Oct 7:1-8.
17. Mullins M, Yarema M, Sivilotti M, Thompson M, Algren D, Beuhler M, **Holstege CP**. Comment on "Acetylcysteine in paracetamol poisoning: a perspective of 45 years of use". Toxicol Res 2019;8:1057.
18. Rege S, Anh N, Ait-Daoud N, **Holstege CP**. Epidemiology of Severe Buprenorphine Exposures Reported to the U.S. Poison Centers. Drug and Alcohol Dependence 2019;202:115-122.
19. Mullins M, Yarema M, Sivilotti M, Thompson M, Algren D, Beuhler M, **Holstege CP**. Transition to two-bag intravenous acetylcysteine for acetaminophen overdose. Clin Toxicol (Phila). 2019 Aug 7:1-3
20. Ait-Daoud N, *Blevins D, Khanna S, Sharma S,* **Holstege CP**, *Amin P*. Women and Addiction: An Update. Med Clin North Am. 2019 Jul;103(4):699-711.
21. Dart RC, Bush SP, Heard K, Arnold TC, Sutter M, Campagne D, **Holstege CP**, Seifert SA, Lo JCY, Quan D, Borron S, Meurer DA, Burnham RI, McNally J, Garcia-Ubbelohde W, Anderson VE. Efficacy of antivenin Latrodectus (Black Widow) equine immune F(ab)2 in the treatment of latrodectism. Ann Emerg Med 2019 March.
22. Ngo DA, Rege SV, Ait-Daoud N, **Holstege CP**. Development and validation of a risk predictive model for student alcohol intoxication associated with emergency department visits – a longitudinal data-linkage study. Drug Alcohol Dependence 2019;197:102-7.
23. Rege S, Ngo A, Ait-Daoud N, *Sharma S, Verplancken E,* **Holstege CP**. Trends and characteristics of naloxone therapy reported to the U.S. poison centers. Addiction 2018 Dec;113(12):2309-2315.
24. *Nobles AL,* Ngo DA, *Curtis BA, Vardell E,* **Holstege CP**. Health insurance literacy: A mixed methods study of college students. J Am College Health. 2018; Jul 6:1-37.
25. Ngo DA, Rege S, Ait-Daoud N, *Ding C, Gallion L,* **Holstege CP**. Validity of diagnostic coding of alcohol intoxication with student university hospital emergency department visits. J Addict Med 2018 Nov/Dec;12(6):499-500.
26. Ngo DA, Rege S, Ait-Daoud N, **Holstege CP**. Trends in incidence and risk markers of student emergency department visits with alcohol intoxication in a U.S. public

university – A longitudinal data linkage study. Drug Alcohol Dependence 2018;188:341-347.

27. *Parker-Cote JL, Rizer J*, Vakkalanka JP, Rege SV, **Holstege CP**. Challenges in the diagnosis of acute cyanide poisoning. Clin Toxicol (Phil). 2018; 56(7): 609-617.
28. Ngo DA, Ait-Daoud N, Rege SV, *Ding C, Gallion L*, Davis S, **Holstege CP**. Differentials and trends in emergency department visits due to alcohol intoxication and co-occurring conditions among students in a U.S. public university. Drug Alcohol Depend 2018 Feb 1;183:89-95.
29. Ait-Daoud N*, *Blevins D, Khanna S*, Sharma S, **Holstege CP**. Women and Addiction. Psychiatric Clinics of NA 2017;40(2):285-297.
30. Vakkalanka JP, Charlton NP, **Holstege CP***. Epidemiologic Trends in Loperamide Abuse and Misuse. Ann Emerg Med. 2017;69(1):73-78.
31. *Mlodzinski SR*, **Holstege CP***. Man with Altered Mental Status and Rash. Ann Emerg Med. 2016;68(3):387-98.
32. Vakkalanka JP*, *King JD*, **Holstege CP**. Abuse, misuse, and suicidal substance use by children on school property. Clin Toxicol (Phila). 2015;53(9):901-7.
33. *Forrester JD**, Vakkalanka JP, **Holstege CP**, Mead P. Comprehensive Review of Lyme disease for Wilderness Medical Providers. Wilderness Environ Med. 2015;26(4):555-64.
34. Stella AC, Vakkalanka JP, **Holstege CP**, Charlton NP*. The epidemiology of caving fatalities in the United States (letter). Wild Environ Med 2015;26(3):436-7.
35. Vakkalanka JP*; *Hardison LS, Bishop M*, Haverstick DM; *Rushton WF*, **Holstege CP**. Evaluation of the Initiation of Urine Drug Screens Intended for Use in Transfer Patients. Am J Emerg Med 2014;32(9):1037-40.
36. Vakkalanka JP*, *Hardison LS*, **Holstege CP**. Epidemiological trends in electronic cigarette exposures reported to U.S. Poison Centers. Clin Toxicol 2014;52(5):542-8.
37. *Mohorn PL**, Vakkalanka JP, *Rushton W, Hardison L*, Woloszyn A, **Holstege CP**, Corbett SM. Evaluation of dexmedetomidine therapy for sedation in patients with toxicological events at an academic medical center. Clin Toxicol 2014;52(5):525-30.
38. *Martinez CP**, **Holstege CP**, Ait-Daoud N. Cold, in Shock, and Confused. Current Psychiatry 2014;13(2):76.
39. Gunderson EW*, Kirkpatrick M, Willing LM, **Holstege CP**. Substituted Cathinone Products: A New Trend in "Bath Salts" and Other Designer Stimulant Drug Use. J Addiction Med. 2013;7(3)153-62.
40. Gunderson EW*, Kirkpatrick M, Willing LM, **Holstege CP**. Clinical Case Discussion: Intranasal Substituted Cathinone "Bath Salt" Psychosis Exacerbated by Diphenhydramine. J Addiction Med. 2013;7(3)163-9.
41. *Carlberg DJ, Borek HA**, Syverud SA, **Holstege CP**. Survival of Acute Hypernatremia due to Massive Soy Sauce Ingestion. J Emerg Med. 2013.
42. Dart RC*, Bogdan G, Heard K, Bartelson BB, Garcia-Ubbelohde W, Bush S, Arnold T, Clark RC, Hendey G, **Holstege CP**, Spradley EA. A Randomized, Double Blind, Placebo Controlled Trial of a Highly Purified Equine $F(ab)_2$ Antibody Black Widow Spider Antivenom. Ann Emerg Med 2013.
43. *Forrester JA**, **Holstege CP**, *Forrester JD.* Fatalities from Venomous and Nonvenomous Animals in the United States (1999 –2007). Wild Environ Med 2012;23:146-152.

44. *Borek HA*, **Holstege CP***. Multiorgan Failure and Hyperthermia after Abuse of "Bath Salts" Containing 3,4- Methylenedioxypyrovalerone. Ann Emerg Med 2012;60(1):103-5..
45. **Holstege CP***, *Borek HA*. Toxidromes. Critical Care Clin. 2012;28(4):479-98.
46. *Stella AC*, **Holstege CP**, Lee J, Charlton NP*. The epidemiology of Caving Injuries in the United States. Wilderness Environ Med. 2012;23(3):215-22.
47. *Bechtel LK**, *Lawrence D*, **Holstege CP**. Ingestion of False Hellebore Plants Can Cross-react with a Digoxin Clinical Chemistry Assay. Clin Toxicol 2010;48(5):435-442.
48. Louters LL, *Stehouwer N, Rekman J, Tidball A, Cok A*, **Holstege CP***. Verapamil inhibits the glucose transporter GLUT1. J Med Toxicol 2010;6(2):100-5.
49. Garcia D, Mattu A, **Holstege CP**, Brady WJ*. Intraventricular Conduction Abnormality - An Electrocardiographic Algorithm for Rapid Diagnosis. Am J Emerg Med 2010;28(1):95-102.
50. *Barker S**, Charlton NP, **Holstege CP**. Accuracy of internet recommendations for prehospital care of venous snake bites. Wilderness Environ Med 2010;21:298-302.
51. Copan L, Ujihara A, Jones C, DasR , Kreutzer R, Roisman R, Haas RA, Perez G, Moezzi B, Miller MD, Solomon G, Ryals R, Vitale L, Davis MR, Rogow M, LePrell RV, Flammia D, Bradshaw RD, Sullivan KE, Davis SF, Watson J, Achter A, Myrick-West A, **Holstege CP**, Norwood VF, Bender TJ. Mercury Exposure Among Users and Nonusers of Skin-Lightening Creams Produced in Mexico — California and Virginia, 2010. MMWR 2012;61(2):33-36.
52. **Holstege CP***, *Forrester JD, Borek HA*, Lawrence DT. A case of cyanide poisoning and the use of arterial blood gas analysis to direct therapy. Hosp Pract 2010;38(4):1-6.
53. *Forrester J**, **Holstege CP**. A mystery infection. Wilderness Environ Med 2010;21(3):262-4.
54. Lawrence DT*, *Bechtel LK*, Charlton NP, **Holstege CP**. 5-Oxoproline–induced anion gap metabolic acidosis after an acute acetaminophen overdose. J Am Osteopath Assoc. 2010;110(9):545-551.
55. Charlton NP*. *Smith M*. **Holstege CP**. Caterpillar dermatitis. Wilderness Environ Med 2010;21(2):164-5.
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H. Picture Credits

1. **Holstege CP**. Hydrofluoric Acid Poisoning ECG. MedEdPORTAL, Association of American Medical Colleges.
2. **Holstege CP**: Methemoglobinemia. In Mader SS: Biology. 10th & 11th edition. McGraw-Hill. ISBN 007-352543-X.
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I. Published Acknowledgements of Assistance

1. *Ross J*. The Importance of Continuing the Dialogue: A Fellow's Perspective on Letters to the Editor. J Medical Toxicol. 2021; 17: 237-8.
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XIX. INVITED LECTURES AND SYMPOSIUMS **(last updated 2021)**

Regional, national & international lectures listed only (other lectures in portfolio)

- *Wilderness Toxicology*. **2020 Southeastern Student Wilderness Medicine Conference.** Roanoke, VA. March 7th, 2020.
- *Threat Assessment.* **American College of Medical Toxicology (ACMT) "Criminal Poisoning & Drug-Facilitated Sexual Assault: Forensic, Legal, and Medical Aspects".** Washington, DC. December 9, 2019.
- *Toxins on the Farm that can Kill & Associated Risk for EMS Personnel*. **2019 Virginia EMS Symposium**. Norfolk, VA. November 06, 2019.
- The Wild and Rapidly Changing Realm of Substance Use & Misuse**. The 46th annual Edward W. Hook Recent Advance in Clinical Medicine.** Charlottesville, VA. October 24th, 2019.
- *Smooth Criminal: Addiction, Criminal Behavior, and Recidivism.* **North American Congress Clinical Toxicology (NACCT) - ACMT Pre-Meeting Symposium. Music City Mixology: The High Notes and Low Notes of Booze and Drug.** Nashville, TN. September 23, 2019.
- *Emerging Substance Use & Misuse Trends.* **Virginia Department of Education. 2019 Summer Institute for School Nursing.** Farmville, VA. July 11, 2019.
- Clinical Effects of Cyanide. **European Association of Poisons Centres and Clinical Toxicologists**. Naples, Italy. May 24, 2019.
- Toxicological Dangers Encountered on the Farm. **March Medical Madness EMS Symposium**. Palmyra, VA March 12, 2019.
- Emerging substance use and misuse trends. **Albemarle County Medical Society**. Charlottesville, VA. March 7, 2019.

- Moonshine and contaminants. **Virginia Department of Health Annual Meeting**. Suffolk, VA. December 6, 2018.
- New Emerging Illicit Drug Trends and the Appropriate EMS management of the inebriated patient. **2018 Virginia EMS Symposium**. Norfolk, Va. November 10, 2019.
- How to Navigate your way through the Epidemic of Emerging Drugs. **2018 Society of Forensic Toxicologists (SOFT) Annual Meeting**. Minneapolis, MN. October 8, 2019.
- Patterns of Heroin Exposures Reported to the US Poison Centers. **European Society of Emergency Medicine Annual Conference**. Glasgow, Scotland. September 11, 2019
- Complications associated with the administration of naloxone. **European Society of Emergency Medicine Annual Conference**. Glasgow, Scotland. September 11, 2019.
- *Resuscitation of the Critically Ill Poisoned Patient.* **Greenville Department of Emergency Medicine & Visiting Faculty Grand Rounds.** Greenville, SC. December 12, 2017.
- *Isolation of Communicable Diseases.* **ACC Emergency Managers Annual Conference.** Charlottesville, VA. December 4, 2017.
- *Criminal Poisoning and the Role of First Responders in Management and Documentation*. **2017 Virginia EMS Symposium**. Norfolk, VA. November 11, 2017.
- *The Opioid & Other Drug Abuse Epidemic & School-aged Children/Young Adults.* **Bedford County School Association.** Bedford, VA. November 8th, 2017.
- A*lcohol & Drug Use in Adolescents and Emerging Adults.* **American Psychological Association Annual Convention.** Washington, DC. August 4, 2017.
- *Criminal Poisoning & the Role of Emergency Medicine.* **Indiana University Visiting Faculty Emergency Medicine Grand Rounds.** Indianapolis, IN. November 15, 2017.
- *Toxicology and Its Impact on Workers' Compensation*. **Commonwealth Contractors Group Self Insurance Association Annual Seminar.** Williamsburg, VA. January 14, 2018.
- *Shock - Managing the Critically Ill Poisoned Patient. Ingestions - Assessment and Management of Acute Oral Poisonings. Environmental - Heat & Cold Related Illness. Acute Allergic Reactions – Learning from other's errors.* **22nd Annual North Lake Tahoe Paramedic Refresher Course.** Lake Tahoe, NV. November 30, 2017.
- *The Opioid & Other Drug Abuse Epidemic & Impact on Teens & Young Adults.* **9th Annual Virginia Teen Culture Conference.** Charlottesville, VA. October 9, 2017.
- *The Opioid Crisis – Current Reality Based on Epidemiologic Study and Emergency Medicine's Role.* **Virginia College of Emergency Medicine (VACP) Annual Conference.** Homestead, VA. February 10, 2018.
- *Bioterrorism and Insider Threat - The Anthrax Mailings of 2001*. **Western State Grand Rounds.** Stanton, VA. February 7, 2018.

- *Envenomations & Large Animal Attacked*. **March Medical Madness EMS Conference**. March 11, 2017. Palmyra, VA
- *Toxins on the Farm that Kill*. **Thomas Jefferson Council Continuing Education EMS Day.** March 4, 2017. Charlottesville, VA.
- *Pediatric Toxicology*. **Pegasus Critical Response**. April 22, 2017. Charlottesville, VA
- *Emerging Illicit Drug Trends and First Responder Management of Excited Delirium.* **2017 Virginia Fire & Rescue Conference**. February 25, 2017. Virginia Beach, VA
- **Rapid Visual Diagnosis Clues for the EMS Provider**. 37th Annual EMS Symposium, November 9th, 2016, Norfolk, VA.
- **Prescription Medication Abuse in the Workplace**. 21st Virginia OSHA Conference. October 19, 2016. Hampton, VA.
- *Lead Poisoning in Children & the Flint Water Crisis*. **Virginia Public Health and Healthcare Preparedness Academy**. Portsmouth, VA. May 17, 2016.
  Pediatric Toxicology: The Latest on Substances of Abuse. **36th McLemore Birdsong Pediatric Conference**. Bath County, VA. May 13, 2016.
- *Toxicology Cases.* **36th McLemore Birdsong Pediatric Conference.** Bath County, VA. May 14, 2016.
- *Emerging Illicit Drug Trends and Appropriate EMS Management of the Inebriated Patient*. **Pegasus Critical Response**. Charlottesville VA. April 9, 2016.
- *The Latest in Party Drugs.* **Aircare 5 Live.** Weirs Cave, VA. April 2, 2016.
- *Rapid Visual Diagnosis*. **March EMS Medical Madness**. Fluvanna, VA. March 12, 2016
- *Emerging Illicit Drug Trends and Appropriate EMS Management of the Inebriated Patient*. **2015 Virginia EMS Symposium**. Norfolk, VA. November 11, 2016.
- *Prescription Drugs in the Workplace & How to Recognize the Problem*. **20th Annual Virginia Occupational Safety Heath Conference**.
  Roanoke, VA. October 21, 2015.
- *Potential Adverse Reactions and Errors with Common Medications*. **Pharmfest - Virginia Council of Nurse Practitioners.** Charlottesville, VA. January 31, 2015.
- *Toxicology for the Neurologist: Drugs of Abuse*. **Virginia Neurological Society Annual Meeting.** Hot Springs, VA. January 30, 2015.
- *Emerging Illicit Drug Trends and Appropriate Management*. **C.A.R.E. Education Symposium**. Fishersville, VA. August 16, 2014.
- *Updates in Resuscitation of Poisoning Emergencies*. **European Congress of Emergency Medicine – European Society of Emergency Medicine**. Amsterdam, The Netherlands. September 28, 2014.
- *Appropriate Antidote Utilization in Emergency Medicine*. **European Congress of Emergency Medicine – European Society of Emergency Medicine.** Amsterdam, The Netherlands. September 28, 2014.
- Moderator. *Research Symposium*. **European Congress of Emergency Medicine – European Society of Emergency Medicine**. Amsterdam, The Netherlands. September 28, 2014.

- *Virginia's Evolving Drugs of Abuse Patterns*. **Virginia EMS Symposium**. Operational Medical Directors Workshop. Norfolk, VA. November 6, 2014.
- *Toxicology for the Neurologist: Drugs of Abuse.* **Virginia Neurological Society Annual Meeting**. Hot Springs, VA. January 30, 2015.
- *Potential Adverse Reactions and Errors with Common Medications*. **Pharmfest - Virginia Council of Nurse Practitioners**. Charlottesville, VA. January 31, 2015.
- *Envenomations*. **March EMS Medical Madness**. Fluvanna, VA. March 14, 2015.
- *Rapid Visual Diagnosis in Emergency Medicine; High Dose Insulin for Calcium Channel Blocker Toxicity; Workshop on a Series of Common Neurotoxin Case Presentations.* **7th Dutch North Sea Emergency Medicine Conference.** Egmond aan zee, The Netherlands. June 6, 2013.
- *Single Swallows and Pills that Kill.* **Critical Response 2013 Regional EMS Conference.** Charlottesville, Virginia. June 1, 2013.
- *Internet Acquired Drugs of Abuse.* **Virginia School Nurses Association & Virginia Chapter of the American Association of Pediatrics State Conference.** Staunton, Virginia. May 31, 2013.
- *New Synthetic Drugs of Abuse.* **Fairfax County 2013 Regional EMS Week.** Fairfax, Virginia. May 15, 2013.
- *Substances of Abuse.* **Aircare Live 2013 Regional EMS Conference.** Weyers Cave, Virginia. April 27, 2013.
- *New Synthetic Drugs of Abuse.* **March Medical Madness Regional EMS Conference.** Palmyra, Virginia. March 16, 2013.
- *Bath Salts and other Synthetic Drugs of Abuse; Toxicology as it Pertains to EMS.* **JEMS EMS Today National Conference.** Washington, DC. March 7, 2013.
- *Drug Facilitated Sexual Assault.* **The Judge Advocate General's School 44th Intermediate Trial Advocacy Course.** Charlottesville, Virginia. January 9, 2013.
- *Emerging Substances of Abuse.* **Virginia Occupational Health and Safety Association State Conference.** Roanoke, Virginia. October 4, 2013.
- *The Amerithrax Case and Substance Abuse.* **Chemical and Biological Treatment Symposium (CBMTS**). Spiez, Switzerland. May 7, 2012.
- *Unstable Overdose Patient; New Drug Trends; Frequent Overdoses and Drug Interactions.* **Florida Emergency Physicians Symposium on Emergency Medicine & Acute Care.** Orlando, Florida. March 24, 2012
- *Pediatric Poisonings.* **Virginia Council of Nurse Practitioners 2012 Annual Conference**. Hot Springs, Virginia. March 10, 2012
- *Virginia Drug Use Trends and Emerging Issues*. **Virginia College Alcohol Leadership Council - Virginia College Substance Abuse Prevention Meeting**. Charlottesville, VA March 6, 2012.
- *Snake Envenomation*. **Advanced Clinical Education Symposium**, PHI Air Medical AirCare 4 & Valley Health. Shenandoah University, Winchester, VA March 3, 2012
- *Internet Promoted Substance Abuse; Rapid Visual Diagnosis of Poisonings*. **Virginia College of Emergency Medicine Winter Meeting**. Hot Springs, Virginia. February 16, 2012.

- *Toxicology*. Resuscitation for Emergency Physicians. **AAEM Scientific Meeting**. San Diego, CA. February 6, 2012
- *The Role of 4-MP in Managing Alcohol Poisoning.* **Asia Pacific Association of Medical Toxicology Congress**. Penang, Malaysia. November 11-14, 2011.
- *Emerging Drugs of Abuse; Cyanide Poisoning; Drug Facilitated Sexual Assaults*. **Clinical Toxicology Workshop**. Taipei, Taiwan. November 9-10, 2011.
- *Pediatric Toxicology Resuscitation.* **Seven Hills Emergency Nurses Association**. Lynchburg, VA. October 20, 2011
- *Emerging Drugs of Abuse*. **Blue Ridge Area Acute Care Nurses Symposium**. Harrisonburg, VA. September 8, 2011.
- Clinical Toxicology. **Toxicology for Industrial and Regulatory Scientists - American College of Toxicology**. Falls Church, Virginia. May 19, 2011.
- Criminal Poisoners. **FBI Violent Crimes Seminar**. Ann Arbor, Michigan. May 2, 2011.
- *The Top 5 Deadly Toxins*. **AirCare 5 Live 2011**. Weyers Cave, Virginia. April 16, 2011.
- *Wilderness Medicine*. **McLemore Birdsong Pediatric Conference**. Charlottesville, Virginia. March 26, 2011.
- *Toxicology Patient in Extremis*. **American Academy of Emergency Medicine Resuscitation Course for Emergency Physicians**. Orlando, Florida. February 27, 2011.
- *Emerging Drugs of Abuse*. **Critical Response 2011**. Charlottesville, Virginia. February 12, 2011.
- *Criminal Poisoning*. **Charlottesville/Albemarle Bar Association**. Charlottesville, Virginia. November 18, 2010.
- *Rapid Visual Diagnosis in Emergency Care" & "Single Pills & Swallows that Kill Children.* **31st Annual Virginia EMS Symposium**. Norfolk, VA. November 12, 2010.
- *Medical Murderers*. **SAEM Mid-Atlantic Regional Meeting.** Charlottesville, Virginia. April 15, 2010.
- *Cyanide Poisoning & Drug Facilitated Sexual Assault*. **American Academy of Emergency Medicine 16th Annual Scientific Session**. Las Vegas; Nevada, February 13, 2010
- *The Toxicology Patient in Extremis*. **American Academy of Emergency Medicine 16th Annual Scientific Session**. Las Vegas; Nevada, February 14, 2010
- *The Approach and Management of the Poisoned Patient.* **30th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 13, 2009.
- *Drug Facilitated Sexual Assaults*. **Asian Pacific Association of Medical Toxicology**. Beijing, China. October 21, 2009.
- *Medical Murderers*. **Workshop on Criminal Poisoning**. Taipei Veterans Hospital. Taiwan. November 8, 2008.
- *Munchausen's by Proxy Using Toxins*. **Workshop on Criminal Poisoning**. Taipei Veterans Hospital. Taiwan. November 8, 2008.

- *Multiple Communications for Poison Centers During Mass Chemical Exposur*e. **Workshop on Criminal Poisoning**. Taipei Veterans Hospital. Taiwan. November 8, 2008.
- *Rapid Visual Diagnosis in Emergency Car 1 & 2*. **29th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 13, 2008.
- *Toxicological Emergencies*. **Second Dutch North Sea Emergency Medicine Congress**. Egmond Aan Zee, The Netherlands. June 6, 2008.
- *Critical cases encountered in Emergency Medicine, case-based interactive presentations*. **Second Dutch North Sea Emergency Medicine Congress**. Egmond Aan Zee, The Netherlands. June 6, 2007.
- *Resuscitations in Toxicology*. **American Academy Emergency Medicine** - Resuscitation for Emergency Physicians, Amelia Island, Florida. February 6, 2008.
- *Chemical Contamination of Food, Drinks & Drugs*. **29th Annual International Disaster Management Conference** – Agents of Opportunity Pre-symposium. Orlando, Florida. January 31, 2008.
- *Cyanide & Fumigants*. **29th Annual International Disaster Management Conference** – Agents of Opportunity Pre-symposium. Orlando, Florida. January 31, 2008.
- *Rapid Visual Diagnosis in Emergency Care.* **28th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 9, 2007.
- *Chemical Agents Utilized in Terrorism*. **First Dutch North Sea Emergency Medicine Congress**. Egmond Aan Zee, The Netherlands. June 7, 2007.
- *Visual Diagnosis in Emergency Medicine*. **First Dutch North Sea Emergency Medicine Congress**. Egmond Aan Zee, The Netherlands. June 7, 2007.
- *Toxicology & Terrorism*. Crisis Management and Terrorism: Enhancing Organizational Reliability. **Center for Crisis Management Research and Training - Swedish National Defense College. Folke Bernadotte Academy**. Sandö, Sweden. March 7, 2007
- *Medical Murderers.* **27th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 11, 2006.
- *Envenomations.* **27th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 11, 2006.
- *Psychiatry versus Toxicology - Updates in the Use of Sedatives in the Management of the Potential Poisoned Agitated Patient.* **North American Congress Clinical Toxicology.** San Francisco, California. October 4, 2006.
- *Potential Agents of Terrorism.* **National Executive Institute Association (FBI).** Sun Valley, Idaho. June 10, 2006.
- *Chemical Disaster Preparedness*. **Blue Ridge Safety Association.** Harrisonburg, Virginia. April 20, 2006.
- *Household Toxins.* **26th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 10, 2005.
- *Advances in the Management of Heat and Cold Illness.* **American College of Emergency Physicians 2005 Scientific Assembly.** Washington, D.C. September 29, 2005.

- *Health Effects of Welding Fumes and Gasses.* **10th Annual Virginia Department of Labor and Industry Conference.** Portsmouth, Virginia. June 9, 2005.
- *Clinical Effects of Dioxin Poisoning*. **25th International Congress of European Association of Poison Centers and Clinical Toxicologist.** Berlin, Germany. May 11, 2005.
- *New Drugs of Abuse*. **25th McLemore Birdsong Pediatric Conference.** Hot Springs, Virginia. April 30, 2005.
- *Chemical & Biological Agents of Terrorism*. Engaging the Mind Series. **Woodberry Forest.** Orange, Virginia. April 14, 2005.
- *Safety, efficacy and feasibility of activated charcoal in first aid*. **International Liaison Committee on Resuscitation (ILCOR) 2005 International Conference on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) Science with Treatment Recommendations**. Dallas, Texas. January 23, 2005.
- *Safety, efficacy and feasibility of wound suction for pit viper envenomation in first aid*. **International Liaison Committee on Resuscitation (ILCOR) 2005 International Conference on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) Science with Treatment Recommendations**. Dallas, Texas. January 23, 2005.
- *Safety, efficacy and feasibility of water irrigation in the first aid management of a toxic exposure to the skin and/or eye*. **International Liaison Committee on Resuscitation (ILCOR) 2005 International Conference on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care (ECC) Science with Treatment Recommendations**. Dallas, Texas. January 23, 2005.
- *History of Chemical Agents of Terrorists*. **The American College of Medical Toxicology's Program on Chemical Agents of Opportunity for Terrorism**. Charlottesville, Virginia. December 15, 2004.
- *Assessing the patient using club drugs.* **25th Annual Virginia EMS Symposium.** Norfolk, Virginia. November 13, 2004.
- *Medical Toxicology Service Overview & Respective Coding.* **2004 Virginia State Coders Conference.** Charlottesville, Virginia. October 28, 2004.
- *Pulmonary Cases in Toxicology.* **23rd Annual Virginia Society for Respiratory Care's Mountain Air Symposium.** Blacksburg, Virginia. October 15, 2004.
- *Envenomations.* **Tazwell County Medical Society**. Tazwell, Virginia. September 17, 2004.
- *Medical Myths in the Workplace*. **9th Annual Virginia Occupational Safety and Health Conference.** Roanoke, Virginia. June 17, 2004.
- *Emergency Department Perspective of Mass Causalities*. **Virginia Northwest Hospital & Health District Forum.** Charlottesville, Virginia. November 17, 2003.
- *Evaluating Workers Exposed to Chemicals*. **Virginia Association of Occupational Health Professionals in Healthcare.** Culpepper, Virginia. November 6, 2003.
- *Single Pills and Swallows that Kill*. **Current Topics in Pediatric Emergency Medicine.** Burlington, Vermont. August 1, 2003.
- *Cases of Pediatric Toxicologic Emergencies*. **Current Topics in Pediatric Emergency Medicine.** Burlington, Vermont. August 1, 2003.

- *Evaluating Workers Exposed to Chemicals*. **8th Annual Virginia Occupational Safety and Health Conference.** Portsmouth, Virginia. June 4, 2003.
- *Single Pills and Swallows that Kill*. **23rd Annual McLemore Birdsong Pediatric Conference**. Hot Springs, Virginia. April 27, 2003.
- *Errors in Prehospital Care of the Poisoned Patient*. **Critical Response 2003**. Charlottesville, Virginia. April 26, 2003.
- *New Drugs of Abuse*. **March Medical Madness Paramedic Symposium**. Louisa County, Virginia. March 8, 2003.
- *Updates in Medical Toxicology*. **23rd Annual Virginia EMS Symposium**. Norfolk, Virginia. November 8, 2002.
- *Herbal & Alternative Medicine Toxicology*. **Virginia Society of Health System Pharmacists.** Norfolk, Virginia. September 14, 2002.
- *Chemical Terrorism and the Potential Role of Poison Centers***. Health Director's Conference - Virginia Department of Health.** Richmond, Virginia. September 12, 2002.
- *Occupational Toxicology*. **7th Annual Virginia Occupational Safety & Health Conference.** Roanoke, Virginia. June 19, 2002.
- *Chemical & Biological Terrorism*. **Fairfax Regional Environmental Health Meeting.** Fairfax, Virginia. May 28, 2002.
- *Alternative Therapies: Which Ones Should I Worry About?* **22nd McLemore Birdsong Pediatric Conference.** Hot Springs, Virginia. May 19, 2002.
- *Acute Management of Bites & Stings***. 22nd McLemore Birdsong Pediatric Conference.** Hot Springs, Virginia. May 19, 2002.
- *Chemical & Biological Terrorism***. Virginia Environmental Health Association Annual Meeting.** Charlottesville, Virginia. April 29, 2002.
- *Chemical & Biological Terrorism***. Critical Response 2002.** Charlottesville, Virginia. April 28, 2002.
- *Chemical & Biological Terrorism*. **10th Annual National American College of Nurse Practioners Conference.** Charlottesville, Virginia. April 14, 2002.
- *Chemical & Biological Terrorism Threats in the Workplace*. **Augusta Safety Network Regional Meeting.** Fishersville, Virginia. March 8, 2002.
- *Chemical & Biological Terrorism*. **Albemarle Medical Society.** Charlottesville, Virginia. January 9, 2002.
- *Chemical Warfare Agents and Emergency Medical Response. Preparing Healthcare Professionals for the Possibility of Bioterrorism.* **University of Virginia Health System Center for Organizational Development.** Charlottesville, Virginia. November 28, 2001.
- *Drugs of Abuse.* **Michigan State University Emergency Medicine Regional Conference.** Grand Rapids, Michigan. September 20, 2001.
- *Herbal Toxicity.* **Michigan State University Emergency Medicine Regional Conference.** Grand Rapids, Michigan. September 20, 2001.
- *Forensic Toxicology*. **East Coast Regional Update in Clinical Forensics.** Charlottesville, Virginia. May 9, 2001.

- *Toxicology Updates*. **21st Annual McLemore Birdsong Conference.** Hot Springs, Virginia. May 6, 2001.
- *Prevalence of Complimentary and Alternative Medicine Use in the Pediatric Emergency Department*. **2001 Mid-Atlantic Society of Academic Emergency Medicine Regional Meeting.** Charlotte, North Carolina. March 31, 2001.
- *Lidocaine: Do Emergency Health Care Providers Know the Correct Dose*. **2001 Mid-Atlantic Society of Academic Emergency Medicine Regional Meeting.** Charlotte, North Carolina. March 31, 2001.
- *Toxicology Update: New Information from the Literature*. **Emergency Medicine: The Challenging Patient Encounter.** Lake Buena Vista, Florida. March 3, 2001.
- *The Sights, Sounds, and Smells of the Poisoned Patient*. **Emergency Medicine: The Challenging Patient Encounter.** Lake Buena Vista, Florida. March 3, 2001.
- *Updates in Pediatric Poisoning*. **Current Topics in Emergency Medicine.** Charlottesville, Virginia. November 17, 2000.
- *Clinical Forensic Toxicology*. **Virginia Association of Forensic Nurses.** Charlottesville, Virginia. April 27, 2000.
- *The Poisoned Patient*. **Critical Response 2000.** University of Virginia. Charlottesville, Virginia. April 8, 2000.
- *Metabolic Acidosis due to Poisoning*. **Emergency Medicine & Critical Care Medicine – The Difficult Patient Encounter.** Lake Buena Vista, Florida. March 29, 2000.
- *Sympathomimetic Poisoning*. **Emergency Medicine & Critical Care Medicine – The Difficult Patient Encounter.** Lake Buena Vista, Florida. March 28, 2000.
- *Munchausen by Proxy Using Toxins.* **Pediatric Emergency Care Conference. 5th Bi-Annual Child Maltreatment Conference.** Grand Rapids, Michigan. March 8, 2000.
- *Alternative Medicines: Therapy or Toxin?* **Indiana College of Emergency Physicians Post Graduate Course in Emergency Medicine.** Indianapolis, Indiana. February 21, 2000.
- *Herbal Toxicology for the Emergency Physician.* **Virginia College of Emergency Physicians 2000 Scientific Assembly.** Hot Springs, Virginia. February 7, 2000.
- *Occupational Toxicology.* **Central Virginia Association of Occupational Health Nurses.** Charlottesville, Virginia. November 17, 1999.
- *Chemical Warfare Agents.* **Virginia College of Emergency Physicians Summer Symposium.** Virginia Beach, Virginia. July 30, 1999.
- *Herbal Toxicology*. **Advances and Alternatives in the Clinical Environment.** Williamsburg, Virginia. April 25, 1999.
- *General Management of the Poisoned Patient*. **American College of Physicians – American Society of Internal Medicine National Session.** New Orleans, Louisiana. April 23, 1999.
- *Management of the Acidotic Poisoned Patient*. **American College of Physicians – American Society of Internal Medicine National Session.** New Orleans, Louisiana. April 23, 1999.

- *Crotalid Envenomation.* **15th Annual Regional Toxicology Seminar – Nature's Poisons.** Indianapolis, Indiana. April 16, 1999.
- *Chemical Warfare Agents*. **Chemical/Biological/Nuclear Warfare Conference.** Quantico Marine University, Virginia. February 24, 1999
- *Medical Toxicology Myths Dispelled*. **Pediatric Emergency Care Conference.** Grand Rapids, Michigan. November 5, 1998.
- *Organophosphate Incidents/Casualties.* **Medical Management Conference of Casualties of Biologic, Radiological and Chemical Attacks.** Hartford, Connecticut. November 17, 1998.
- *Herbal Medicines*. **14th Annual Toxicology Seminar: Trendy Toxins.** Indianapolis, Indiana. April 21, 1998.
- *Nerve Agents*. **14th Annual Regional Toxicology Seminar: Trendy Toxins.** Indianapolis, Indiana. April 21, 1998.
- *Organ Procurement after Brodifacoum Poisoning*. **Midwest Regional Toxicology Conference.** Louisville, Kentucky. April 8, 1998.
- *Snake Venom Poisoning*. **Midwest Regional Toxicology Seminar.** Indianapolis, Indiana. November 5, 1997.
- *Wide Complex Dysrhythmia in Calcium Channel Blocker Overdose Responsive to $NaHCO_3$ Therapy.* **Midwest Regional Toxicology Seminar.** Indianapolis, Indiana. November 5, 1997.
- *Uncoupling in Cocaine Intoxication*. **Midwest Regional Toxicology Conference.** Louisville, Kentucky. December 4, 1996.
- *Cerebral Vascular Accident following Methcathinone Intoxication*. **Midwest Regional Toxicology Conference.** Chicago, Illinois. November 13, 1996
- *Metered-Dose Inhalers: Do Emergency Health Care Providers Know What to Teach?* **18th Annual British Virgin Islands Medical Conference.** Tortola, British Virgin Islands. January 29, 1996.

XX. COMMUNITY

Media

Consultant

- Medical Unit of ABC News, 2002 – present
- Discovery Channel, Daily Planet (Canada), 2002 – 2009

Invited Television Programs (examples)

- OH vs. Essa. Court TV. 2021
- Topic: Lead Toy Recall. Episode name: *Lead – What You Need to Know*. Good Morning America. August 15, 2007. http://abcnews.go.com/Video/playerIndex?id=3481526
- Topic: Moonshine. Episode name: *White Lightning*. National Geographic Channel. February 7, 2007. http://www.criticalmention.com/ctv3-1/landing_email.php?type=alert&random_string=4e91d9a906c471ad1ebdb8954a1e3075

- Topic: Snake Envenomation First Aid. Episode name: *H2Ouch*. Dr. Know. Discovery Channel. 2006. http://health.discovery.com/tvlistings/episode.jsp?episode=4&cpi=111981&gid=0&channel=DHC
- Topic: Sarin. Episode name: *Sarin Sabotage*. Daily Planet. Discovery Channel. May 17, 2004. http://www.exn.ca/dailyplanet/view.asp?date=5/17/2004
- Topic: Ricin. Episode name: *Ricin Report*. Daily Planet. Discovery Channel. February 3, 2004. http://www.exn.ca/dailyplanet/view.asp?date=2/3/2004
- Topic: Nerve Agents. Episode name: *What is atropine*? Daily Planet. Discovery Channel. January 27, 2002. http://www.exn.ca/dailyplanet/view.asp?date=1/27/2003
- Topic: Moscow theater event. Episode name: *What went wrong*? Daily Planet. Discovery Channel. October 28, 2002. http://www.exn.ca/dailyplanet/view.asp?date=10/28/2002

*Over 500 media interviews performed in print, radio, and television.

Invited Published Newspaper/Magazine Articles

- **Holstege CP.** *Ask the Expert: What are the most common causes of an overdose, and what can be done to treat and prevent them?* Daily Progress. Charlottesville, Virginia. August 29th, 2021.
- **Holstege CP.** *Ask the Expert: What can parents do to protect their children from drowning?* Daily Progress. Charlottesville, Virginia. June 20th, 2021:C3.
- **Holstege CP**. *Herbal Medicines – Be Informed*. Vital Signs. Daily Progress. Charlottesville, Virginia. July 1, 2007:E3.
- **Holstege CP**. *Lead poisoning remains a risk to Virginia's children*. Vital Signs. Daily Progress. Charlottesville, Virginia. May, 2005:C3.
- **Holstege CP**. *Poison proofing the home*. Albemarle Kids Magazine. Spring 2004.
- **Holstege CP**. *Return of "Green Fairy" should be red flag*. Vital Signs. Daily Progress. Charlottesville, Virginia. January 25, 2004:C3.
- Kell SO, **Holstege CP**. *Poison Safety for the Holidays Quick Guide to Common Holiday Hazards and First Aid.* Albemarle Family Magazine. 2003;Winter:18-19.
- **Holstege CP**. *Keep household poisons under wraps*. Daily Progress. Charlottesville, Virginia. March 23, 2003:C7.
- **Holstege CP**, Kirk MA. *Snakebites – myths & reality*. Daily Progress. Charlottesville, Virginia. July 28, 2002:E3.
- **Holstege CP**. *Do your homework on herbal medicine*. Daily Progress. Charlottesville, Virginia. February 17, 2002:E3.
- **Holstege CP**. *Carbon monoxide is a silent indoor killer*. Daily Progress. Charlottesville, Virginia. December 31, 2000:E3.

01 NOV 2021

Christopher P. Holstege, MD

Date

Handout 15

Madison County Jail Records – Jonathan Whiston

Handout 15
Madison County Jail Records – Jonathan Whiston

Page 1

Sealed by Order of the Court.

Handout 15
Madison County Jail Records – Jonathan Whiston

Page 2

Sealed by Order of the Court.

Booking Report

WHITSON, JONATHAN RUSSELL

Inmate Name ID: W000248

Inmate Booking Control #	Security Class	Booking Status	Booked	Released
		In Jail	01/06/2011 18:16	

Weekender ☐

Address Line 1	Booking Officer
12681 NC 197S	J ELKINS
Address Line 2	**FingerPrint Officer**

City	State	Zip	Search Officer
BURNSVILLE	NC	28714-	J ELKINS

Race	Sex	Date Of Birth	Place Of Birth	Height	Weight
White	Male	01/20/1982	NORTH CAROLINA	5'11"	150

Eyes	Hair	Complexion	FBI Number	SBI Number	AFIS ID
Brown	Brown	Medium			

Social Security Number	Driver's Lic. No.	State	Occupation (s)
[redacted]	27667850	NC	LABORER

Employer

CONSTRUCTION

Next of Kin	Relationship		Address	Phone
Emergency Contact	**Relationship**		**Address**	**Phone**
STEPHANIE WHITSON	Fiance or Fiancee	BURNSVILLE NC		(828) 208-3992
Doctor			**Address**	**Phone**
Attorney			**Address**	**Phone**

Charges:

01/06/2011	SIMPLE POSSESS SCH II			Pre-Trial
	Court: District	02/11/2011	9:30	
01/06/2011	Possession Of Drug Paraphernalia			Pre-Trial
	Court: District	02/11/2011	9:30	

Confinement Dates:

Confined Date/Time		Released Date/Time	Released By
	Booking Control Number		Released To
Confinement Code		Release Reason	

01/06/2011
18:16
Booking

Total Number of Confinement Dates 1 From: 01/06/2011 18:16:00 To:

000003
NCIIC-Madison County Jail

ARREST REPORT

AGENCY INFO.

Agency Name	ORI	Date/Time of Arrest (Mo Date Year)	OCA
Madison	058000 NC	1 6 11 1800 Hrs.	

Taken	Fingerprint Card Check Digit # (CKN)	Arrest Tract	Residence Tract	Arrest Number
☐ Prints ☐ Photos				

ARRESTEE INFORMATION

Name (Last, First, Middle)	D.O.B.	Age	Race	Sex	Place of Birth	Country of Citizenship
Whitson Jonathan Russell	1/20/82	28	W	M	Spruce Pine	US

Current Address	Phone	Occupation	☒ Resident ☐ Non-Resident ☐ Unknown
12681 NC 197 S Burnsville	828 208-3992		

Employer's Name	Address	Phone

Also Known As (Alias Names)	Hgt	Wgt	Hair	Eye	Skin Tone	Consumed Drug/Alcohol
	5'11	150	BRN	BRN	M	☐ Yes ☒ No ☐ Unk

Scars, Marks, Tattoos	Social Security #	OLN and State	Misc. # and Type
Right Arm Rebel Flag	[redacted]	27667850 NC	

Nearest Relative Name	Address	Phone
Stephanie Whitson	Burnsville	828 208 3992

ARREST INFO.

If Armed, Type of Weapon	☐ On-View ☐ Criminal Summons ☐ Order for Arrest ☐ Citation ☒ Warrant	Place of Arrest
		Yancey Co Line

		Counts	DCI Code	Offense Jurisdiction (If not arresting agency)	Statute #	Warr. Date (Mo Date Yr)
Charge #1 Simple Poss F TA	☐ Fel ☒ Misd	1	3536		90-95 D 2	9 7 10
Charge #2 Poss Drug Para	☐ Fel ☒ Misd	1	3401		90-113.22	9 7 10
Charge #3	☐ Fel ☐ Misd					

VEH. INFO.

VYR	Make	Model	Style	Color	Lic/Lis	Vin

Vehicle: 1. ☐ Left at Scene ☐ Secured ☐ Unsecure Date/Time: _____ Hrs. _____
2. ☐ Released to other at owners request ☐ Name of Other _____
3. ☐ Impounded ☐ Place of storage _____ Inventory on File? _____

CONFINED BOND INFO.

Date/Time Confined	Place Confined	Committing Magistrate
1/6/11 1827 Hrs.	MCSD	D. Goddard

Type Bond	Amt. Bond	Trial Date	Court of	City
☐ Written Promise ☐ Unsecured ☒ Secured ☐ No Bond ☐ Other	5000	02-11-2011	Madison	Marshall

Assisting Officer Name/ID Number	Released By: Name/Dept/ID	Date/Time Released
		Hrs.

Status Codes L-Lost S-Stolen R-Recovered D-Damaged Z-Seized B-Burned C-Counterfeit / Forged F-Found
(Check "OJ" column if recovered for other jurisdiction)

DRUGS AT TIME OF ARREST

DCI	Status	Quantity	Type Measure	Suspected Type	Check up to 3 types of activity for each: Possess	Buy	Sale	Mfg.	Importing	Operating

COM-PLAIN-ANT

Name: Complainant ☐ Victim ☐	Address:	Phone:

NARRATIVE

STATUS

Arresting Officer Signature/ID #		Date/Time Submitted (Mo Date Yr)	Supervisor Signature
	B-3	1 6 11 1830 Hrs.	

Case Status	Case Disposition	Arrestee Signature
☐ Further Inv. ☐ Inactive ☐ Closed	☐ Cleared By Arrest / No Supplement Needed ☐ Arrest/No Investigation	

DCI-608F NCIIC-Madison County Jail Rev. 3/92

Inmate Property

WHITSON, JONATHAN RUSSELL

Race: W Sex: M DOB: 1/20/1982

Inmate Name ID: W000248

Location BOX

Qty	Property	Description	Taken	Taken By	Returned	Returned To	Returned By
1	Billfold	BLACK WALLET	1/6/2011 21:00	J ELKINS			
1	Hat	Baseball Cap	1/6/2011 21:00	J ELKINS			

Location PROOM

Qty	Property	Description	Taken	Taken By	Returned	Returned To	Returned By
1	Pants	BLUE JEANS	1/6/2011 21:01	J ELKINS			
1	Coat	BROWN CARHART	1/6/2011 21:01	J ELKINS			
1	Shoes	BROWN WORK BO	1/6/2011 21:01	J ELKINS			

I certify that the above listed property is a true and complete accounting of all personal property taken from me at the time I was committed to this jail.

Signatur Jonathan R Whitson Date _____

Witness _____ Date 01-06-2011

Inmate Suicide Screening

WHITSON, JONATHAN RUSSELL

Race: W Sex: M DOB: 1/20/1982

Inmate Name ID: W000248

Booking #: **Booked: 01/06/2011 18:16**

1	Does the inmate's behavior suggest the risk of suicide?	No
2	Does the arresting officer believe that the inmate may be a suicide risk?	No
3	Does the inmate appear mentally confused?	No
4	Does the imate appear to be under the influence of drugs or alcohol?	No
5	Does the inmate seem unusually embarrased or ashamed?	No

Signatur _____ Date 01-06-2011

Handout 15
Madison County Jail Records – Jonathan Whiston

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Handout 15
Madison County Jail Records – Jonathan Whiston

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File No.	See Attachment	Law Enforcement Case No.	LID No.	SID No.	FBI No.
10CR 050775	☐	MADISON COUNTY SHERIFFS OFFICE			

ORDER FOR ARREST

11OFA21417

STATE OF NORTH CAROLINA

MADISON County

In The General Court Of Justice ☐ District ☐ Superior Court Division

Offense

I SIMPLE POSSESS SCH II CS (M)
II POSSESS DRUG PARAPHERNALIA

THE STATE OF NORTH CAROLINA VS.

Name, Address & Telephone No. Of Defendant

JONATHAN RUSSELL WHITSON

410 ENGLISH BRANCH ROAD

BURNSVILLE NC 28714
YANCEY COUNTY (828) 682-9383

Race	Sex	Date Of Birth	Age
W	M	01/20/1982	

Social Security No.	Drivers License No. & State
[redacted]	27667850 NC

Name And Address Of Defendant's Employer

Date Defendant Failed To Appear

01/04/2011

Amount Of Bond	Type Of Bond
$ $5,000.00	SECURED

TRUE BILL OF INDICTMENT ONLY

Date Of Arrest & Check Digit No. (As Shown On Fingerprint Card)

Offense Code	Offense In Violation Of G.S.

Date Of Offense	Date Issued
	01/04/2011

To any officer with authority and jurisdiction to serve an Order For Arrest:
The Court finds that:

☒ 1. FTA - RELEASE ORDER [G.S. 15A-305(b)(2)]
the defendant has been arrested and released from custody and has failed on the date shown to appear as required by the Release Order. ☐ The defendant has failed to appear on these charges on two or more prior occasions.

☐ 2. FTA - CRIMINAL SUMMONS OR CITATION (Do not use for infraction.) [G.S. 15A-305(b)(3)]
the defendant has failed on the date shown to appear as required by a duly executed Criminal Summons or by a Citation that charged the defendant with a misdemeanor.

☐ 3. TRUE BILL OF INDICTMENT [G.S. 15A-305(b)(1)]
a Grand Jury has returned a true bill of indictment against the defendant, a copy of which is attached.
[Note To Arresting Officer: *If this option is checked, defendant must be fingerprinted. G.S. 15A-502(a).*]

☐ 4. FTA - SHOW CAUSE AFTER FTC [G.S. 15A-305(b)(8)]
the defendant has failed on the date shown to appear as required in a Show Cause Order entered in this criminal proceeding.

☐ 5. FTA - SHOW CAUSE ORDER IN ORIGINAL CRIMINAL JUDGMENT
[G.S. 15A-305(b)(8); -1362(c); -1364(a)]
the defendant has failed by the date shown to pay a fine or costs or both as required by a judgment entered in this case and has also failed, as required upon such failure, to appear on that date and show cause why the defendant should not be imprisoned.

☐ 6. PROBABLE CAUSE THAT DEFENDANT MAY FAIL TO APPEAR - CRIMINAL CONTEMPT
[G.S. 15A-305(b)(9); 5A-16]
this Court has initiated plenary proceedings for contempt against the defendant under G.S. 5A-16, has issued a show cause order and finds probable cause to believe that the defendant will not appear as required in response to that order.

☐ 7. PROBATION VIOLATION [G.S. 15A-305(b)(4); -1345(a)]
the probation officer has provided the court with a written statement, signed by the probation officer, alleging that the defendant has violated specified conditions of the defendant's probation and a copy of the written statement is attached.

☐ 8. Other: *(specify)*

You are DIRECTED to take the defendant into custody and bring the defendant before a judicial official for the purpose of:
☒ determining conditions of release, and for commitment if the defendant is unable to comply.
☐ commitment since release of the defendant is not authorized.

Signature	Location Of Court	Court Date
MARK A CODY ☐ Magistrate ☐ Deputy CSC ☐ DC Judge ☐ Asst. CSC ☒ Clerk Of Superior Court ☐ SC Judge		Court Time ☐ AM ☐ PM

AOC-CR-217, Rev. 3/09

(over)

OTHER AGENCY COPY - NOT FOR SERVICE

Inmate Property

WHITSON, JONATHAN RUSSELL

Race: W Sex: M DOB: 1/20/1982

Inmate Name ID: W000248

Location BOX

Qty	Property	Description	Taken		Taken By	Returned		Returned To	Returned By
1	Billfold	BLACK WALLET	1/6/2011	21:00	J ELKINS	3/4/2011	18:26		ARCHIE WATTS
1	Hat	Baseball Cap	1/6/2011	21:00	J ELKINS	3/4/2011	18:26		ARCHIE WATTS

Location PROOM

Qty	Property	Description	Taken		Taken By	Returned		Returned To	Returned By
1	Pants	BLUE JEANS	1/6/2011	21:01	J ELKINS	3/4/2011	18:26		ARCHIE WATTS
1	Coat	BROWN CARHART	1/6/2011	21:01	J ELKINS	3/4/2011	18:26		ARCHIE WATTS
1	Shoes	BROWN WORK BO	1/6/2011	21:01	J ELKINS	3/4/2011	18:26		ARCHIE WATTS

I certify that I have received all property listed above and due me following my release from this jail.

Signatur Jonathan A Whitson Date 3-4-11

Witness _____ Date _____

STATE OF NORTH CAROLINA

MADISON County

File No. 10CR 050775

In The General Court Of Justice
[X] District [ ] Superior Court Division

STATE VERSUS

Name And Address Of Defendant
JONATHAN RUSSELL WHITSON

410 ENGLISH BRANCH ROAD

BURNSVILLE NC 28714

CONDITIONS OF RELEASE AND RELEASE ORDER

11RO23370

G.S. Chapter 15A, Art. 25, 26

Amount Of Bond
$ $5,000.00

Offenses And Additional File Numbers
10CR50775 SIMPLE POSSESS SCH II CS (M); POSSESS DRUG PARAPHERNALIA

[ ] See Attachment

Location Of Court	[X] District [ ] Superior	Date	Time
Madison County Courthouse; 000B		02/11/2011	09:30 [X] AM [ ] PM

To The Defendant Named Above, you are ORDERED to appear before the Court as provided above and at all subsequent continued dates. If you fail to appear, you will be arrested and you may be charged with the crime of willful failure to appear.

The defendant has been advised of charge(s) against him/her and his/her right to communicate with counsel and friends.

[X] Your release is authorized upon execution of your:

- [ ] WRITTEN PROMISE to appear
- [ ] CUSTODY RELEASE
- [ ] ELECTRONIC HOUSE ARREST administered by *(agency)* _____ and the SECURED BOND above.
- [ ] UNSECURED BOND in the amount shown above
- [X] SECURED BOND in the amount shown above

You may leave your residence for the purpose(s) of [ ] employment [ ] counseling [ ] course of study [ ] vocational training

You will be arrested if you violate the following restrictions:
VIOLATE NO LAWS. NOT TO USE, CONTROL, POSSESS, ANY CONTOLEED SUBSTANCES UNLESS IN A PRESCRIBED CONTAINER FOR JONATHAN RUSSELL WHITSON

[ ] Your release is not authorized.

[ ] The defendant has been [ ] (i) charged with a felony while on probation *(complete AOC-CR-272, Side One)*. [ ] (ii) arrested for violation of probation with a pending felony charge or prior conviction requiring registration under G.S. 14, Article 27A *(complete AOC-CR-272, Side Two)*.

[X] The defendant was arrested or surrendered after failing to appear as required under a prior release order. [ ] two or more times in this case.

[ ] Your release is subject to the conditions as shown on the attached [ ] AOC-CR-270. [ ] Other: _____.

Additional Information

Date	Signature Of Judicial Official	
2-06-2011		O H GODDARD

[ ] Magistrate [ ] Deputy CSC [ ] Assistant CSC [ ] Clerk Of Superior Court [ ] District Court Judge [ ] Superior Court Judge

ORDER OF COMMITMENT

To The Custodian Of The Detention Facility Named Below, you are ORDERED to receive in your custody the defendant named above who may be released if authorized above. If the defendant is not sooner released, you are ORDERED to: [X] produce him/her in Court as provided above.
[ ] hold him/her [ ] as provided on the attached AOC-CR-272. [X] for the following purpose: SEE ABOVE.

[ ] *[Check in all domestic violence and stalking cases covered by G.S. 15A-534.1(b)]* produce him/her at the first session of District or Superior Court held in this county after the entry of this Order or, if no session is held before *(enter date and time 48 hours after time of arrest)* _____, _____
[ ] AM [ ] PM produce him/her before a magistrate of this county at that time to determine conditions of pretrial release.

Name Of Detention Facility	Date	Signature Of Judicial Official
MADISON DETENTION CENTER		O H GODDARD

WRITTEN PROMISE TO APPEAR OR CUSTODY RELEASE

I, the undersigned, promise to appear at all hearings, trials or otherwise as the Court may require and to abide by any restrictions set out above.

I understand and agree that this promise is effective until the entry of judgment in the District Court from which no appeal is taken or until the entry of judgment in Superior Court. If I am released to the custody of another person, I agree to be placed in that person's custody, and that person agrees by his/her signature to supervise me.

Date	Signature Of Defendant	Signature Of Person Agreeing To Supervise Defendant

Name Of Person Agreeing To Supervise Defendant (Type or Print)	Address Of Person Agreeing To Supervise Defendant

DEFENDANT RELEASED ON BAIL

Date	Time	Signature Of Jailer
	[ ] AM [ ] PM	

AOC-CR-200, Rev. 12/09

OTHER AGENCY COPY

000011
NCIIC-Madison County Jail

CONDITIONS OF RELEASE MODIFICATIONS

The Conditions of Release on the reverse are modified as follows:

Modification	Date	Signature Of Judicial Official
Cpc Clinton Rudisill 3-11-11	2/4/11	
Bond unsecured per Judge Horne at 18:15 on 3-4-2011.	3-4-11	

SUPPLEMENTAL ORDERS FOR COMMITMENT

The defendant is next Ordered produced in Court as follows:

Date	Time	Place	Purpose	Signature Of Judicial Official

DEFENDANT RECEIVED BY DETENTION FACILITY

Date	Time	Signature Of Jailer

DEFENDANT RELEASED FOR COURT APPEARANCE

Date	Time	Signature Of Jailer

NOTE TO CUSTODIAN: *This form shall accompany the defendant to court for all appearances.*

Handout 16

Jonathan Whitson Medical History Chart – Mission Hospital

Sealed by Order of the Court.

Handout 17

Nathan Angel
Criminal History
Chart

MURPH "NATHAN" ANGEL

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
DWLR (M)	AVERY	03/18/2007	05/10/2007
POSSESSION OF COCAINE	YANCEY	03/31/2006	09/15/2006
ILLEGAL DUMPING (M)	YANCEY	02/09/1996	03/19/1996
ASSAULT ON A FEMALE (M)	YANCEY	12/16/1994	02/17/1995
FISHING WITHOUT A LICENSE (M)	MADISON	09/29/1990	11/13/1990
BREAKING AND ENTERING	YANCEY	04/18/1982	08/11/1982

Handout 18

Thomas Farmer
Criminal History
Chart

THOMAS FARMER

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
WILLFUL FAIL DISCHARGE DUTIES (M)	YANCEY	01/02/2011	07/06/2012

Handout 19

Affidavit of Attorney Sofia Hernandez

STATE OF NORTH CAROLINA

COUNTY OF YANCEY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
11 CRS 304, 11 CRS 305

STATE OF NORTH CAROLINA,

v.

JOHN H PRITCHARD

AFFIDAVIT OF ATTORNEY
SOFIA HERNANDEZ

NOW COMES Sofia Hernandez having first been duly sworn, who deposes and says the following:

1. I have been an attorney licensed to practice law in North Carolina since 2012. I briefly represented John H. Pritchard for his appeal of a conviction of Second Degree Murder, Delivery of a Schedule II Controlled Substance, Possession with Intent to Sell, Manufacture, or Deliver a Schedule II Controlled Substance, and Maintaining a Vehicle, Dwelling, or Place for Delivery of a Controlled Substance.

2. I have forwarded all files that were in my possession for this case to the North Carolina Innocence Commission.

3. I do not recall any conversations with Mr. Pritchard. I have no recollection of Mr. Pritchard ever admitting any guilt. A client admitting guilt would be out of the ordinary, and I believe that I would remember if Mr. Pritchard had done so.

FURTHER THE AFFIANT SAYETH NOT.

This the 23rd day of June, 2021

Sofia Hernandez

KELLY Y. COLLINS NOTARY PUBLIC DURHAM COUNTY, NC

STATE OF NORTH CAROLINA
COUNTY OF Durham

Sworn to and subscribed before me,
this 23 day of June, 2021.

Kelly Y. Collins (Seal)
Notary Public
My Commission Expires: 4-11-2022

Handout 20

Affidavit of Attorney Christine Vance

STATE OF NORTH CAROLINA

COUNTY OF YANCEY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
11 CRS 304, 11 CRS 305

STATE OF NORTH CAROLINA,

v.

JOHN H PRITCHARD

AFFIDAVIT OF ATTORNEY
CHRISTINE VANCE

NOW COMES Christine Vance having first been duly sworn, who deposes and says the following:

1. I have been an attorney licensed to practice law in North Carolina since 2012. My current status with the North Carolina State Bar is inactive. I briefly represented John H. Pritchard for his appeal of a conviction of Second Degree Murder, Delivery of a Schedule II Controlled Substance, Possession with Intent to Sell, Manufacture, or Deliver a Schedule II Controlled Substance, and Maintaining a Vehicle, Dwelling, or Place for Delivery of a Controlled Substance.

2. I do not have any files for this case. I submitted my resignation on July 30, 2014, to Brownstone, P.A., the law firm that represented Mr. Pritchard on appeal, and formally resigned 30 days later in August 2014. After the Superior Court granted my removal from the case, I stopped practicing law due to personal family reasons. Upon my resignation, I forwarded all files in my possession to Brownstone, P.A.

3. I do not recall any specific details about the case. I do not recall meeting Mr. Pritchard or having any conversations with him.

FURTHER THE AFFIANT SAYETH NOT.

This the 26th day of August, 2021

C Vance

Christine Vance

STATE OF NORTH CAROLINA
COUNTY OF HC

Sworn to and subscribed before me,
this 26th day of August, 2021.

Bernard Oppong

Notary Public

My Commission Expires: 08/06/2025

BERNARD OPPONG NOTARY PUBLIC WAKE COUNTY, NC (Seal)

Handout 21

Affidavit of Attorney Brandi Bullock

STATE OF NORTH CAROLINA

COUNTY OF YANCEY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
11 CRS 304, 11 CRS 305

STATE OF NORTH CAROLINA,

v.

JOHN H PRITCHARD

AFFIDAVIT OF ATTORNEY
BRANDI JONES BULLOCK

NOW COMES Brandi Jones Bullock having first been duly sworn, who deposes and says the following:

1. I have been an attorney licensed to practice law in North Carolina since 2013. I represented John H. Pritchard for his appeal of a conviction of Second Degree Murder, Delivery of a Schedule II Controlled Substance, Possession with Intent to Sell, Manufacture, or Deliver a Schedule II Controlled Substance, and Maintaining a Vehicle, Dwelling, or Place for Delivery of a Controlled Substance.

2. I have forwarded all files that were in my possession for this case to the North Carolina Innocence Commission.

3. I do not recall any specific details about the case. I recall meeting with Mr. Pritchard one time. I remember that Mr. Pritchard claimed innocence in this case.

FURTHER THE AFFIANT SAYETH NOT.

This the 26th day of July, 2021

Brandi Jones Bullock

STATE OF NORTH CAROLINA
COUNTY OF Cabarrus

Sworn to and subscribed before me,
this 26th day of July, 2021.

MARILYN S. LOWERY NOTARY PUBLIC ROBESON COUNTY, N. C.

(Seal)

Notary Public
My Commission Expires: 8/20/25

Handout 22

Affidavit of Attorney

Robert Sirianni, Jr.

STATE OF NORTH CAROLINA COUNTY OF YANCEY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 11 CRS 304, 11 CRS 305
STATE OF NORTH CAROLINA, v. JOHN H PRITCHARD	AFFIDAVIT OF ATTORNEY ROBERT SIRIANNI, JR.

NOW COMES Robert Sirianni, Jr. having first been duly sworn, who deposes and says the following:

1. I represented John H. Pritchard *pro hac vice* on his appeal in this case for convictions of Second Degree Murder, Delivery of a Schedule II Controlled Substance, Possession with Intent to Sell, Manufacture, or Deliver a Schedule II Controlled Substance, and Maintaining a Vehicle, Dwelling, or Place for Delivery of a Controlled Substance.

2. I have forwarded all documents that were left in my possession for this case to the North Carolina Innocence Commission. When my firm moved to a cloud-based system in 2020, many of the client files were not transferred, including that of Mr. Pritchard. Additionally, all original documents were returned to my clients. As a result, I no longer have a file for Mr. Pritchard.

3. I do not recall any conversations with Mr. Pritchard. I have no recollection of Mr. Pritchard ever admitting any guilt or maintaining his innocence. A client admitting guilt would be out of the ordinary, and I believe that I would remember if Mr. Pritchard had done so.

FURTHER THE AFFIANT SAYETH NOT.

This the 29 day of June, 2021

Robert Sirianni, Jr.

STATE OF FLORIDA
COUNTY OF FLORIDA

Sworn to and subscribed before me,
this 29 day of June, 2021.

Notary Public (Seal)
My Commission Expires: April 29, 2025

PATRICIA A. JACKSON
MY COMMISSION EXPIRES
APRIL 29 2025
NOTARY PUBLIC
STATE OF FLORIDA

Handout 23

Excerpt from

Hockaday Interview

MS. BRIDENSTINE: You talked about this in the beginning. But what was your theory of defense at trial?

MR. HOCKADAY: Well, that John didn't do it. There were other people that were involved. Sounds like from what you're reminding me of, there were obviously other medical issues with the victim. We had the issues with Hall. A big issue, I felt like, was whether the 404(b) evidence would get in.

You know, John's position from day one was, this was not me that did it. I mean, he didn't even agree that he had seen the guy that day. So it wasn't a, yeah, I saw him, but I just didn't give him the controlled substance. It was, I didn't see him.

So our stance was -- and theory was, everybody that was testifying that John had interaction with this guy was a liar. And we -- if you've read the transcript, I'm sure you've seen that I cross-examined all these people.

MS. BRIDENSTINE: Uh-huh.

MR. HOCKADAY: But John's position was, it wasn't me. Wasn't around. Don't know what they're talking about. From what I remember.

Handout 24

Affidavit of Attorney Daniel Hockaday

STATE OF NORTH CAROLINA COUNTY OF YANCEY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 11 CRS 304, 11 CRS 305
STATE OF NORTH CAROLINA, v. JOHN PRITCHARD	AFFIDAVIT OF ATTORNEY DANIEL HOCKADAY

NOW COMES Daniel Hockaday having first been duly sworn, who deposes and says the following:

1. I am an attorney first licensed to practice law in North Carolina in 1992. I have been practicing law for over 29 years.

2. I represented John Pritchard prior to his trial and at his jury trial in April 2014 on charges of Second Degree Murder, Delivery of a Schedule II Controlled Substance, Possession with Intent to Sell, Manufacture, or Deliver a Schedule II Controlled Substance, and Maintaining a Vehicle, Dwelling, or Place for Delivery of a Controlled Substance.

3. I was first contacted by the North Carolina Innocence Inquiry Commission in May 2021 regarding my case file. I do not have a file for this case because it was previously destroyed pursuant to my retention policy.

4. During the course of my representation, John Pritchard did not admit guilt to me at any time.

5. During the course of my representation, John Pritchard maintained his innocence to me related to this crime.

FURTHER THE AFFIANT SAYETH NOT.

This the 11 day of October, 2021

Daniel Hockaday

STATE OF NORTH CAROLINA
COUNTY OF Yancey

Sworn to and subscribed before me,

this 14th day of October, 2021.

Pamela M Fox (Seal)

Notary Public

My Commission Expires: 09/14/24

Handout 25

Witness Statements to Commission about the Victim

Witness Statements to Commission about the Victim

WITNESS	Saw Victim Prior to Death	Victim had medical issues	Victim was partying night before death	Victim had alcohol before death	Victim's body was moved	Victim took blood pressure pills
Christine Angel (step-grandmother of Victim)	Yes.	No personal knowledge. Heard from the Victim's sister that they believe he died from a heart issue rather than an overdose.	Not asked.	Not asked.	Not asked.	Not asked.
Floyd Ayers (cousin of Victim)	Yes. He looked good. He said it was cold.	Does not know.	Not asked.	Not asked.	Not asked.	Not asked.
Robert Silvers (grandson of Christine Angel)	Yes.	Saw the Victim at their grandmother's house the morning of the day before he died, and he looked fine. He did not seem to have a cold. He was not aware of any medical issues. He did not see the Victim's arm.	Does not know. Never heard of any.	Not asked.	Not asked.	Not asked.
Tammy Ayers (former girlfriend of Victim)	Yes. She saw him. He appeared to be "jonesing." He seemed a little ill.	No. Was not aware of anything specifically but thought there might have been "one thing going on health wise."	Does not know. Only heard talk that he was with Robbie Silvers.	Does not know.	Not asked.	Not asked.
Russell Wilson (biological father of Victim)	No.	He was not aware of any medical issues, including any issues with his arm.	Not asked.	Not asked.	Nena Angel told him that he was moved from Nathan Angel's house by Brian Silvers and another guy.	Not asked.

Witness Statements to Commission about the Victim

WITNESS	Saw Victim Prior to Death	Victim had medical issues	Victim was partying night before death	Victim had alcohol before death	Victim's body was moved	Victim took blood pressure pills
Nikki Angel (sister of Victim)	No, but saw his body after death.	He had a heart murmur when he was born. He went to hospital before jail for left arm. He had blood clots. Victim was told his arm could be amputated. Spoke to Victim in jail, who reported to feeling ok but said his arm hurt. Heard Victim had a cold before he died from grandmother. Saw Victim's body after death and left arm was red and swollen. Saw white stuff coming out of nose and reddish-brown stuff coming out of mouth.	No personal knowledge. Heard rumors that the Victim was hanging out with Shannon Allison, Sharon Biggs, Brian Silvers, and Carrie Hinds. Did not know if they were partying or not. Heard the Victim was not doing drugs and was doing good. Has no personal knowledge.	No personal knowledge. Heard the Victim went to a bar with CJ the night before he died.	No personal knowledge. She and her mother thought his body must have been moved based on the way he was dressed and the fact that he was not allowed to stay at Christine Angel's house.	Heard a voicemail message left by Stephanie Whitson Randolph that she gave the Victim blood pressure pills, she injected them into the Victim, and she felt responsible.
Nena Angel (sister of Victim)	No.	Knew Victim had been in hospital before jail with a blood clot. Never saw the Victim's arm. Heard he was looking good before he died.	No personal knowledge. Heard rumors he was partying with several people at Nathan Angel's trailer.	Does not know.	No personal knowledge. Heard story that body was moved by Brian Silvers and Stephanie Whitson. Thinks she heard this from Brian Silvers.	Stephanie Whitson told her on the phone when discussing funeral arrangements that she gave the Victim blood pressure pills instead of morphine. She also said that it should have been her instead of him.
Aaron Collins (son of Robbie Brown and roommate of John Pritchard at time)	No.	He did not see the Victim for two years prior to his death, but he heard he had blood pressure problems.	No personal knowledge. Heard that the Victim was at Nathan Angel's the night before he died. Denies Nikki Angel's allegations that he shot up the Victim with drugs. He denies leaving a voicemail for Annette Whitson Greene. He did not see the Victim at all before his death.	Not asked.	No personal knowledge. Heard Victim's body was moved.	No personal knowledge. Heard Stephanie gave the Victim blood pressure pills that looked like Percocet. The Victim injected those pills. He heard the pills looked like "Roxy" pills.

Witness Statements to Commission about the Victim

WITNESS	Saw Victim Prior to Death	Victim had medical issues	Victim was partying night before death	Victim had alcohol before death	Victim's body was moved	Victim took blood pressure pills
Danny Edwards (friend of Victim)	Yes.	The Victim did not appear to be ill. He had been out of jail for three weeks the day before his death. He knew him to carry an inhaler for slight asthma and an EpiPen for an allergy to bees.	Did drugs with the Victim prior to his death. They crushed and injected Roxicet and morphine pills. Heard that later that night after the Victim finished the pills Pritchard gave him, people came over and gave the Victim more pills.	Started drinking beer with the Victim at 9:00 a.m. the day before the Victim died. They brought beer to their work, which was logging. While drinking that morning, he thinks they did Xanax and methadone.	Not asked.	Not asked.
Brian Silvers (friend of Victim and nephew of Robbie Brown)	No.	No personal knowledge. Heard from Robbie Brown that he went to the hospital before he went to jail with an infected arm. He was told it might have to be amputated.	No personal knowledge, but he was not there.	No personal knowledge. The Victim did not like the drink.	Denies that this happened. States Annette Whitson Greene made up this rumor and it is a lie.	No personal knowledge. Heard from Nathan Angel right after the Victim died that Stephanie Whitson Randolph bought blood pressure pills at Lincoln Park. She thought they were Roxi 30s. The Victim injected them and did not feel right. They looked up the pill on a website and identified them as blood pressure medication.
Carrie Hinds (ex-girlfriend of Nathan Angel)	Yes. She saw him for 20 minutes the day before he died. He did not look sick. He looked good but a little thin. Also saw his body after death, but he was covered by a blanket.	Does not know. Believes he had an abscess or an infection in his arm before he went to jail. She thought it had healed up and was not a concern in jail.	Does not know.	Does not know.	Does not know.	No personal knowledge. Heard the rumor that Stephanie Whitson Randolph had gotten pills

Witness Statements to Commission about the Victim

WITNESS	Saw Victim Prior to Death	Victim had medical issues	Victim was partying night before death	Victim had alcohol before death	Victim's body was moved	Victim took blood pressure pills
Emma Wheeler (aunt of Victim)	No, but she saw his body after he died. He was covered by a blanket.	Does not know.	Not asked.	Not asked.	Not asked.	Not asked.
Lacey Pritchard (daughter of claimant)	Not asked.	Not asked.	No personal knowledge. Heard from two possible defense witnesses at trial that he was partying with others the night before he died.	Not asked.	Not asked.	Not asked.
Annette Whitson Greene (mother of Victim)	No.	The Victim told her he had been in the hospital and they wanted to amputate his arm because of a blood clot and he wouldn't let them and left. She saw him once between when he left the hospital and when he went to jail and his arm looked swollen to twice its size. He was born with a hole in his heart.	No personal knowledge. She did not see the Victim but heard that he was at a party at Nathan Angel's trailer with 6-7 other people.	Does not know.	No personal knowledge. She has heard several stories about the Victim being moved to Christine Angel's trailer.	No personal knowledge. She heard the Victim had taken a 100mg blue blood pressure pill.
Stephanie Whitson Randolph (girlfriend of Victim)	Yes.	The Victim had a blood clot or abscess in his arm before he went into the hospital. His arm was swollen, red, and a lot bigger. He was hospitalized for three days and she stayed with him. She didn't hear any discussion of amputation.	She could not recall what time she left Christine Angel's – maybe 10:00 p.m., maybe 2:00 a.m. The family was still awake. She does not know if he did any partying after she left, but he was crying when she left.	No.	Has not heard that.	Denies.
John Pritchard (claimant)	Yes.	He saw him before he went to the hospital. His left arm was swollen, puffy, and black and blue. He had an abscess that had pus. The day before he died, he was sweaty and appeared to be sick. He showed his arm, which was black and blue, reddish-purplish, swollen, and filled with pus. He could see track marks.	No personal knowledge. Heard from Danny Edwards that Edwards had gone to Nathan Angel's and the Victim and others were drinking and offered Edwards drugs.	No personal knowledge. Heard he slept over at Nathan's trailer and drank too much.	No personal knowledge. Heard that Nathan Angel and his brother William moved the body.	Not asked.

Handout 26

Witness Statements to Commission about

Pritchard and Brown

Witness Statements to Commission about John Pritchard and Robbie Brown

WITNESS	Robbie Brown was a drug dealer	Pritchard was a drug dealer/Provided Pills to Victim Before	Pritchard provided drugs to Victim on 3/6/2011
Christine Angel (step-grandmother of Victim)	Not asked.	Not asked.	Not asked.
Floyd Ayers (cousin of Victim)	Not asked.	Not asked. Did not know Mr. Pritchard.	Not asked.
Robert Silvers (grandson of Christine Angel)	Does not know.	Does not know.	Does not know. Denies what he told Sheriff Banks, which is that Pritchard gave Opanas to Jonathan that he got from Robbie Brown.
Tammy Ayers (former girlfriend of Victim)	Yes. She bought drugs from her. Robbie knew that some of the medication she gave to Pritchard was getting sold.	Nathan Angel told her that Pritchard sold him pills. Pritchard would not come into the house and Nathan Angel would go out to him. She saw this a few times when she was at the house.	Nathan Angel told her that Pritchard was coming over with morphine and asked if she wanted any. She knew Nathan was getting 10 pills. She saw Pritchard talking to Nathan when she left. She heard later from Nathan that the Victim did 9 of the pills. She never saw the transaction.
Russell Wilson (biological father of Victim)	No personal knowledge. Heard rumors she was.	No personal knowledge. Stephanie Whitson Randolph told him that Pritchard provided drugs to her at a restaurant.	No personal knowledge. Nena Angel told him that Pritchard had provided the morphine to the Victim.
Nikki Angel (sister of Victim)	No personal knowledge. Did not know it for a fact because she never saw it, but she heard from people that you could get drugs from her.	She knew that he provided pills to people.	No personal knowledge. Pritchard told her he did not do it. Heard a rumor Stephanie Whitson Randolph got the pills from Thelma Massey. Believed that John Pritchard was mad at the Victim for having a relationship with Robbie Brown, and he did not want to have anything to do with Jonathan Whitson.
Nena Angel (sister of Victim)	No personal knowledge. Heard that she was a drug dealer.	No personal knowledge. Heard he sold pills to people before the Victim died. Also heard he sold the Victim morphine pills before	No personal knowledge. Heard Pritchard sold pills to the Victim after he got out of jail and before he died.

Witness Statements to Commission about John Pritchard and Robbie Brown

WITNESS	Robbie Brown was a drug dealer	Pritchard was a drug dealer/Provided Pills to Victim Before	Pritchard provided drugs to Victim on 3/6/2011
Aaron Collins (son of Robbie Brown and roommate of John Pritchard at time)	Robbie Brown was the biggest drug dealer in the county. She probably gave pills to the Victim. He saw her give pills to the Victim before. Robbie Brown told him Pritchard did not give drugs to Victim.	Pritchard and his mother Robbie Brown would give him pills. Pritchard's pills were purple 30 mg from the VA. He never saw John Pritchard sell to anyone else. Robbie Brown was the biggest drug dealer in town and she gave him pills all the time. She dealt pills, cocaine, pot, heroin, "whatever."	Pritchard came into the house nervous on the day the Victim died and said the Victim overdosed. Pritchard said they were going to get him for murder. Pritchard said he gave the Victim 10 morphine pills.
Danny Edwards (friend of Victim)	Does not know. Did not know her.	Knew a lot of people would buy pills from Pritchard. Edwards never bought pills from Pritchard. In jail, Pritchard told him that he did sell pills and did not do it. Pritchard asked him to lie for him. Pritchard wanted him to say that Pritchard did not sell pills.	Was with the Victim that day. Saw Pritchard with the Victim at the Riverside gas station around 3:30 p.m. – 4:00 p.m. Pritchard came by an hour later and Victim went to Pritchard's truck to get drugs. He did not see the transaction, but knows it happened because they had pills afterwards.
Brian Silvers (friend of Victim and nephew of Robbie Brown)	Not asked.	No personal knowledge. He knew Pritchard was prescribed morphine from the VA Hospital. He heard that Pritchard gave drugs to Jonathan Whitson.	No personal knowledge.
Carrie Hinds (ex-girlfriend of Nathan Angel)	Not asked.	No personal knowledge. Heard he was a drug counselor and sold to young people.	No personal knowledge. Heard a rumor he supplied the drugs.
Emma Wheeler (aunt of Victim)	Not asked.	Not asked.	Not asked.
Lacey Pritchard (daughter of claimant)	No personal knowledge. She believes so.	Not specifically asked. She never saw her father share his medication with anyone, and he kept it in a lockbox because Robbie Brown's sons would try to steal it.	Not asked.

Witness Statements to Commission about John Pritchard and Robbie Brown

WITNESS	Robbie Brown was a drug dealer	Pritchard was a drug dealer/Provided Pills to Victim Before	Pritchard provided drugs to Victim on 3/6/2011
Annette Whitson Greene (mother of Victim)	She says "possibly, yes" because her daughter dated Robbie's son Aaron and he would bring pills. She does not know if Robbie exchanged drugs with the Victim for work he did at her house.	No personal knowledge. She does not know if he was a drug dealer. She never got drugs from him and didn't know of him giving drugs to anyone.	No personal knowledge. She has heard from the streets that Pritchard gave the drugs to Stephanie, who gave them to the Victim.
Stephanie Whitson Randolph (girlfriend of Victim)	Yes.	She knew Pritchard to be a drug dealer and had personally seen Pritchard hand pills to the Victim on a past occasion.	The Victim called Pritchard to get pills. Pritchard picked the Victim up and when the Victim came back he had 10 pills.
John Pritchard (claimant)	Yes.	He admits to giving someone drugs one time in the past, which resulted in him being charged. He denies being a drug dealer.	Denies.

Handout 27

Robbie Brown
Letters Chart

Letters Written by Robbie Brown

Date/Recipient (Citation)	Description
3/4/2012 **John Pritchard** **(Documents Received from Pritchard 8/11/2021, pgs. 7-14)**	• The Victim got out of jail two days before he (the Victim) died last year. • Nathan Angel (Nathan) said the Victim was on the couch snoring at 10 am and had snored all morning long. • Nathan said the Victim's girlfriend had given him (the Victim) blood pressure pills the night before. When the Victim broke up with the girlfriend, she told the Victim they were Percocet 30s and he shot them up. • Robbie remembers she had a staph infection once like the Victim had in his arm. The Victim's arm swelled to the size of his leg in December 2010. Robbie's doctor told her at the time that a systemic infection causes vegetative growth on your heart valves. • The Victim already had heart problems, a murmur, if Robbie remembers correctly. • "If [the Victim] was locked in jail with his arm swelled like that and the infection went untreated all those 90 days he was locked up – No antibiotics…No Dr. to care for him and then [his girlfriend] gave him blood pressure pills…All that would definitely contribute to serious problems maybe even death?"
6/26/2012 – 6/27/2012 **John Pritchard** **(Documents Received from Pritchard 8/11/2021, pg. 15-16)**	• If Robbie is called as a witness for Pritchard's trial she will say she wasn't there and doesn't know anything. She got her information about what occurred from second-hand gossip. • Robbie says Pritchard told her that he went to Riddles then took the Victim to Nate's where Stephanie met him. Stephanie gave him blood pressure pills and told the Victim they were pain pills and he shot them up. • Robbie believes that Riddles is closed now because she heard they sold drugs there. • The Victim, like Aaron, has become a junkie over the years. • Aaron told Robbie that he was with Pritchard. Robbie knows Aaron lived with Pritchard. • Robbie says that's the end of her story and she is with Pritchard. Robbie writes she loves Pritchard and would never hurt him.

Handout 28

Robbie Brown

Criminal History Chart

ROBBIE BROWN

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
FICTITIOUS INFO TO OFFICER (T)	MADISON	04/18/2013	02/17/2014
SHOPLIFTING CONCEALMENT OF GOOD (M)	YANCEY	11/01/2013	03/04/2014
PWIMSD SCH II CS	YANCEY	08/16/2011	06/03/2013
PWIMSD SCH II CS	YANCEY	06/21/2011	06/03/2013
DWLR (M)	YANCEY	01/06/2007	10/01/2007
DWI – LEVEL 5 (M)	YANCEY	04/04/2006	10/01/2007
POSSESSION SCH II CS	YANCEY	01/01/2005	03/21/2005
POSSESSION SCH II CS	YANCEY	08/12/2004	03/21/2005
POSSESSION OF COCAINE	YANCEY	06/04/2004	03/21/2005
CONSPIRE TO POSSESS SCH II CS (M)	YANCEY	08/21/2002	04/07/2004
MAINTAIN VEH/DWELL/PLACE CS (M)	YANCEY	08/21/2002	04/07/2004
POSSESS DRUG PARAPHERNALIA (M)	YANCEY	06/06/2000	05/08/2001
DWLR (M)	BUNCOMBE	02/28/1998	06/03/1998
CARRYING CONCEALED WEAPON (M)	BUNCOMBE	02/28/1998	06/03/1998
SIMPLE WORTHLESS CHECK (M)	BUNCOMBE	10/03/1997	04/21/1998

ROBBIE BROWN

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
SIMPLE WORTHLESS CHECK (M) (X2)	BUNCOMBE	10/01/1997	03/23/1998
WORTHLESS CHECK ACCOUNT CLOSED (M)	BUNCOMBE	10/01/1997	03/23/1998
SIMPLE WORTHLESS CHECK (M)	BUNCOMBE	09/29/1997	03/23/1998
SIMPLE WORTHLESS CHECK (M) (X2)	BUNCOMBE	09/28/1997	03/23/1998
SIMPLE WORTHLESS CHECK (M)	BUNCOMBE	09/25/1997	03/23/1998
WORTHLESS CHECK ACCOUNT CLOSED (M)	BUNCOMBE	09/24/1997	03/23/1998
WORTHLESS CHECK ACCOUNT CLOSED (M)	BUNCOMBE	09/23/1997	03/23/1998
SIMPLE WORTHLESS CHECK (M)	BUNCOMBE	09/21/1997	03/23/1998
WORTHLESS CHECK ACCOUNT CLOSED (M)	BUNCOMBE	09/21/1997	03/23/1998
WORTHLESS CHECK ACCOUNT CLOSED (M)	BUNCOMBE	09/20/1997	03/23/1998
SIMPLE WORTHLESS CHECK (M) (X2)	MADISON	09/17/1997	03/20/1998
SIMPLE WORTHLESS CHECK (M)	MADISON	02/04/1997	08/06/1997
SIMPLE WORTHLESS CHECK (M)	MADISON	01/26/1997	08/06/1997

Handout 29

Robert Silvers
Criminal History Chart

ROBERT SILVERS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESSION OF FIREARM BY FELON	YANCEY	12/09/2018	01/09/2019
HABITUAL FELON	YANCEY	02/16/2017	01/09/2019
POSSESSION OF FIREARM BY FELON	YANCEY	02/16/2017	01/09/2019
POSSESSION SCH II CS	YANCEY	02/17/2017	05/31/2017
POSSESS DRUG PARAPHERNALIA (M)	YANCEY	02/17/2017	05/31/2017
DWLR (M)	YANCEY	04/05/2016	10/25/2016
DWLR (M)	YANCEY	02/10/2015	04/06/2015
DWLR (M)	YANCEY	05/16/2014	06/23/2014
SIMPLE ASSAULT (M)	YANCEY	05/25/2012	09/11/2012
DWI – LEVEL 1 (M)	YANCEY	10/20/2010	01/20/2011
DWLR (M)	YANCEY	10/20/2010	01/20/2011
DWI – LEVEL 5 (M)	YANCEY	06/20/2010	01/20/2011
OBTAIN BY PROPERTY FALSE PRETENSE	YANCEY	12/11/2008	07/21/2009
SELL/DELIVER SCH II CS	MITCHELL	11/10/2007	08/26/2008
COMMON LAW UTTERING (M) (X2)	YANCEY	06/30/2007	07/24/2007
LARCENY (M)	YANCEY	06/26/2007	07/24/2007
SIMPLE ASSAULT (M)	YANCEY	05/08/2006	07/28/2006

ROBERT SILVERS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
SELL/GIVE MTBV/U-WN TO <21 (M)	BUNCOMBE	06/17/2005	11/08/2005
INJURY TO PERSONAL PROPERTY (M)	YANCEY	02/12/2005	04/29/2005
COMMUNICATING THREATS (M)	YANCEY	09/19/2004	11/09/2004
CONSUME BEER/WINE UNDERAGE (M)	YANCEY	08/27/2004	10/25/2004
POSS MTBV/U-WN BY 19/20 (M)	YANCEY	09/15/2003	11/19/2003
POSS MTBV/U-WN BY 19/20 (M)	YANCEY	06/15/2003	08/11/2003
SIMPLE POSSESS SCH VI CS (M)	YANCEY	01/23/2002	05/31/2002
SIMPLE POSSESS SCH VI CS (M)	YANCEY	01/16/2002	04/05/2002
POSS MTBV/U-WN NOT 19/20 (M)	YANCEY	07/05/2001	08/10/2001
POSS MTBV/U-WN NOT 19/20 (M)	MITCHELL	03/20/2000	04/28/2000

Handout 30

Tammy Ayers

Criminal History Chart

TAMMYMAE "TAMMY" AYERS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESSION OF FIREARM BY FELON	YANCEY	05/24/2011	01/31/2012
SELL/DELIVER SCH II CS	YANCEY	05/13/2011	01/31/2012
MAINTAIN VEH/DWELL/PLACE CS	YANCEY	05/11/2011	01/31/2012
SELL/DELIVER SCH II CS	YANCEY	05/11/2011	01/31/2012
PWIMSD SCH III CS	YANCEY	03/06/2009	09/01/2009
PWIMSD SCH IV CS	YANCEY	03/06/2009	09/01/2009
POSSESS METHAMPHETAMINE	YANCEY	12/11/2007	10/28/2008
POSSESSION OF COCAINE	YANCEY	12/11/2007	10/28/2008
POSSESS DRUG PARAPHERNALIA (M)	HENDERSON	06/05/2007	09/24/2007
POSSESSION OF COCAINE	YANCEY	11/07/2006	03/09/2007

Handout 31

Ward Russell Wilson

Criminal History Chart

WARD "RUSSELL" WILSON

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
DWI – LEVEL 5 (M)	MADISON	12/21/1991	02/24/1992
DWI (M)	BUNCOMBE	03/19/1989	06/02/1989

Handout 32

Nikki Angel

Criminal History Chart

HAZEL "NIKKI" ANGEL

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
LARCENY (M)	BUNCOMBE	10/04/2017	03/07/2018
DWLR (M)	MITCHELL	05/25/2017	12/01/2017
DWLR (M)	YANCEY	07/03/2006	01/18/2007
DWLR (M)	YANCEY	04/03/2006	01/18/2007
BREAK COIN/CURRENCY MACHINE (M)	MADISON	03/08/2006	08/25/2006
DAMAGE COIN/CURRENCY MACHINE (M)	MADISON	03/08/2006	08/25/2006
LARCENY (M)	MADISON	03/08/2006	08/05/2006
DWLR (M)	YANCEY	07/02/2004	09/09/2004
DWI – LEVEL 5 (M)	YANCEY	03/27/2004	09/09/2004

Handout 33

Nena Angel Tipton

Criminal History Chart

NENA ANGEL TIPTON

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESS IMMED. PRECURSOR CHEMICAL	MADISON	01/01/2010	07/17/2012

Handout 34

Aaron Collins

Criminal History Chart

AARON COLLINS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESS FIREARM BY FELON	CURRITUCK	05/22/2019	04/12/2021
DWLR (M)	MCDOWELL	08/06/2020	11/16/2020
POSSESS CS PRISON/JAIL PREMISE	MCDOWELL	08/06/2020	09/02/2020
CRIMINAL CONTEMPT (M)	MCDOWELL	08/01/2020	08/18/2020
ASSAULT ON A FEMALE (M)	YANCEY	05/31/2017	08/11/2017
COMMUNICATING THREATS (M)	YANCEY	05/31/2017	08/11/2017
ASSAULT ON A FEMALE (M)	MCDOWELL	11/28/2014	02/13/2015
RESISTING PUBLIC OFFICER (M)	MCDOWELL	01/22/2012	05/01/2013
LARCENY OF A FIREARM	YANCEY	06/15/2012	10/3/2012
POSSESS DRUG PARAPHERNALIA (M)	BUNCOMBE	08/10/2012	09/21/2012
OBTAIN PROPERTY BY FALSE PRETENSE	MCDOWELL	08/28/2011	02/08/2012
LARCENY OF A FIREARM	MCDOWELL	08/28/2011	02/08/2012
LARCENY (M)	MITCHELL	07/06/2011	06/12/2012
DOMESTIC CRIMINAL TRESPASS (M)	MCDOWELL	04/01/2007	05/04/2007

AARON COLLINS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
INJURY TO PERSONAL PROPERTY (M)	MCDOWELL	04/01/2007	05/04/2007
DOMESTIC CRIMINAL TRESPASS (M)	MCDOWELL	02/22/2007	05/04/2007
BREAKING OR ENTERING (M)	MCDOWELL	02/22/2007	05/04/2007
INJURY TO REAL PROPERTY (M)	MCDOWELL	02/22/2007	05/04/2007
ASSAULT ON A FEMALE (M)	MCDOWELL	02/22/2007	05/04/2007
INJURY TO PERSONAL PROPERTY (M)	MCDOWELL	02/22/2007	05/04/2007
ASSAULT ON A FEMALE (M)	MCDOWELL	01/29/2007	05/04/2007
CARRYING A CONCEALED WEAPON (M)	MCDOWELL	08/03/2006	09/06/2006
DWI – LEVEL 4 (M)	YANCEY	10/18/2001	12/10/2001
POSS MTBV/U-WN NOT 19/20 (M)	YANCEY	08/14/1999	10/04/1999

Handout 35

Danny Edwards
Criminal History Chart

DANNY EDWARDS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
HABITUAL FELON	YANCEY	05/23/2016	05/23/2016
FAIL REPORT NEW ADDRESS – SEX OFFENSE	YANCEY	04/29/2016	05/23/2016
POSSESS STOLEN GOODS/PROP (M)	YANCEY	07/09/2012	07/25/2013
SELL/DELIVER SCH III CS	YANCEY	06/20/2011	07/25/2013
RESISTING PUBLIC OFFICER (M)	BUNCOMBE	09/10/2012	03/19/2013
POSSESS SCH II CS	BUNCOMBE	09/10/2012	03/19/2013
DWLR (M)	YANCEY	04/14/2010	09/23/2010
DWI – LEVEL 4 (M)	YANCEY	01/18/2008	10/27/2008
POSSESS SCH VI CS	YANCEY	01/18/2008	10/27/2008
INJURY TO PERSONAL PROPERTY (M) (X2)	YANCEY	09/16/2007	06/10/2008
POSSESS DRUG PARAPHERNALIA (M)	MITCHELL	10/20/2006	11/28/2006
POSSESS MARIJUANA UP TO ½ OZ (M)	MITCHELL	10/20/2006	11/28/2006
SIMPLE POSSESS SCH VI CS (M)	YANCEY	04/22/2006	09/06/2006
BREAKING AND/OR ENTERING	YANCEY	06/16/2000	06/14/2001

DANNY EDWARDS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
ABDUCTION OF CHILDREN	YANCEY	06/16/2000	06/14/2001
POSS/SELL NONTAX PAID ALC BEV (M)	YANCEY	03/18/2000	05/12/2000
POSSESS DRUG PARAPHERNALIA (M)	YANCEY	03/18/2000	05/12/2000
UNAUTHORIZED USE OF MOTOR VEH (M)	YANCEY	12/17/1999	01/13/2000
BREAKING OR ENTERING (M)	YANCEY	02/22/1999	04/09/1999
BREAKING OR ENTERING (M)	YANCEY	02/10/1999	04/09/1999
BREAKING OR ENTERING (M)	YANCEY	02/05/1999	04/09/1999
LARCENY (M)	YANCEY	01/31/1999	04/09/1999
BREAKING OR ENTERING (M)	YANCEY	01/25/1999	04/09/1999
LARCENY (M)	YANCEY	01/25/1999	04/09/1999
SIMPLE POSSESS SCH VI CS (M)	YANCEY	10/25/1998	01/28/1999
SIMPLE POSSESS SCH IV CS (M)	YANCEY	05/29/1998	07/24/1998
BREAKING OR ENTERING (M)	YANCEY	03/20/1998	04/30/1998

Handout 36

Brian Silvers

Criminal History Chart

BRIAN SILVERS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
LARCENY (M)	BUNCOMBE	06/06/2008	07/09/2008
POSSESS DRUG PARAPHERNALIA (M)	YANCEY	07/26/2003	10/15/2003
POSSESSION OF MARIJUANA >1/2 TO 1 ½ OZ	YANCEY	07/26/2003	10/15/2003
NOISE ORDINANCE VIOLATION (M)	YANCEY	05/10/2000	06/22/2000

Handout 37

Carrie Hinds

Criminal History Chart

CARRIE HINDS

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
DWI – LEVEL 5 (M)	YANCEY	04/22/2000	05/26/2000

Handout 38

Lacey Pritchard

Criminal History Chart

LACEY PRITCHARD

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
DUI (M)	GEORGIA	01/22/2015	04/13/2015
DWI – LEVEL 5 (M)	BUNCOMBE	10/07/2011	03/14/2012

Handout 39

Annette Whitson Greene

Criminal History Chart

ANNETTE "ANN" WHITSON GREENE

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESS DRUG PARAPHERNALIA (M)	MITCHELL	07/05/2005	11/30/2005
SIMPLE WORTHLESS CHECK (M)	MITCHELL	02/27/2004	10/25/2004
SIMPLE WORTHLESS CHECK (M)	MITCHELL	02/25/2004	10/25/2004
SIMPLE WORTHLESS CHECK (M) (X2)	MITCHELL	02/21/2004	10/25/2004
DWLR (M)	YANCEY	05/21/1998	08/24/1998
DWI – LEVEL 3 (M)	MITCHELL	09/26/1997	12/15/1997
UNSEALED WINE/LIQUOR IN PASS AREA (M)	YANCEY	03/04/1995	05/24/1995
POSS/CONS BEER/WINE PUBLIC STREET (M)	YANCEY	10/14/1989	11/17/1989

Handout 40

Stephanie Randolph

Criminal History Chart

STEPHANIE WHITSON RANDOLPH

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
POSSESS DRUG PARAPHERNALIA (M)	YANCEY	06/14/2018	03/27/2019
CHILD ABUSE (M)	YANCEY	06/14/2018	03/27/2019
PWISD METHAMPHETAMINE	YANCEY	06/14/2018	03/27/2019
DWI – LEVEL 1 (M)	YANCEY	09/14/2013	03/27/2014

Handout 41

Stephanie Randolph Deposition Digest, Transcript, and Exhibit

December 9, 2021

Deposition of Stephanie Whitson Randolph by Julie Bridenstine

Page #	Description of Randolph's Testimony	Exhibit
1	• Commission Staff Attorney Julie Bridenstine (JB) deposes Stephanie Whitson Randolph (Stephanie). Commission Staff Attorney Brian Ziegler (BTZ) swears Stephanie in.	
1-4	• JB explains the Commission to Stephanie.	
4	• Stephanie does not have counsel. She has only testified at John Pritchard's (Pritchard) trial.	
5-8	• JB goes over deposition ground rules and procedures.	
8-9	• Stephanie is not taking any medications or drugs and does not have any medical conditions that would interfere with her ability to testify. She is not currently under the influence of any alcohol or drugs, either illegal or prescription. No other circumstances are preventing her from testifying fully.	
9-11	• She has not done anything to prepare for the deposition. She has talked to her husband, Brandon Randolph (Brandon) about the deposition. She told him that she was confused and didn't remember a lot. She thought all of this was done. She last talked to him on 10/24/2021. She has not examined or reviewed anything. She doesn't have any materials related to this case. No one has asked her to withhold information or misrepresent any facts.	
11-13	• JB gets Stephanie's demographic information.	
13	• Stephanie discusses custody issues with her children related to a drug charge from 2017. Stephanie asks to take a five (5) minute break.	
14	• Stephanie met the Victim through a friend in 2010. They were not dating, they were friends. She met him about three months before he went to jail in January 2011.	
14-15	• Stephanie denies being romantically involved with the Victim or being boyfriend/girlfriend with him. Other people thought they were dating because she stayed with him a lot and they were together all the time.	
15-16	• Stephanie and the Victim were both using drugs at the time they met. Stephanie doesn't know when the Victim first started using drugs.	
16	• The Victim used pain pills, "anything he could find," intravenously. She never saw him swallow or snort pills. She only knew him to use prescription pain pills. She does not know of him using any street drugs. He didn't use street drugs around her.	
16-17	• The Victim would put some water on the pills and suck it into a syringe. She has never done that part of it.	
17	• Stephanie was only using pain pills. She would eat or snort them until she met the Victim. After she met him, she started using them intravenously as well. She never injected herself; the Victim would do it for her. The Victim would inject drugs into both of his arms daily.	
18-19	• The Victim got drugs from different places. During the period Stephanie knew the Victim, he was getting his drugs from Pritchard. When asked if anyone else provided drugs to the Victim, Stephanie says she's sure they did. She had been there when Pritchard came by and the Victim would get pills. They were 30mg morphine pills that were round and purple. The pills had the number "30" on them. She has also seen Pritchard's bottle of pills with	

	his name on it at Robbie Brown's (Robbie) house. She never actually witnessed the exchange of the pills.	
19-20	• Pritchard picked her up from work at Little Tokyo in Burnsville one day before the Victim went to the jail and took her to the Victim's house. Pritchard handed the Victim some morphine pills. The Victim wanted pills and Pritchard wanted to offer the Victim a way to get on his feet. She tried to stay out of it. This was probably a month before the Victim went to jail.	
20-21	• Stephanie probably saw Pritchard's pill bottle at Robbie's house in the first month she was friends with the Victim.	
22	• The day the Victim got out of jail he made multiple phone calls to Pritchard. The Victim told her Pritchard was coming by to give him some pills and went outside. She saw Pritchard's truck but didn't see the interaction. The Victim came back inside with pills. Pritchard had a white Ford Ranger.	
22-23	• When she saw Pritchard's pill bottle at Robbie's house, Robbie was looking at it. She doesn't know what happened with that bottle. The Victim would get pills from Robbie as well.	
23	• The Victim also got drugs from a lady named Thelma Massey (Massey). She's sure he got them elsewhere, too, but doesn't know from where. The Victim would do yard work for Robbie and she would provide drugs to him. Stephanie would see Robbie give him Opanas.	
23-24	• Robbie was a drug dealer. Nathan Angel (Nathan) was a drug user and kept to himself. She is sure he would share drugs occasionally but was very "stingy" with his drugs.	
24	• JB asks if the Victim had ever gotten pills from somewhere Stephanie didn't know about, and Stephanie says yes. The Victim did not have any prescriptions.	
24	• Stephanie started using drugs a few years before meeting the Victim.	
24-25	• The Victim went to jail in January 2011. They spoke over the phone a few times.	
25-26	• She does not know what medical issues the Victim had before he went to jail. He had a blood clot in his arm and had to go to the hospital. She isn't sure what arm. She was with him during the entire three-day hospital stay. It was either a clot or an abscess. Before he went to the hospital, the arm looked swollen and red and was a lot bigger than the other arm. The Victim called an ambulance because he needed a ride to the hospital. She knows that it was an abscess but doesn't know if it threw a clot.	
27	• She doesn't know of any preexisting medical issues the Victim had. She hasn't heard about asthma or a hole in his heart.	
27-28	• Stephanie was with the Victim when he left the hospital. He didn't leave with any medication. She was with him for about three days after the hospital. Her parents picked her up for Christmas and then she went back to Burnsville for a few days. To her knowledge, he wasn't taking medication for his arm after leaving the hospital. She doesn't know of him filling a prescription.	
28-29	• The Victim was using prescription pain pills after leaving the hospital, but she did not see him taking any prescribed medications related to the hospital visit.	

29	• The Victim's arm looked a lot better after leaving the hospital, but he was still in pain.	
29-30	• The Victim was good when he was in jail. He was trying to get in touch with his lawyer. He did not mention feeling bad or anything about his arm. He just wanted to get out. He told her he was in jail for a failure to appear from seven years before in Madison County.	
30-31	• During his hospital stay, medical staff told the Victim that if he kept using like he was he would eventually die. They said he would throw a clot in his arm and it would go to his heart. They told him he was a "ticking time bomb." She didn't hear any discussion about amputating the arm.	
31-32	• To her knowledge, the Victim did not receive any treatment for his arm after leaving the hospital. The swelling had gone down, but he had it wrapped. When he unwrapped it the day he came home from the hospital, it still looked pretty bad.	
32-33	• Stephanie does not know if the Victim was using drugs while in jail. He did tell her that someone had dropped off a bottle of vodka and he drank it.	
33	• The Victim got into a fight while in jail and either the Victim or the other guy was taken to the hospital.	
33	• Stephanie does not know if the Victim went through withdrawal when he first went to jail. Stephanie had a clean period while the Victim was in jail. She did not experience any withdrawal symptoms.	
34	• At the time the Victim died, her phone number was 828-208-3992. The Victim used her phone and Christine Angel's (Christine) phone.	
34-35	• **Ex. 18** is phone records for 828-208-3992. Stephanie doesn't know Pritchard's number. She points out the numbers she recognizes on the records.	**Ex. 18**
35-36	• The Victim called her around lunchtime on March 5th to say he was out of jail. She remembers the phone said 12:14. He wanted to see her, so she went to Nathan's house (a trailer above Christine's house). She does not know if this was the 4th or the 5th. Stephanie doesn't know how the Victim got out of jail. She got to Nathan's a little after 3:00 p.m.	
36-38	• The Victim seemed upbeat and happy. He did not talk about how he was feeling. He appeared normal to her, which she guesses means he was under the influence, but she doesn't know. He did not seem sick. She doesn't remember him coughing, but he did mention running a fever. He told her the fever wasn't from lack of pills, and she didn't ask what it was from.	
38	• Stephanie doesn't know if the Victim had already used drugs when he was telling her about the fever, but she doesn't see him going that long without using something. She did not pay any attention to his arm.	
39	• JB asks Stephanie to walk her through March 5, 2011. Stephanie says the Victim asked to use her phone to call Pritchard to get drugs. They went to Christine's house. The Victim said Pritchard was coming up Marion Mountain and would drop some off. The Victim and Stephanie had been there for an hour and a half when Pritchard came by. The Victim came back into the house with 10 pills.	
39-42	• Stephanie was not present for the phone conversation between the Victim and Pritchard. The Victim told her he asked Pritchard to stop by to bring pills. He did not say what kind of pills. She saw Pritchard's truck through the	

	window but didn't see Pritchard. The Victim was outside with Pritchard for about five minutes. She saw the Victim lean his head into the truck but can't remember if he actually got into the truck. Pritchard's truck left after that. The Victim came back into the house with the pills.	
42-43	• Stephanie does not know if the truck came back. She only saw it come into the driveway once and leave once. The truck was there for about 10 minutes. They were at Christine's house during this exchange.	
43	• The Victim came back into the house with 10 morphine pills. The Victim put three of them in a spoon and melted them down and they both used. Stephanie left to get something to eat and buy cigarettes with her god-mom.	
44	• Stephanie's god-mom picked her up and the Victim gave her five of the pills so he wouldn't use them. She was gone for an hour and a half. No one else was there when she got back. They "used and used" until she left at 2:00 a.m.	
44-45	• The pills were morphine pills that were purple and had "30" on them. The Victim said he got the pills from Pritchard. Stephanie clarifies they used three pills together and he gave her five when she left. She does not know what happened to the other two pills. They used the three pills in the driveway in her father's Jeep. The Victim crushed the pills and added water. He didn't usually heat the spoon. He would then draw the crushed-up pills and water into the syringe.	
46	• Stephanie is not sure how many doses would come from three pills in the spoon. She thinks the Victim injected her three times and injected himself more than that. She thinks they stayed in the Jeep the whole time they injected those first three pills.	
47-48	• Stephanie then says she thinks she left in the Jeep to meet her god-mom. She was very high but could walk and talk. The Victim seemed fine and could walk around. He was not coughing. Stephanie did not think her god-mom could tell she was high.	
49	• The morphine did not seem to have much of an effect on the Victim. He was acting like he felt really good. Stephanie went through the Hardee's drive-thru and to a gas station to get cigarettes with her god-mom, Jane Honeycutt (Jane). She estimates she was gone from about 3:30 p.m. or 4:00 p.m. until about 5:00 p.m. Stephanie does not think the Victim drove at all that day.	
50	• Stephanie did not go anywhere else with Jane. She was gone for about an hour and a half, then went back to the Victim and the two of them used drugs in the bathroom at Christine's house. She thinks he put three pills in the spoon. The Victim injected the pills into both of his arms.	
51	• Stephanie does not remember the Victim's arms looking swollen that day. He would inject the drugs on the inside of the bend in his arm and sometimes at the bottom of his forearm.	
52	• Nothing looked unusual about his arms, and he always had track marks. Stephanie is not sure how long they used drugs in the bathroom. She is not sure what time she left. It may have been 10:00 p.m. or maybe 2:00 a.m., but everyone was still awake.	
53	• Christine knew what they were doing and told the Victim and Stephanie she would rather them not do that in her house. Stephanie is not sure how many pills they injected in the bathroom because there was always residue in the	

	spoon. The Victim would add to the spoon that started with three pills. She does not think he had any pain pills on him when she left for Hardees because he gave her five pills and told her to hold onto them so he didn't do them. They started with ten, used three, and he gave her five. She does not know what happened to the other two pills.	
54	• Stephanie does not know if the Victim used drugs when she was with Jane. The pills they were doing were morphine. The Victim had the pills and Stephanie assumes they came from Pritchard. When she got back, she gave the five pills back to the Victim. She is not sure if they used all five when they were in the bathroom.	
55	• She doesn't know how many times they each injected in the bathroom, but it was a lot because that was all they were doing. They may have done it six times apiece. The spoon was bigger than a soup spoon.	
56	• Stephanie says it may have been the size of a serving spoon. Stephanie does not know where it came from. Stephanie did not use drugs with anyone other than the Victim that day and did not see anyone else using. She was high but did not feel sick.	
57	• Stephanie says doing too many drugs makes you feel like you need to throw up. She did not think the Victim had that feeling. He could walk and carry on a conversation, and he never expressed feeling bad. He said his knuckles hurt because he hit someone in jail. The Victim said he had been running a slight fever, but Stephanie says he did not appear to feel bad.	
58	• Stephanie is sure there was morphine left when she left the bathroom. She then drove home and the Victim did not want her to leave. Stephanie has never felt nauseated from too much morphine. She is not sure what symptoms a person might feel if they took too much.	
59	• Too much Percocet has made Stephanie feel like she needed to throw up in the past. She is not sure what time she left Christine's house. She drove to her parents' house and her mom was waiting for her. Her mom did not notice she was high. The Victim said he was going to lay down when Stephanie left. He was crying and walking around.	
60	• Stephanie did not notice the Victim coughing. She may have stuck her head into Nathan's trailer that day to say hello. She thinks he was living there at the time. Jane was around 50 years old and was not a drug user. March 5, 2011 was the most morphine Stephanie and the Victim continuously used together. The Victim would usually give her a shot and then shield her from what he used.	
61	• Stephanie did not use drugs when the Victim was in jail. She did not use any drugs after leaving that day. She felt fine when she left Christine's house. She watched TV with her mom and went to bed. She had used morphine with the Victim prior to that day.	
62	• The morphine they used were always pills. They were purple. They sometimes used Robbie's red Opanas or green Percocet 15s from Massey. Stephanie thinks the morphine was purple, but it may have been blue. She cannot recall.	
63	• She is pretty sure the morphine they used on March 5, 2011 was purple. She thinks she and the Victim used about the same amount when they were	

	together, but she does not know what he did when she left. She is sure he used more because there was more left in the spoon.	
64	• There was residue in the spoon that could be used by adding more water without crushing any more pills. She does not know if the Victim used it after she left. She thinks the pills were purple that day, but they had used blue morphine before from a guy named Tim.	
65	• Stephanie did not see Pritchard give morphine to the Victim on March 5th. Riddle's or Riverside is a gas station and store. A lot of drug dealing happened there.	
66-67	• C.J. Wilson (C.J.) is the Victim's brother and Russell Wilson's son. C.R. is Massey's nephew or grandson, but she raised him as if he were her son. Stephanie did not see C.J. on March 5, 2011. She did see C.R. at Nathan's that day but did not talk to him. He left around the time Stephanie arrived. Other than Christine's family, she cannot recall seeing anyone else there. She does not know if Brian Silvers (Brian) was there.	
68	• C.R. was a drug user and occasional dealer. She does not know if he provided drugs to anyone at Nathan or Christine's. C.R. would use whatever drugs he could get and sold whatever Massey had. She knew the Victim would get drugs from C.R. She also knew the Victim would meet people at Riddle's but did not know if it was to get drugs. She thinks Pritchard's drugs were prescribed. She does not know of Pritchard ever being angry with the Victim.	
69	• Stephanie was never aware of a disagreement between Pritchard and the Victim about Robbie. She never talked to Pritchard about this case but said hello to him at the trial. Pritchard never gave her drugs. He always dealt with the Victim. She did not know Pritchard to provide drugs to anyone other than the time in the truck.	
70	• Stephanie's father was a bondsman, but she does not think that ever prevented anyone from providing her drugs. Nikki Angel (Nikki) is Nathan's daughter and the Victim's sister. Stephanie believes Nikki was occasionally romantic with Pritchard. She does not know Pritchard to be romantically involved with anyone else other than Robbie. Stephanie never talked to Nikki about the Victim's death.	
71	• Stephanie has never talked to Nena Angel (Nena), Nikki's sister, except maybe once on the phone with the Victim. She never spoke to Annette Whitson Greene (Greene) about what happened with the Victim. Stephanie found out about his death when a deputy called her dad's house around 7:00 a.m. and said she needed to give a statement.	
72	• She met Ryan Higgins (Higgins) to give her statement. No one else was present. She thinks she talked to him around 9:00 a.m. She went straight there to talk after learning about the Victim's death. There was some talk that the Victim may have done more drugs than morphine before he died, but she does not know and cannot recall where she heard that.	
73	• Brian may have told her about it much later. Stephanie went to the funeral but did not talk to anyone there about what happened. Lincoln Park is a road with apartments and houses where drugs are sold. Stephanie did not go there on March 5, 2011 and has never gone there by herself.	

74-75	• She had been there to buy drugs with the Victim twice in the past but did not end up getting anything. A guy named Bam Bam had sold what was supposed to be pink Percocet pills but were allegedly birth control pills. Someone else said they tried to buy pills from Bam Bam that turned out to be heart medicine. A person at Nathan's trailer said this sometime before the Victim went to jail. Stephanie denied buying pills on March 5, 2011 and denied giving pills to the Victim. She also denied ever getting blood pressure pills from anyone.	
76	• Stephanie did not get any pills herself that the Victim injected – she just brought the five back that he had given her to hold. She did not tell Nathan that she got blood pressure pills form Lincoln Park that she thought were pain pills. She does not know why multiple people would report that. It is not true.	
77	• Nothing about the story involving Stephanie and blood pressure pills is true. She has never heard this before. She does not know anything about the Victim drinking alcohol. He never drank alcohol around Stephanie but told her he drank in the past. Christine allowed people to drink in her house, but Stephanie does not know if there was any alcohol in the house on March 5th.	
78	• William Angel would visit Christine's from Morganton or wherever he lived. Stephanie does not know if the Victim drank with anyone before he died or if he did any other drugs.	
78-79	• The Victim cried when Stephanie left because he did not want her to go. She told him she did not want to see him again, that she was done, and her parents were onto her. She told the Victim he had a baby on the way and good things were coming. It wasn't a breakup because they were not together romantically. • Stephanie does not know Tammy Ayers. Brian is Robbie's nephew and was friends with the Victim. C.R. was also friends with the Victim. Brian was a drug user and occasional dealer.	
80	• Brian would just deal pills. She saw C.R. at Nathan's on March 5th and thinks Brian was there but is not sure. Stephanie knows of Danny Edwards but is not sure of his relationship to the Victim. She does not think the Victim worked on March 5, 2011.	
81	• Carrie Hinds was Nathan's girlfriend. She would pop in and leave. Stephanie thinks she saw her on March 5th. She was a drug user. Stephanie never used drugs in her presence or Nathan's presence. Stephanie does not know Sharon Biggs or Shannon Allison. The Victim knew Aaron Collins (Aaron) who is Robbie's son.	
82	• Stephanie did not see Aaron on March 5, 2011. She never heard about him providing drugs to the Victim before he died. Stephanie thinks Nathan stayed at his trailer that night, and does not know if the Victim went there after she left or if anyone was hanging out there. She is not aware of any parties or whether the Victim saw his brother C.J.	
83	• Stephanie never heard anything about the Victim dying at Nathan's trailer and being moved to Christine's house. She heard that the Victim looked like he was sleeping the morning he died. • Nikki is a drug user and has mental health issues. Stephanie thinks the mental health issue is related to Nikki injecting horse tranquilizers.	

	Stephanie only met Greene one time, and they never had words. Stephanie did not call her after the Victim died.	
84	• Stephanie never left a voicemail for Greene. She has never given anyone blood pressure pills. The only officer she talked to was Higgins with the Yancey County Sheriff's Office (YCSO). She does not think she talked to Chief Deputy Thomas Farmer on the phone and did not meet with prosecutors or defense attorneys.	
85	• Stephanie did go to Yancey County on September 22, 2021 for her scheduled Commission deposition. Her husband threw the papers away. She talked to three people while she was there, and none of them knew anything about the deposition. This was around 3:30 p.m. or 4:00 p.m. She did receive text messages from JB that day on the phone she shared with her husband.	
86	• Stephanie cannot think of anyone else the Commission should speak with who would have information about the case. She cannot think of anything else she wants the Commission to know but will get in touch later if she thinks of something. She understands she is under subpoena to appear at the Commission hearing starting next Tuesday in Raleigh.	
87-88	• She knows if she makes bond she has to get to the hearing. She will call if she has questions. No one told her what to say, made promises, threats, or put pressure on her about her testimony. She was truthful. She does not remember anything additional.	
88	• Deposition concludes.	

STATE OF NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
COUNTY OF YANCEY	
STATE OF NORTH CAROLINA, Petitioner, -vs- JOHN PRITCHARD, Defendant.	File No. 11 CRS 304 File No. 11 CRS 305

DEPOSITION

OF

STEPHANIE WHITSON RANDOLPH

December 8, 2021

This is the transcript of the audio recording of the deposition of STEPHANIE WHITSON RANDOLPH. The deposition was conducted by Julie Bridenstine, Staff Attorney for the North Carolina Innocence Inquiry Commission. The witness was affirmed by Brian Ziegler, Staff Attorney for the North Carolina Innocence Inquiry Commission. The deposition took place in the Jury Room of the Johnston County Courthouse, 207 East Johnston Street, Smithfield, North Carolina, on Wednesday, December 8, 2021.

A P P E A R I N G

Ms. Julie Bridenstine
Staff Attorney
North Carolina Innocence Inquiry Commission
Raleigh, North Carolina

Mr. Brian Ziegler
Staff Attorney
North Carolina Innocence Inquiry Commission
Raleigh, North Carolina

Ms. Stephanie Whitson Randolph

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E X H I B I T S

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P R O C E E D I N G S

STEPHANIE WHITSON RANDOLPH

MS. BRIDENSTINE: This is the deposition of Stephanie Whitson Randolph by the North Carolina Innocence Inquiry Commission. Today's date is December 8th, 2021, the time is 10:05 a.m.

Present at the Jury Room at the Courthouse in Johnston County in Smithfield are Julie Bridenstine and Brian Ziegler of the Innocence Inquiry Commission, and Stephanie Randolph who appears in custody.

Mr. Ziegler, could you please place Ms. Randolph under oath.

(Witness duly affirmed.)

EXAMINATION BY MS. BRIDENSTINE:

Q. Would you please state your full name for the record.

A. Stephanie Whitson Randolph.

Q. Ms. Randolph, my name is Julie Bridenstine, and I will be taking your deposition today. I am an attorney for the North Carolina Innocence Inquiry Commission, a neutral state agency that investigates post-conviction innocence claims.

You are being deposed today in the matter of State of North Carolina versus John Pritchard, Case Number 11 CRS 304 and 11 CRS 305, for convictions arising

out of Yancey County in 2014.

This case involved the second degree murder, delivery of Schedule II controlled substances, possession with intent to sell, manufacture or deliver Schedule II controlled substances, and maintaining a vehicle, dwelling place for controlled substances that all occurred on March 5th, 2011, and March 6th, 2011. The victim in this case was Jonathan Whitson.

The North Carolina Innocence Inquiry Commission is a neutral and truth-seeking commission. We are not prosecutors and we do not represent the defendants who make innocence claims with our agency.

We do not represent you, we do not represent Mr. Pritchard. I am only looking for the truth in this case.

Are you represented by counsel?

A. No.

Q. Have you ever been deposed before?

A. I'm sorry?

Q. Have you ever testified at a deposition before?

A. Just the trial. Just the trial.

Q. You're referring to the trial of John Pritchard?

A. Uh-huh.

Q. Have you testified in anything else?

A. I don't think so.

Q. I just have a few things to go over to begin with, including some ground rules so that we all have the same understanding. Does that sound fair?

A. Uh-huh.

Q. And I will need you to answer audibly. Say yes or no.

A. Okay.

Q. First, do you understand that you are testifying under affirmation today?

A. Yes.

Q. Do you understand that your answers are subject to the penalty of perjury?

A. Yes.

Q. Do you understand that this is the same affirmation that you would make if you were testifying at trial?

A. Yes.

Q. You are under affirmation and you are expected to answer completely and truthfully. Do you understand that?

A. I do.

Q. Do you understand that at today's deposition I will ask questions, you will answer. And everything

that I say and that you say will be taken down and later transcribed?

A. Yes.

Q. Do you understand that you will have the right to review that transcript and make corrections before the deposition is completed?

A. Yes.

Q. Do you understand that when you review the transcript you can make any changes of form or substance so that your testimony in the script is true, accurate and complete?

A. Yes.

Q. Do you also understand that we want to find out everything you know about the facts and events in this case, and so we want your answers to be as full, accurate and complete as possible?

A. Yes.

Q. Now I understand that you might want to answer questions before I finish asking them. However, please wait until you hear my entire question before you answer. Do you understand this request?

A. Yes, ma'am.

Q. And also, because inaudible responses are sometimes difficult to record, can you please provide audible responses to my questions?

A. Yes.

Q. If you do not understand a question, that's okay. Please just inform me that you do not understand the question and ask me to clarify.

Will you agree to ask me to clarify any question that you do not understand?

A. Yes.

Q. If you do not ask me to clarify a question, I will assume that you understood the question and that you gave a complete response. Do you understand that?

A. Yes.

Q. After you have given an answer you may remember more information later on in the deposition that responds to an earlier question. If that is the case, please stop me, let me know, and provide the information that you remember later regarding an earlier question.

A. Okay.

Q. If I believe that I have a document that will help you respond to a question, I will label it as an exhibit and ask you to review it.

If you believe that I have a document that will refresh your memory and help you respond to a question, please ask to see it, and I will provide it to you if I have it. Okay?

A. Yes.

Q. Do you understand that I want you to review records that may refresh your memory?

A. Yes.

Q. Will you ask me for these records if you believe them to be available?

A. Yes.

Q. If you need a break, I do ask that you answer any question that is pending before we break. Will you agree to do that?

A. Yes.

Q. And again, if you do need a break, then just stop me and let me know. Okay?

A. Okay.

Q. Is there any reason you can't give full and complete responses today?

A. No.

Q. Are you taking any medications or drugs of any kind that might interfere with your ability either to recall past events accurately or testify about them fully and completely today?

A. No.

Q. Do you have any conditions that may interfere with your ability to recall past events accurately?

A. No.

Q. Do you have any conditions that might interfere with your ability to testify fully and completely today?

A. No.

Q. Is there any reason why your ability to recall past events accurately and testify about them fully and completely is not as good today as it normally is?

A. No.

Q. Are you feeling okay today?

A. Uh-huh. Yes.

Q. Are you currently under the influence of alcohol or drugs, either illegal or prescription?

A. No.

Q. Are there any other circumstances or issues preventing you in any way from giving truthful, accurate, and complete testimony today?

A. No.

Q. Have you done anything to prepare for your deposition?

A. No.

Q. Have you talked about this case with anyone after you learned that the North Carolina Innocence Inquiry Commission wanted to speak to you regarding it?

A. I have talked to my husband.

Q. Who is your husband?

A. Brandon Randolph.

Q. What did you talk about with Brandon Randolph?

A. Just that I probably didn't -- I was just confused on everything and didn't remember much because I've tried to put that out of my head. And I thought all of it was done, and it's just overwhelming.

Q. When is the last time you talked to Brandon Randolph?

A. Probably the 24th of October.

Q. How many times did you talk about this case with him?

A. I mean probably just once. I mean I didn't -- we didn't really go into detail because I don't really open up about this to him either.

Q. Did you examine or review anything in preparation for the deposition today?

A. No.

Q. Do you have any materials related to this case?

A. No.

Q. Have you been asked by anyone to withhold information or misrepresent any facts during the deposition today?

A. No.

Q. And when did you first learn that the North Carolina Innocence Inquiry Commission wanted to take your deposition?

A. Whenever we text and I was supposed to meet you in Yancey County, I think, to the best of my knowledge.

Q. What is your date of birth?

A. 12/3/85.

Q. Where do you currently live?

A. 70 Bellflower Lane, Yancey County.

Q. Do you own that residence?

A. No.

Q. Who owns it?

A. My mother and father-in-law.

Q. Your mother-in-law and your father-in-law?

A. Uh-huh. Yes.

Q. Where does Brandon Randolph live?

A. That's his residence. But currently he is staying -- he's working on this house. I don't know the residence that he's staying at, but --

Q. Is there any other location where you either stay or reside?

A. With my mom occasionally.

Q. What's your mother's address?

A. 205 Weeping Willow Lane.
Q. Where is that?
A. It's in Yancey County.
Q. Is that in Burnsville?
A. Uh-huh. Yes. Sorry.
Q. What is your phone number?
A. I just got a new phone. I don't have -- I don't know it. It's 691-77 -- 7765, I think.
Q. Is that an 828 area code?
A. Yes. Yes, ma'am.
Q. Are you currently employed?
A. No, ma'am.
Q. What was your last employment?
A. Anchors Away.
Q. What did you do there?
A. I was a waitress.
Q. When did that employment end?
A. May of 2021.
Q. Do you have any children?
A. Yes.
Q. How many children do you have?
A. Two.
Q. What are their ages?
A. 8 and 2.
Q. Where do your children reside?

A. The 8 year old is with my mother and father-in-law. And the 2 year old is currently in foster care.

Q. Why is your 2 year old in foster care?

A. Because I had the open case when he was born. I had the open case in Yancey County for my 8 year old.

Q. What was the case about related to the 8 year old?

A. In 2017 the -- when we got caught for Schedule II.

Q. What was the Schedule II substance?

A. Methamphetamine.

Q. Was it for possession?

A. It was. Can we break? Can we break?

Q. What do you need a break for?

A. I just -- that was a little overwhelming for me.

Q. Sure. We can take a --

A. Just a second.

Q. Two -- five minutes?

A. Yeah.

MS. BRIDENSTINE: All right. Time is 10:16.

(Proceedings recessed at 10:16 a.m., and a discussion was held off the

record. Proceedings resumed at 10:20 a.m.)

MS. BRIDENSTINE: All right. We are back on the record. It is -- time is 10:20.

Q. Ms. Randolph, you are still under affirmation to tell the truth.

How did you meet Jonathan Whitson?

A. Through a friend.

Q. When did you meet him?

A. I guess it was 2010, I guess it was.

Q. When did you first start dating?

A. We wasn't really dating, we were just friends. I don't -- I'd known him for a period of three months before he got locked up. So that was -- that's what I knew.

Q. You met him three months before he went to jail?

A. Yes.

Q. When did he go to jail?

A. I think it was in January.

Q. Of what year?

A. It would have been 2011.

Q. Were you more than friends with Jonathan?

A. No.

Q. Were you ever romantically involved with

him?

A. No.

Q. Were you his girlfriend?

A. No.

Q. Was he your boyfriend?

A. No.

Q. Did other people think that you two were dating?

A. They thought that we were dating, but we was not dating. He wanted to date, but I -- it was strictly -- I was just a friend.

Q. Do you know where that perception that people had that you were a couple came from?

A. I mean I stayed down there with him a lot. I mean we were together all the time. But I mean that didn't mean we were dating.

Q. When you met Jonathan -- and I'm going to refer to Jonathan Whitson as just Jonathan throughout the deposition. Okay?

When you met Jonathan, was Jonathan a drug user?

A. He was.

Q. Were you a drug user?

A. I -- yes.

Q. When did Jonathan first start using drugs?

A. That I don't know.
Q. What kind of drugs did he use?
A. Pain pills.
Q. Which pain pills?
A. Anything he could find.
Q. How did he use those pain pills?
A. He -- intravenously.
Q. Can you describe what you mean by that?
A. He -- he would put them in a syringe and shoot them.
Q. Did you ever see him take pain pills by mouth and swallow them?
A. No.
Q. Did you ever see him snort drugs?
A. No.
Q. When you say pain pills, do you mean prescription pain pills?
A. Yes.
Q. Did you ever know him to use any street drugs, like heroin?
A. Not that -- not that I know of. When I was around him, he never. But I'm sure he did. But --
Q. How would he get the pills into the syringe?
A. He would put some water in the -- and suck it up through the syringe. I don't know. He always done

that part.

Q. Did you ever do that part?

A. I've never done that part.

Q. When you met Jonathan, what kind of drugs were you using before you met him?

A. Just pain pills. And I would just eat them or snort them until Jonathan.

Q. How did you start using pain pills after you met Jonathan?

A. The same way he did, the --

Q. So you would also crush them up --

A. He would --

Q. -- and inject them?

A. He would crush them and administer them.

Q. Did you ever inject them yourself?

A. I have never done that myself, no.

Q. Who would inject you?

A. He was the only one that's ever done that to me.

Q. Where would Jonathan inject drugs?

A. In his arms.

Q. Did he have a particular arm?

A. He'd use both.

Q. When did you know him to inject drugs into his arms?

A. Every day. I mean --
Q. Was that his practice when you first met him?
A. Uh-huh. Yes, ma'am.
Q. Where did Jonathan get drugs?
A. He -- he got them from different places. But he -- the period that I knew him, he got from Pritchard.
Q. You said John Pritchard?
A. I did.
Q. Did anyone else provide drugs to Jonathan?
A. I'm sure they did.
Q. How do you know John Pritchard provided drugs to Jonathan?
A. I've been there. And I've not been in the room with them when they traded or what not, but I've been there when he would come by or what not, and he would have the pills.
Q. What kind of pills?
A. It was the 30 milligram morphines.
Q. What did they look like?
A. They are round, purple.
Q. Was there any numbers or letters on them?
A. There was. I know there's a 30 on them. I don't know the other.

Q. How do you know that they were 30 milligram morphine pills?

A. Because that's what they said. I mean I've seen the bottle.

Q. Whose bottle did you see?

A. John Pritchard's.

Q. Where did you see that?

A. At Robbie Brown's house, his girlfriend.

Q. When did that -- when did you see that?

A. I don't know. It was in the period of three months. I don't know. But I seen it one time.

Q. Who did the bottle belong to?

A. John Pritchard.

Q. How do you know that?

A. That was the name on the label.

Q. How many times did you see that bottle?

A. One time.

Q. What happened the time that you saw the bottle of the morphine?

A. I probably turned and went outside, then they always done what they done. I mean I didn't -- I was never involved in the interaction of the exchange.

Q. Did you ever see John Pritchard provide pills to Jonathan?

A. I've seen him hand him a few before. But --

Q. When did you see that?

A. That was within the period of three months. I don't know. John Pritchard had picked me up from work because I didn't have a ride one day, and was taking me back to Jonathan's house, and he handed him some pills.

Q. What kind of pills were they?

A. It was the morphine.

Q. When did that happen?

A. I mean that was before he went to jail. Way before.

Q. Before who went to jail?

A. Before Jonathan Whitson went to jail.

Q. Where were you working?

A. I was working at the Little Tokyo in Burnsville.

Q. Did you ever see John Pritchard provide pills to Jonathan any other time than the time you were in the car?

A. No.

Q. So going back to that time you were picked up from the Little Tokyo Restaurant, walk me through what happened.

A. I just got in the truck, and I -- we started down the road. And they were talking about -- I don't know. He was -- he was wanting some pills. And John

Pritchard wanted to offer him a way to get on his feet. And that's all I can remember as far as the talk. I mean I really tried to stay out of -- out of the --

Q. Did you see an exchange of pills?

A. Yeah. I mean he handed him -- he went like this and handed him some. But I didn't see what he handed him. I mean I didn't see them. But I did see him do his hand like that.

Q. And you said this happened before Jonathan went to jail?

A. Yeah.

Q. How close in time to jail was that?

A. Probably a month, probably.

Q. How -- let me ask it this way. When did you see the bottle at Robbie Brown's house?

A. That was probably -- me and Jonathan hadn't been like running around long together. So probably would have been the first month that we were -- maybe the first two or three weeks maybe. I don't know.

Q. Other than the time you said you were picked up by John Pritchard from Little Tokyo --

A. Uh-huh.

Q. -- and the time you saw the morphine bottle that belonged to John Pritchard, did you ever see anything else regarding John Pritchard providing drugs to

Jonathan?

A. The day he got out -- the day that Jonathan Whitson got out, he had made a couple of phone calls to Pritchard. And I was in the house, and I -- he said that he was coming by to give him some pills. And he went outside.

And I seen the truck, the white Ranger, but I didn't see any interaction of the pills. But he come -- when he come back in, he had the pills. So that's the last time I knew of him giving him any pills.

Q. When you were picked up at the Little Tokyo Restaurant, what was John Pritchard driving?

A. A white Ford Ranger.

Q. And then when you saw the bottle that you said was a prescription bottle for John Pritchard -- is that right --

A. Uh-huh.

Q. -- at Robbie Brown's, did you see Mr. Pritchard do anything with that bottle?

A. No.

Q. Why did you see it?

A. I think Robbie -- Robbie handed it and was looking at it.

Q. Do you know if anything happened with his bottle of medication?

A. Not to -- not to the best of my knowledge. Because Jonathan Whitson would get pills from Robbie Brown too. So I mean --

Q. Did he get them from anywhere else?

A. He got them from a lady, Thelma Massey. And other than that, I don't know of anybody else. I'm sure he did, but I -- we wasn't on that type of terms.

Q. Did Jonathan ever work for Robbie Brown?

A. He would mow her yard and stuff, yeah.

Q. Did she provide drugs to Jonathan?

A. She did.

Q. Did you ever see it?

A. I did.

Q. What did you see?

A. She would give him what she thought she owed him in pills. She had Opanas. I don't know much about any of it other than I know that most of the time it was the Opanas. But he got a lot of his pills from her.

Q. Was Robbie Brown a drug dealer?

A. Uh-huh. Yes, ma'am.

Q. Did Nathan Angel ever provide drugs to Jonathan?

A. He didn't really have -- he kept to hisself. I mean I'm sure he probably did share occasionally if he did. But he was very stingy with what he had.

Q. Was Nathan Angel a drug user?
A. Yes.
Q. Did anyone other than Thelma Massey, Robbie Brown or John Pritchard provide drugs to Jonathan?
A. I don't know. Those are the people that I know that did. But I don't know about where else he got -- I know he did get, but I don't know about where else.
Q. Were there ever occasions where Jonathan had pain pills and you just didn't know where he had gotten them?
A. Uh-huh. Yes, ma'am.
Q. Did Jonathan have prescriptions for any pain pills?
A. No.
Q. When did you start using drugs?
A. Probably -- let's see. I'd probably been using a couple years before I met Jonathan.
Q. When did Jonathan go to jail in Madison County?
A. I think it was in January. I can't -- I can't entirely remember. I think it was in January, though.
Q. Of what year?
A. I guess it would have been 2011 then.

Q. Did you talk to Jonathan when he was in jail?

A. A couple of times.

Q. Was that on the phone, visits?

A. On the phone.

Q. Did Jonathan have any medical issues before he went to jail in January 2011?

A. That I don't know. Well he did have a -- he had had a blood clot in his arm before. And he had to go to the hospital.

Q. Which arm?

A. I'm not sure. I'm not sure.

Q. What do you know about that hospital stay?

A. I think he stay -- it was a three-day stay, I think.

Q. Did you see him during that hospital stay?

A. I was with him the whole time.

Q. What was your understanding of what the issue was?

A. That it was a blood clot to his arm.

Q. Did he receive treatment for it?

A. He did. Or maybe they said it was an abscess.

Q. Did you see that arm where he was having trouble?

A. Uh-huh. Yes.
Q. What did it look like?
A. It was swollen and red, and a lot bigger than the other one.
Q. When did you see it looking like that?
A. Before he went to the hospital. When he called the ambulance and went.
Q. He called an ambulance to go to the hospital?
A. Uh-huh. Yes.
Q. Why did he call an ambulance?
A. For the ride, I'm thinking.
Q. I guess what I'm trying to ask is, was it an emergency that caused him to call an ambulance?
A. Oh no. He needed a ride to go to the hospital is what that was.
Q. What was he told at the hospital about that clot?
A. I'm thinking -- I don't -- I may have thought clot, but maybe it was just an abscess. I know that it was an abscess. But I don't know if it threw the clot or what. So I know that they gave him some medicine for it to come down. And they treated him for three days. I think it was three days.
Q. When did they give him medicine?

A. When he was at the hospital, those three days.

Q. Are you aware of any other preexisting medical issues Jonathan might have had?

A. Not to my knowledge.

Q. Did you ever hear anything about any other medical problems he might have had?

A. No.

Q. Did you ever hear anything about asthma?

A. No.

Q. Or a hole in his heart?

A. No.

Q. Were you with Jonathan when he left the hospital?

A. Yes.

Q. Did he leave the hospital with anything?

A. No.

Q. Did he leave the hospital with any medication?

A. No.

Q. Were you with Jonathan after he left the hospital?

A. Yes.

Q. Did you -- how often would you see him?

A. Do what?

Q. How often would you see him after he left the hospital?

A. I'm thinking that -- I know like Christmas day, my parents took me back down there. So this would have been sometime then. I mean it's just now coming to me.

I was with him maybe three days after he left the hospital. And then my parents picked me up and I stayed with them for a while, through Christmas and all that. And then I went back down there for a couple days. And then they picked me up again. So I don't know.

Q. When you saw him after he got out of the hospital, was he taking any medication for his arm?

A. Not to my knowledge. I don't remember him taking any that was gave to him for that. No.

Q. Were you aware if he filled a prescription for anything?

A. No.

Q. When you saw him after he left the hospital or on the days that you saw him, how much time would you spend with him?

A. Sometimes two days, two days at a time.

Q. Did you see him taking any medication for his arm?

A. I mean he would use.

Q. And I understand he might have been using pain pills --

A. Yeah.

Q. -- as a drug user. But did you see him using any prescribed medications for --

A. For him?

Q. -- for him?

A. No.

Q. How was his arm doing after the hospital?

A. It was a lot better. It still -- he still had pain in it. But it was on the mend. So --

Q. He told you he still had pain?

A. Uh-huh. Yes.

Q. Was that before he went to jail?

A. Yes. Yes.

Q. Earlier I think you mentioned you had a couple occasions where you spoke to him on the phone when he was in jail.

A. I did.

Q. How was he doing?

A. He was good. He was trying to get in touch with his lawyer. And he was just ready to get out.

Q. Did he talk to you about how he was feeling physically?

A. He didn't say anything about feeling bad or

anything like that. He was in -- he was in pretty good spirits.

Q. Did he tell you anything about how his arm was doing?

A. No, he didn't mention anything like that. So I'm sure he -- I mean he was good. He just -- he was really wanting to get out.

Q. What was he in jail for?

A. I think it was a -- I think it was a -- he had told me that when the -- he was on the phone with me when the jailer had come from Yancey County to pick him up, that it was something that was over seven years old from Madison County. I think it was a failure to appear.

I think -- I'm pretty sure that's what he said. And that's all I know. I don't -- I didn't ask what for or what not. But I think it was a seven-year-old case.

Q. Going back to the hospital stay that he had for his arm.

A. Uh-huh.

Q. What did the doctors or medical staff there tell him about it?

A. They said that if he kept using like that that he would -- he would eventually die. That may have been where the blood clot came from. Said you're going

to throw a blot clot from your arm, and it will go to your heart. That may be where that's coming from. Because that's what they told him. They said that, hey, if you keep using as much they had seen his arm and that he was a ticking time bomb, really.

Q. Did you ever hear any discussion about the potential need to amputate his arm?

A. No, I did not.

Q. And when you said he was told that he was a ticking time bomb, and that he could eventually die from blot clots if he kept using, were you present for those conversations?

A. Uh-huh. Yes.

Q. Did Jonathan receive any medical treatment for his arm after he left the hospital?

A. Not that I know of.

Q. And I think you said it was looking better after he received treatment at the hospital.

A. It was looking better.

Q. Did it --

A. I mean he had it wrapped, so I don't know. But the swelling had went down tremendously from the time that he was at the hospital to the time that he was home. I mean --

Q. Did you ever see what it was looking like

under the bandages?

A. Not -- not -- no, I don't think I did. Maybe -- maybe once. But I don't know enough about it to know that it was -- it looked better than it did when he went to the hospital. But like when he unwrapped it, and it looked -- still looked pretty bad.

Q. When did you see it looking still pretty bad?

A. I mean when he come home, the day he come home from the hospital.

Q. From the hospital.

A. I mean because he unwrapped it then to look at it and to rebandage it. But all the swelling had went down.

Q. Was Jonathan using any drugs when he was in jail?

A. I do not know that. I know that he said that somebody had dropped off a bottle of vodka somehow or another in the drink machine.

Q. At the jail?

A. At the jail. And that's just what he told me. I don't know that for sure.

Q. Did he drink that?

A. He said that he did.

Q. Do you know if he did any drugs when he was

in jail?

A. I do not know that. He did not say anything about drugs. Just the drinking.

Q. Did he receive any medical treatment when he was in the jail for anything?

A. I don't know. Wait. I think he did get in a fight, and he -- I don't know if they took him to the hospital or took the other guy to the hospital. But one of -- I mean there was something going on.

Q. Do you know if he went through withdrawal when he first went to the jail?

A. I don't know if he did.

Q. When Jonathan was in jail in January 2011, were you using drugs during that time period?

A. When he went to jail. No, I wasn't. I had a clean period until he got out.

Q. Was that difficult for you?

A. Not really. I mean --

Q. Did you go through withdrawal?

A. I didn't do as much as he did, so --

Q. Did you experience withdrawal symptoms?

A. Huh-uh. No, I did not. Sorry.

Q. That's okay. I understand. I'll try to remind you when I need an audible response.

A. I'm sorry. I get caught up.

Q. What was your phone number at the time Jonathan died?

A. It was 3992 -- 208-3992. And that stayed my phone number even up until maybe three years ago.

Q. What was Jonathan's phone number?

A. He went by my phone number.

Q. Oh, you guys shared a phone?

A. Uh-huh. Yes, ma'am. And he used his granny's, Nathan's mother's home phone.

Q. Is that Christine Angel?

A. It is, yes.

Q. I am showing you what I just marked as Exhibit 18. If you could take a look at that.

(Exhibit Number 18 marked.)

A. (Witness reviews document.) Okay.

Q. And there are multiple pages for that exhibit.

A. (Witness continues to review document.) Okay.

Q. Ms. Randolph, these are documents that came out of the Yancey County Sheriff's file. And they are phone records for phone number 828-208-3992.

A. Okay.

Q. Is that your phone number?

A. That's my phone number. Any time Jon wanted

to get ahold of -- or Jonathan wanted to get ahold of John Pritchard, he used my phone usually. We shared the phone. So --

Q. What was John Pritchard's phone number?

A. I do not know. I don't know. All these that's on here. This is my godmom's, the 7 -- the 678-0014 was my godmom's.

Q. Okay.

A. And the 5114, that's my parents' house.

Q. Okay. And this is a cell phone. Right?

A. The 3992 is my cell phone, yes.

Q. Okay. When did you first know that Jonathan was out of jail? And this is the time he was in jail before he died.

A. He called me. I guess it was about lunchtime on the 5th, I guess. I guess it would have been the 5th. Yeah, it was about lunchtime. I want to say I remember it said 12:14 on the phone when I looked at it. Because I mean I was like, hey, you know, it's Jon. That was the first time I learned he was out of jail.

Q. What did you guys talk about?

A. He just wanted to see me. And I went down there.

Q. Where did you go?

A. I went to Nathan Angel's house.
Q. Where was Nathan Angel's house?
A. Right above Christine Angel's house.
Q. Was it a trailer?
A. It was.
Q. When did Jonathan get out of jail?
A. I guess it was the 5th wasn't it?
Q. Do you know?
A. I don't know if it was the 4th or the 5th.
Q. Do you know how he got out of jail?
A. I do not.
Q. Do you know how he got from jail to Nathan's?
A. I don't know.
Q. When did you first see Jonathan on March 5th, 2011?
A. I think it was a little after three, I think.
Q. Where did you see him?
A. In the driveway. In the driveway from Christine's to Nathan's.
Q. How did he appear when you first saw him?
A. Like he always was. I mean he was upbeat and happy.
Q. How was he feeling?

A. I didn't notice that he was feeling -- like he always was.

Q. Did he talk to you about how he was feeling?

A. He didn't.

Q. Did he appear to be under the influence of anything?

A. I always knew him when he was under the influence, so he appeared normal. So I guess he was under the influence. But I don't know, he was just happy like he always was.

Q. Do you know if he was under the influence of any drugs or alcohol?

A. Not at that time I didn't.

Q. Did he seem sick at all?

A. He didn't. Not to me.

Q. Did he have a cough?

A. I don't remember.

Q. Did he have a fever?

A. He said something about he was -- he had been running a fever.

Q. What did he say?

A. Just that he had been running a fever, he had a slight fever that he didn't know -- but he said it wasn't from the lack of pills because he hasn't had any pills. So -- but that's all that was said.

Q. And I just want to clarify. On March 5th when you saw him, he told you he had been running a slight fever?

A. I guess it was, yeah.

Q. Was that when you first saw him or a long time --

A. It was later that night when he told me that.

Q. And he told you it was not from lack of drugs?

A. Pain pills. Yes.

Q. Pain pills. So is that a reference to maybe like going through withdrawal?

A. I guess so. He -- he said I know it's not from using or not using. He said it's from something else. And he didn't clarify and I didn't ask. I mean I didn't --

Q. When he told you that he was running a fever, had he been using any drugs at that point?

A. I don't know. I don't see him going that long without something, but I don't know. So I would have to say no, I don't know. He didn't say that he was -- he had used anything or had anything.

Q. Did you see his arm or his arms?

A. I didn't pay attention to them.

Q. All right. Why don't you walk me through that day and what you remember happening from when you went over to Nathan Angel's trailer and saw Jonathan on March 5th, 2011.

A. He -- I saw him. And then he wanted to use the phone. He was going to call Pritchard to see if he could get something.

And we went down to Christine Angel's house. And apparently he had got ahold of him, and he was coming up Marion Mountain I remember him saying. And he was waiting on him to come by and drop some off.

And then we may have been there like an hour and a half before he came and dropped something off. I wasn't out there when he came. But when he came -- when Jon came back in the house, he had 10 pills.

Q. Okay. Before we continue on, let's go back through some of what you just said.

Did Jonathan use your phone to call Mr. Pritchard?

A. He did.

Q. And that was that day?

A. Uh-huh. Yes.

Q. Were you present?

A. Not for the phone conversation. He walked outside and talked to him.

Q. Do you know what was said?

A. He -- Jon just said when he come in, he said that he had asked for him to come by. And he was coming up Marion Mountain, so he should be there.

Q. Do you know what Mr. Pritchard was coming by for?

A. I'm assuming to drop off some pills. But he could have been coming by for something else. But I just know what Jonathan said, he was supposed to come by to bring some pills.

Q. Did Jonathan tell you that Mr. Pritchard was coming by to bring pills?

A. Uh-huh. Yes.

Q. Did he say what kind of pills?

A. He didn't. But --

Q. Did you see Mr. Pritchard on March 5th, 2011?

A. I seen the truck. I didn't see Pritchard.

Q. When did you see the truck?

A. In roughly the time it took to get up Marion Mountain. I just looked out the window and seen the truck. But I didn't see who was in the truck. So --

Q. How long was Jonathan gone for?

A. When he went outside?

Q. Yes. After you saw the truck.

A. Maybe five minutes.

Q. Did the truck stay at the residence?

A. No, it left.

Q. When is the next time that you saw Jonathan after the truck left?

A. The next time I saw Jonathan. He come back into the house with the pills.

Q. Did you see him outside before he came back into the house?

A. I seen Jon walking in the house, yeah.

Q. Did you see Mr. Pritchard's truck?

A. I seen him drive away.

Q. Was that the first time you saw the truck, or did you see the truck again?

A. I mean I seen the truck pulling in. And then when they went to leave, I seen them leave. Or I seen the truck leave. I didn't see who was in the vehicle, but I seen the truck leave.

Q. So I just want to clarify what you saw. You said you were in the house, and you looked outside and you saw a truck. Is that right?

A. Uh-huh. Yes.

Q. And then you saw Jonathan do what when the truck arrived?

A. He leaned his head into the window.

Q. Did you see if he got into the truck or not?
A. I can't remember if he got in the truck or if he just stood there.
Q. And you were in the house looking out the window during this time?
A. Yeah. I mean I didn't just watch them watch them, you know.
Q. Did you see the truck leave?
A. I did see the truck leave.
Q. Was that --
A. Because I heard the truck -- I mean I heard it start back up. And so I looked out, and Jon was walking in the house and the truck was leaving.
Q. Okay. Do you know if the truck, once you saw it arrive and Jonathan lean in and talk to someone, do you know if that truck left the area and came back or not?
A. What do you mean? Like if it come back again?
Q. Yes.
A. I do not know that. It's possible.
Q. All right. So you saw the truck arrive once. And then you heard it leave once?
A. Yes.
Q. Did you see it leave?

A. I mean I seen it leave, yeah.

Q. Okay. So you saw it arrive once, and you saw it leave once?

A. Yes.

Q. And what was the time period from the time you saw it arrive and the time you saw it leave?

A. He wasn't there long. Maybe 10 minutes at most I want to say.

Q. And after the truck left, you saw Jonathan come back in the house?

A. Right.

Q. All right. And you were at which house again?

A. Christine's.

Q. What happened when Jonathan came back into Christine's house?

A. He had 10 morphine pills. And he -- we used. I mean he put three of them in a spoon and melted them down, and we used.

And I don't remember what he did with the other two. I know that he -- he left -- like I was leaving. I was going to leave and go with my godmom to get something to eat. Because she called and wanted me to go get something to eat, and go with her to get cigarettes.

And so she picked me up, and he left me with five, five of the pills. Because he -- he said that he didn't want to do them. And I wouldn't do them, because I didn't do them like that. He only done them. And so he said, I don't need to do these, you hang onto them. And it was five of them.

So when I left, I was gone maybe an hour and a half, and then I went back. And there was nobody new there. It was just us. And we used and used up until I left that night, at like 2:00 a.m.

Q. So when you saw the 10 pills, what did they look like?

A. They were the purple morphine 30 pills.

Q. Did Jonathan tell you where he got the pills from?

A. From Johnny.

Q. Did he tell you that?

A. He did.

Q. And who is Johnny?

A. John Pritchard.

Q. You said you did three initially, and then you left with five?

A. Yeah. We -- from my memory, he put three in the spoon, and we used and used and used. And he may have put two -- I don't know what happened to the other

two.

I know that he just left me with five, and said take these so I don't do them. And I said okay, and I'll be back. And that's what I know.

Q. Where did you use the three pills that you initially did in the spoon?

A. In the driveway.

Q. Were you out in the open?

A. No. We were in my father's Jeep.

Q. Now you described that you put three pills in a spoon. Is it fair to assume that you crushed the pills and you added water to that?

A. He crushed them and added water to that, yeah.

Q. Okay. And then what's the step after that? Do you heat it?

A. I mean he usually didn't heat it. He would just draw it up.

Q. And how much of that spoon -- let me ask it this way.

When you said you used from that spoon, those three pills. You would draw up some of the solution into a syringe?

A. Uh-huh.

Q. Is that right?

A. Yes.

Q. And for a spoon where you had three pills and it's in the spoon, how many doses would that equal until you didn't have any left?

A. I have no idea. I really don't know. I mean because he done all that. I couldn't even venture.

Q. How many times were you injecting from that spoon?

A. I think he done me three times, and he -- he always done a lot more. So I don't know. I mean it wasn't like three times in a row. It was like three times -- or like one time. And then maybe 30 minutes, maybe an hour would go by and then he would draw up again and do it that way.

Q. If you were spacing it out like that, would the effects wear off before the next time that you took the pill -- or you took the injection again?

A. Yes.

Q. Were you in the Jeep the whole time you were injecting from that first spoon of three pills?

A. I want to say yes. But I can't -- I can't remember. Because I mean we were -- I cannot remember if we went -- we went into the bathroom at Christine's house.

And I don't remember if I left -- if I left

from the bathroom or left from the Jeep when I went with my godmom and come back. And I would have come back to the bathroom where he was at. But I don't -- I don't know which one it was.

Q. Did you go anywhere in the Jeep?

A. No, not until I left to go home. I think -- I don't know. I may have left. Yes, I left to meet her. I don't know where I met her at, but I did leave to meet her. And I don't have a clue because I would have been very high.

Q. How was the morphine affecting you?

A. I don't know. I mean it just -- I don't know. It's a good feeling. I don't --

Q. Were you walking around? Were you able to walk around?

A. Yeah, I could walk around and talk. She didn't know anything had went on.

Q. When you met --

A. Yeah.

Q. -- your godmother?

A. Uh-huh.

Q. How was Jonathan acting?

A. Fine. I mean he seemed fine.

Q. Was he able to walk around?

A. Uh-huh. Yes.

Q. Was he coughing at all?
A. Yes.
Q. Tell me more about that.
A. He just said, I'll see you when you get back.
Q. Oh. I said coughing.
A. Oh. Do what?
Q. Did you misunderstood --
A. I thought you said talking.
Q. Okay. He was talking. Was he coughing?
A. Oh, no. I didn't hear any coughing.
Q. Okay. So just to clarify. You said he was talking?
A. Talking.
Q. And not coughing at that point?
A. Not coughing.
Q. Okay. Do you think anyone else would have been able to perceive that you were high?
A. I don't know. Possibly. But if she couldn't tell, then it would probably be hard for anybody else to tell. Because she was pretty -- I mean I seen her every day. So --
Q. Was Jonathan acting any differently?
A. I didn't notice him acting any differently. He just said I'll see you when you get back.

Q. Did it seem like the morphine was having any sort of an effect on him?

A. No more than usual. I mean --

Q. How did he --

A. He just acted like he felt really good. I mean he was just like, woo. I mean --

Q. When you left to go meet your godmother, what time was it?

A. I'm trying to think. It was probably -- I hadn't been there that long. I want to say I was back by like five. So I mean it would have been between 3:30 and four-ish.

Because we just -- we -- I went with her to the drive-through at Hardee's and got a sandwich. And we went to the Gas House in Burnsville and got her cigarettes. And she took me back -- I mean took me back to the vehicle, wherever I met her at. I don't remember where I met her at. I may have met her at Hardee's. I don't know. I can't remember.

Q. Did you drive to go meet her?

A. I did.

Q. What is your godmother's name?

A. Jane Honeycutt. She's passed away.

Q. Did Jonathan drive at all that day?

A. No, not that I know of.

Q. How long were you gone when you went out to meet Jane Honeycutt?

A. Maybe an hour and a half maybe.

Q. Did you do anything other than go to Hardee's and go --

A. No. That was it.

Q. -- to get cigarettes?

A. That was it.

Q. What did you do after you left Jane Honeycutt?

A. I went back to Jon's. I went back to Christine's.

Q. What happened there?

A. We just used and used and used.

Q. Where did you use?

A. In the bathroom at Christine's.

Q. How much did you use?

A. I don't know. He -- I want to say that he had put three more in the spoon. I can't -- I can't remember, to be honest.

Q. Where did Jonathan inject the drugs?

A. In his arms.

Q. Which arm?

A. Both of them.

Q. Did you see him inject?

A. Yes.
Q. Was Jonathan right-handed or left-handed?
A. I want to say right-handed, but I'm not sure.
Q. How did his arms appear to you on March 5th?
A. Like they always -- like I always knew them. I mean normal, I guess.
Q. Did either of his arms seem swollen at all?
A. Not to my knowledge. I think he had complained about one of his hands, though. He had hit a guy when he was in jail. But I don't know which hand it would have been. But I know he said that his knuckles was hurting because he had hit -- he had hit that guy.
Q. Where in his arms would he inject?
A. In the middle of the arms.
Q. Okay. Kind of where your arm --
A. Yeah.
Q. -- bends?
A. Right there, yeah.
Q. On the inside?
A. Uh-huh. Yes.
Q. Did you notice any --
A. And sometimes he would do it on the bottom, like right here.
Q. On the side of his forearm?

A. Yeah. Sometimes.

Q. Did you notice anything unusual about either of his arms?

A. I didn't.

Q. Did you see any track marks or anything?

A. He always had track marks.

Q. So when you say his arms, you know, looked normal, normal for Jonathan was to always have track marks on his arms?

A. Yes.

Q. How long were you using in Christine's bathroom?

A. I don't know. I don't know if I left at 10. I can't remember if I left at 10 or I left at two. I mean it's all a -- so -- I mean everybody was still up when I was going to leave, so I would say it was 10. So -- but I can't verify for sure.

Q. Were you in the bathroom the entire time?

A. We was.

Q. Were other family members present in the house?

A. Yes. Christine was there. She knew what we were doing. I want to say Christian was there. I don't know who else was there. But I know Christine was there.

Q. How do you know Christine knew what you were

doing?

A. Because she said that she'd rather us not do that in the house.

Q. How many pills did you do in Christine's bathroom?

A. Possibly four. I don't know. I mean he added to the spoon that had the three. So I mean he never took the three out of the spoon. Like there was always residue. So I don't know.

Q. When you left to go to Hardee's with Jane Honeycutt, did Jonathan have any pain medication on him?

A. I don't know. I don't think so. I mean I don't think so. Because he -- he gave me the five pills and said, here, you hold onto these, that he didn't want to do them.

Q. If you started out with 10, and you used three --

A. So he would have had -- yeah.

Q. -- what happened to the two that were left over?

A. He would have had the two.

Q. Do you know what happened to those two pills?

A. I don't know what happened to those two.

Q. Do you know if he was using any drugs when

you were gone to see Jane Honeycutt?

A. I don't know that.

Q. Did he tell you anything about that?

A. No.

Q. What kind of pills were you doing in Christine's bathroom?

A. It was the morphines. That's all that we had done, I had done with him that day.

Q. Where did those pills come from?

A. Jonathan had those pills. But I'm assuming they came from John Pritchard.

Q. What happened to the five pills that you took to Jane?

A. I brought them back and gave them to Jonathan. And he -- we used them.

Q. Did you use all of the pills that you brought back?

A. I don't know if he -- I mean I gave them to him. I don't know if he put all of them in the spoon. I think he just put four in the spoon. Or maybe two at a time. I can't remember. I really don't remember. I just know that I gave them to him, and he -- we just sat and talked and done.

Q. You sat in the bathroom and talked and used the pills multiple times?

A. Yes.

Q. How many times did you inject in the bathroom?

A. I don't know how many times that would have happened. I mean --

Q. How many times did Jonathan inject in the bathroom?

A. For that to be all that we were doing, we would have had to have -- I mean it would have had to been a lot. I mean because if that's all we were doing.

But I don't know an answer to give that would be -- because that period of my life was the -- I done it when I was with him. And so I don't know what to compare it to if it's a lot or what not. But it's like we would have had to just keep doing in order to stay there that long I would think.

So I can't -- I can't say how long or how many times. I would say at least three times. I mean definitely maybe six times apiece.

Q. Did you guys use the same amount?

A. I think so.

Q. How big was the spoon?

A. I think it was -- it was a big spoon. It was bigger than a soup spoon I want to say. I don't know.

Q. Bigger than a tablespoon?

A. Yeah. Maybe the mouth of it was like this I want to say. I can't really remember.

Q. Are you describing more like a serving spoon?

A. Yes. I want to say that.

Q. Where did he get the spoon from?

A. I don't know if he had it in his pocket or if he got it out of Christine's. I don't know. He might have done that.

Q. Did you use drugs with anyone else that day --

A. No.

Q. -- other than Jonathan?

A. No.

Q. Did you see anyone else using drugs other than Jonathan?

A. No.

Q. When you were in Christine's bathroom, how did you feel?

A. I mean I knew I was high. I just -- looking back on it, I don't know if it's the time that's went by and I just didn't pay attention or I was really that high.

I felt fine. I mean I didn't feel sick or

anything, like I would have done too much or anything like that. I never had that feeling.

Q. What is that feeling like if you've done too much?

A. Just like you want to throw up. Just like you really need to throw up. Like it needs to come out. And I never had that. Jon didn't have that. He was fine.

Q. Were you able to carry on a conversation?

A. I was.

Q. Were you able to walk around?

A. I was.

Q. Was Jonathan able to carry on a conversation?

A. He was.

Q. Was he able to walk around?

A. He was. You couldn't tell a difference. I mean --

Q. Did he ever express to you that he was feeling bad at any point?

A. He didn't. He just -- I mean he said that his knuckles hurt because he had hit that guy in jail. And he said that he had been running a slight fever, but he didn't know what it was from. But that's all he said. He didn't really appear to feel -- seem like he felt bad.

He just said I've been running a slight fever. So --

Q. When you left Christine's bathroom, was there any morphine left?

A. I'm sure there was. I don't -- I don't know what was left. I mean I was probably to the point I was just -- I just -- I don't know. I mean I think it was time to go, and I was going home.

Q. How did you get home?

A. I drove.

Q. How did Jonathan appear when you left?

A. He didn't want me to go. But I left anyway.

Q. When you describe the feeling of feeling nauseated when you've taken too much drugs, are there any other things that you've experienced feeling?

A. Not me, I haven't. It's just, hey, like you've just taken too much and you need to throw up.

Q. Are you aware of any other symptoms that people might experience if they've taken too much morphine?

A. No.

Q. That feeling of being nauseated if you've taken too much, is that something you've experienced with morphine before?

A. No.

Q. What kind of drugs have led to that

sensation?

A. Percocet.

Q. When you left Christine's on March 5th, you said you didn't know if it was 10:00 p.m., or it could have been 2:00 a.m.?

A. Yeah.

Q. Where did you go?

A. I went to my parents' house on 205 Weeping Willow Lane.

Q. Did you talk to Jonathan after you left?

A. No. I don't think I did. But my mom was up waiting on me.

Q. Did she notice if you were high or not?

A. No.

Q. What was Jonathan doing or planning to do after you left. Do you know?

A. He said he was going to go lay down.

Q. How did he appear when you left?

A. He didn't want me to go. He was crying. He didn't want me to go.

Q. Other than crying --

A. That's it.

Q. Was he walking around?

A. Uh-huh. Yes.

Q. Was he talking?

A. He was.
Q. Was he coughing at all?
A. The only time I'm aware of, I didn't ever notice a cough.
Q. Did you go into Nathan Angel's trailer on March 5th, 2011?
A. I may have stuck my head in and said hello. I can't remember. I don't know.
Q. Was Nathan living there at the time?
A. He was.
Q. Jane Honeycutt, was she a drug user?
A. No.
Q. And you said she was your --
A. Godmother.
Q. -- godmother. What was the age difference between the two of you?
A. She was 50 -- she was 51 maybe. I think she passed at 53. But she wasn't a drug user.
Q. Had you had days with Jonathan before March 5th, 2011, where you would use morphine throughout the day together?
A. We -- not like that. I mean like he would usually -- like if we were together, he would give me a shot. And then he would -- he didn't let me see what he did. I guess he tried to shield me from all that. But I

kind of -- I kind of knew he used.

But I mean, you know, I didn't need anything or anything, so I didn't -- we wasn't on that type of relationship, hey, you're doing something, I'm not, type of terms. So it didn't really --

Q. If I'm understanding your testimony correctly, when he was in jail, you were not using any drugs.

A. Right.

Q. And so when you saw him on March 5th, you were using drugs that day with Jonathan. Correct?

A. I was.

Q. And at the end of the day when you left, did you use any drugs after that?

A. No.

Q. And how did you feel when you left Christine Angel's house? Did you feel okay? Did you feel sick at all?

A. I didn't feel sick at all. I felt fine. I mean I went home. And me and my mom watched the second runaround of Nancy Grace. And then we went to bed. And then I woke up to the phone call, hey --

Q. Had you ever used morphine before March 5th, 2011?

A. With Jon, yeah.

Q. With Jonathan?
A. Uh-huh. Yes.
Q. Were they pills?
A. They was.
Q. What did they look like?
A. They was the purple, the same pills that we had. I mean that's all we used.
Q. Did you ever use any other color pills?
A. We did.
Q. What were those?
A. There was -- it was Robbie's Opanas. And --
Q. What color were the Opanas?
A. Red. And I guess that's it. Between the two, I mean in that time period. I think there was a few times that we had a couple of Percocet 15s. But I mean that would have been very few that we had from Thelma Massey.
Q. What color are the Percocet?
A. They're green.
Q. Green. Did you ever use any blue pills?
A. I can't -- I can't remember if the morphine was purple or blue. I think it was purple. I'm not sure.
Q. When can you not remember if it was purple or blue?

A. Looking back at it, I can't remember if it was purple or blue.

Q. Are we talking about on March 5th, 2011?

A. They were purple. I'm pretty sure they were purple.

Q. When you were using with Jonathan on March 5th, 2011, I think you said when you were in Christine's bathroom you were using about the same amount of morphine. Is that right?

A. I want to say so. I think he would do a shot, and then he would give me a shot, and that sort of thing.

Q. Was that true throughout the whole day?

A. It was. I don't know -- I don't know what he did when I left. I mean if he done anything or used from that spoon. He could have. I don't know. I mean I'm sure he did. Because there was some left in that spoon.

Q. How much was left?

A. I mean I don't know. I mean sometimes he could go, go and go on one pill. So I don't know. When I got back, you could still see residue from the pills. So I know there was still some more in there. So --

Q. Okay. So if I'm understanding you correctly, if it's residue with no liquid, you would just

add more water to the same --

A. That's correct.

Q. -- spoon without crushing up anymore pills?

A. That's correct.

Q. When you left Christine's bathroom on March 5th, 2011, what did the spoon look like?

A. I mean he used all the water. There was still quite a bit of mixture in there. No water, but just -- you could tell there was a lot of pill in there.

Q. How many pills?

A. Three or four maybe. I don't know.

Q. Do you know if he continued to use after you left?

A. I don't know that.

Q. When you said earlier that you weren't sure if the morphine pills you used were purple or blue, but you thought they were purple on March 5th, 2011. Is that right?

A. That's right.

Q. Did you ever use blue pills before?

A. We have used blue pills before.

Q. And what kind of medication were those pills?

A. That was morphine also. And that would have came from -- the guy's name was Tim. I don't know if

we've got -- I don't know his last name. But there was only a couple times he got from him. And they wasn't as high milligram, but I don't remember what milligram they was. But those was blue.

Q. Did you ever see Mr. Pritchard give morphine to Jonathan Whitson on March 5th, 2011?

A. I didn't see him give them to him, no.

Q. Did Jonathan have any money on March 5th, 2011?

A. Not that I know of.

Q. What is Riddle's Gas Station, which I think is also known as Riverside Gas Station.

A. Riverside Gas Station?

Q. Uh-huh. Or Riverside Store.

A. It is -- yeah, it's a gas station and a store.

Q. You're familiar with it?

A. Uh-huh. Yes.

Q. Was that a place where people could buy drugs back then?

A. There was a lot of drug dealing back then there.

Q. At the Riverside Gas Station?

A. Yes.

Q. Did it also go by the name Riddle's, or did

people refer to it as Riddle's?

A. I think Riddle's used to be in there, like halfway in the other part of it, where they would sell washing machines or something. And then they moved to South Toe. So -- but back when Jon was around, it would have been Riddle's and Riverside, Riddle's Riverside.

Q. So back in 2011 it was a location where people could by drugs?

A. Yes.

Q. Who is CJ Wilson?

A. That would have been Thelma Massey's grandson. I think her grandson. Not her grandson. She raised him like he was hers because her sister -- it was her sister's boy. But her sister wasn't all there at all. So I don't know if he knew that she was not -- I don't know if he knew which one was the mom and which one was like the aunt.

Q. So I understand that CJ Wilson was Jonathan's brother. That his father --

A. Okay. Wait.

Q. -- Russell Wilson's son.

A. Okay. Yeah. Yeah, that one.

Q. Who were you thinking of?

A. CR is who I'm thinking of. Sorry.

Q. Okay. Did you know CJ Wilson?

A. I did not know CJ Wilson.
Q. Did you know who he was at the time?
A. I've met him before. But I don't know him, like know him know him.
Q. Did you see him at all on March 5th, 2011?
A. I did not.
Q. Did you see CR?
A. I did.
Q. Where did you see him?
A. I think -- I want to say he was at Nathan's. But I don't know in between what happened or why -- what he was doing there or --
Q. Did you talk to him at all?
A. I don't think so.
Q. Did you see anyone else there that day other than Christine's family who lived there?
A. I don't think so.
Q. Did you see Brian Silvers there?
A. I don't know that he was when I was there.
Q. How long was CR at Nathan's?
A. I don't know. Maybe -- I just -- a glimpse of the truck, and CR came to mind. It's like I don't know. I know he was there, but not long, when I got there. So I don't know how long he was there before I got there. Because he was -- he must have been leaving

when I first got there. I don't know.

Q. Was CR a drug user at that time?

A. He was.

Q. Was he a drug dealer?

A. Occasionally.

Q. Do you know if he provided drugs to anyone at Nathan Angel's or Christine Angel's?

A. I don't know that.

Q. What kind of drugs did CR use?

A. Anything he could get.

Q. What kind of drugs did he deal?

A. Whatever Thelma had.

Q. Did you ever know Jonathan to get drugs from CR?

A. Yeah.

Q. Did you ever know Jonathan to get drugs from anyone at the Riverside Gas Station?

A. Not -- I mean I know he's met people there. But I don't know. I don't know.

Q. Where did John Pritchard get drugs from?

A. I don't know. I think he was prescribed them.

Q. Was John Pritchard ever angry with Jonathan about anything?

A. Not -- not to my knowledge, he wasn't.

Q. Were you ever aware or hear anything about a disagreement between John Pritchard and Jonathan over Robbie Brown?

A. No.

Q. Did you ever talk to John Pritchard about this case?

A. No.

Q. When is the last time you talked to John Pritchard?

A. Probably the trial.

Q. What did you talk about at trial?

A. We didn't talk. I just said hello.

Q. Did John Pritchard ever give you drugs?

A. No.

Q. Other than the occasion where you described the drugs in the truck after you were picked up from Little Tokyo Restaurant --

A. But he never gave me drugs, period.

Q. Right.

A. He always dealt with Jon.

Q. I'm just -- well what I was going to ask was did you ever know John Pritchard to provide drugs to anyone else other than that time in the truck?

A. No.

Q. Was your father a bondsman in March 2011?

A. He was.

Q. Was the fact that your father was a bondsman, did that ever prevent anyone from giving drugs to Jonathan?

A. Not to my knowledge.

Q. Was the fact that your father was a bondsman ever prevent anyone from providing drugs to you?

A. No.

Q. Who is Nikki Angel?

A. His sister, Nathan's daughter.

Q. What was Nikki Angel's relationship to John Pritchard?

A. From my understanding, they seen each other occasionally.

Q. What do you mean by that?

A. Romantically.

Q. When did that start?

A. I have no idea.

Q. Was John Pritchard romantically involved with anyone else?

A. Not to my -- Robbie. Other than Robbie, not that I know of.

Q. Did you ever talk to Nikki Angel about Jonathan's death?

A. Not to my knowledge.

Q. Did you ever talk to Nena Angel --
A. No.
Q. -- about funeral arrangements?
A. No.
Q. Did you ever talk to Nena Angel?
A. I've never talked to Nena Angel.
Q. Do you know who that is?
A. That's Nikki's sister.
Q. Have you ever talked to her on the phone?
A. I don't -- I don't know if Jon was with me when I talked to her on the phone one time. I'm not sure. I know she hated me. I don't know why. I don't know what the deal was. But I can't remember.
Q. Did you ever talk to Annette Whitson Greene about what happened to Jonathan?
A. No.
Q. Tell me about how you found out that Jonathan had died.
A. A deputy called my dad's house at seven that morning, a little after seven, and said that they had found him deceased. And I needed to go up to the annex and give my statement.
Q. Did you go and give your statement?
A. I did.
Q. Who did you meet with there?

A. I met Ryan Higgins.
Q. Was anyone else present?
A. I mean it was just him. My dad sit outside in the truck.
Q. About what time did you talk to Ryan Higgins?
A. I want to say nine.
Q. In the morning?
A. Uh-huh. Yes.
Q. Did you talk to anyone else from the time you heard about Jonathan's death until the time you talked to Ryan Higgins?
A. No. No. I went straight and just -- just my dad.
Q. Did you go over to Christine Angel's house?
A. No.
Q. Did you ever hear that Jonathan took anything other than morphine before he died?
A. I don't know. I mean I don't -- there was some talk about he'd got something else or maybe done something else because his levels was so high. But I don't know. I mean all that is just a blaze -- blur to me.
Q. Where did you hear talk about that?
A. I can't remember. I can't remember who said

something about it. I don't know if Brian had something about it, Brian Silver or -- this wold have been way after he passed away. Because I don't -- I don't see -- I don't know.

Q. Did you go to Jonathan's funeral?

A. I did.

Q. Did you talk to anyone there?

A. Umm --

Q. About what happened?

A. No.

Q. What is Lincoln Park?

A. It's a park -- it's -- Lincoln Park is a road. It's got a lot of apartments and houses on it.

Q. Is that known as a location where people can buy or sell drugs?

A. It is.

Q. Did you go to Lincoln Park on March 5th, 2011?

A. Not to my knowledge, no.

Q. What do you mean by not to my knowledge?

A. I'm pretty sure that I didn't. I'm positive I didn't. Yeah, I didn't.

Q. Did you ever go there yourself to buy drugs?

A. No.

Q. Did you ever go with anyone to buy drugs?

A. I went with Jonathan before to buy drugs.

Q. When did you go with Jonathan there to buy drugs?

A. Probably early on. And he never got -- he never ended up getting anything.

Q. How many times did you go to Lincoln Park?

A. Just like twice.

Q. Who is Bam-Bam?

A. The guy that we was going to get drugs from. He was supposed to have several pink Percocets. And he ended -- it ended up being birth control.

Q. How did you know that?

A. Jon told me. I don't know.

Q. Did you do the pills?

A. No.

Q. Do you know of any other circumstances where people got drugs from Bam-Bam and it turned out it was something other than what he said it was?

A. Somebody else had said that they thought that it was some kind of heart medicine I want to say. But I don't remember who it was, who would have said that. But I am recalling that that was said.

Q. What were they referencing?

A. That whatever -- because whatever I got was supposed to have been the pink Percocet 10s, and it was

birth control. And whatever they got, I don't know what they were supposed to get, but it turned out to be something for your heart.

Q. When did that happen?

A. Not long after we bought those probably.

Q. Was that before Jonathan went to jail or after?

A. Yeah, before.

Q. And who bought something expecting pain pills?

A. I don't remember who it was. I can't remember who it was.

Q. Where did you hear this story?

A. It may have been at Nathan's.

Q. Did you get pills yourself from someone else on March 5th, 2011?

A. No.

Q. Did you obtain pills and give them to Jonathan on March 5th, 2011?

A. No.

Q. Did you obtain blood pressure pills from someone else on March 5th, 2011?

A. No.

Q. Did you mistakenly get blood pressure pills from someone else on March 5th, 2011, thinking that they

were some sort of pain pill?

A. No.

Q. Did you get any pills on March 5th, 2011, that Jonathan then injected into himself?

A. Say that again.

Q. Did you get any pills yourself on March 5th, 2011, that Jonathan injected --

A. No.

Q. -- into himself?

A. No. Just what I said, that when I brought those five back.

Q. Did you exchange those five pills for any other pills?

A. No.

Q. Did you tell Nathan Angel that you got pills from someone in Lincoln Park thinking that they were pain pills, but they turned out to be blood pressure pills?

A. No.

Q. Why do you think multiple people are reporting that you unknowingly obtained blood pressure pills and provided them to Jonathan, who crushed them up and injected them into his body on March 5th, 2011?

A. I don't know.

Q. Is this true?

A. It's not true.

Q. Is any part of the story involving you and blood pressure pills, is any part of that true?

A. There's none of that true.

Q. Have you ever heard anything about this story?

A. No.

Q. One of the results from toxicology testing from the autopsy was that Jonathan had ethanol or alcohol in his blood at the time that he died.

Do you know anything about Jonathan drinking?

A. I don't know anything about him drinking.

Q. Did you ever see him drink alcohol?

A. He never drank alcohol.

Q. Did you ever know of him to drink alcohol?

A. He said he used to in the past. But he never drank alcohol when I was around him.

Q. Did Christine Angel allow people to drink in her house?

A. She did.

Q. Do you know if there was any alcohol at Christine's house on March 5th?

A. I don't know if there was any alcohol or not. I know his Uncle Mokes -- they call him Mokes, it was William -- I know that he drank. But I don't know if

he had anything there to drink. But she allowed it.

Q. Was William Angel living at Christine's at the time?

A. I don't know if he was at the time. But he would come up ever so often.

Q. Where would he come up from?

A. I want to say Morganton, but I'm not sure where they lived.

Q. Did you ever hear if he was drinking with anyone before he died?

A. I didn't, no.

Q. Did you ever hear if he was doing anything else, other drugs?

A. No.

Q. You mentioned that when you left Jonathan was crying. Is that right?

A. Yes.

Q. What was he crying about?

A. He didn't want me to go.

Q. Why was he so upset over the idea of your going?

A. Because I had just told him I didn't want to see him again.

Q. Why did you tell him that?

A. Because I was done. And my parents was onto

me about being around down there. And I told him that he had a baby on the way that he needed to -- he had a lot of good things coming. So --

Q. Did you tell Jonathan that you wanted to break up with him?

A. I told him I didn't want to hang out with him anymore like that, because we wasn't -- everybody presumes we were together together. And we wasn't together like that. We spent a lot of time together and we were friends, but it was never romantically.

Q. Who is Tammy Ayers?

A. I don't know.

Q. You mentioned Brian Silvers. Who is that?

A. That's Robbie's nephew.

Q. Robbie Brown?

A. Yes.

Q. What was his relationship to Jonathan?

A. I think they were just really good friends.

Q. What was CR's relationship to Jonathan?

A. They were friends.

Q. Was Brian Silvers a drug user?

A. He was.

Q. Was he a drug dealer?

A. Occasionally.

Q. What kind of drugs did he deal?

A. Just pills, some kind of pills. I don't know. It'd be pills.

Q. Okay. So earlier you said you saw CR at Nathan Angel's on March 5th. Is that correct?

A. Correct.

Q. Did you see Brian Silvers at all?

A. I want to say he was there. But I don't know to be sure.

Q. Is CR's full name -- do you know him as Charles Robert Hensley?

A. I do not know his full name. I just know him as CR.

Q. Who is Danny Edwards?

A. His dad is Dennis Edwards. But I -- I don't know Danny. I've never seen Danny as far as -- he used to ride horses with a bunch of people. But I don't know him in the setting that Jon would have been around him.

Q. Do you know what his relationship was to Jonathan?

A. I don't have a clue.

Q. Did they ever do work together?

A. Not that I know of.

Q. On March 5th, 2011, was Jonathan doing any work of any sort?

A. I don't think so.

Q. Who is Carrie Hinds?
A. That's Nathan's -- was Nathan's girlfriend.
Q. Was she Nathan's girlfriend at the time Jonathan died?
A. She was.
Q. Did you see her on March 5th?
A. I want to say so. I mean she would pop in and leave.
Q. Was she a drug user?
A. She was.
Q. Did you do any drugs in her presence?
A. No.
Q. Did you do any drugs in Nathan Angel's presence?
A. No. Any time that we done drugs that he would shield me from everybody else. I mean --
Q. Who is Sharon Allison -- excuse me -- Shannon Allison?
A. I don't know.
Q. Who is Sharon Biggs?
A. I don't know.
Q. Who is Aaron Collins?
A. Robbie's son.
Q. What was Aaron's relationship to Jonathan?
A. I just know that he knew him is all I know.

I don't know if they had a more -- better relationship than that. But around me, I never seen nothing.

Q. Did you see Aaron Collins on March 5th, 2011?

A. No.

Q. Do you know if Jonathan saw Aaron Collins on that day?

A. I don't know.

Q. Did you ever hear anything about Aaron Collins providing drugs to Jonathan before he died?

A. No.

Q. On March 5th, 2011, where was Nathan Angel staying?

A. At his trailer. I think at his trailer.

Q. Do you know if Jonathan went over to Nathan Angel's trailer after you left that night?

A. I don't know.

Q. Was anyone hanging out at Nathan Angel's trailer that night?

A. I can't remember.

Q. Are you aware of any parties that might have been going on at Nathan Angel's trailer that night?

A. No.

Q. Do you know if Jonathan saw his brother CJ?

A. I don't know that.

Q. Did you ever hear anything about Jonathan dying at Nathan Angel's trailer instead of at Christine's house, and people moving his body?

A. I didn't hear anything about that.

Q. Did you ever hear anything about how Jonathan appeared the morning he died?

A. I just heard that he looked like he was asleep.

Q. What do you know about Nikki Angel?

A. She's a drug user.

Q. Does she have any mental health issues?

A. Yes.

Q. What do you know about that?

A. I don't what she -- I don't what she has. I know that she -- like there was a period that they would -- she would be injected, or they would inject back and forth horse tranquilizers. And I think that led to some of her mentalness, I think. But I don't know what they ever referenced it. But she does have mental issues.

Q. What was your relationship like with Annette Whitson Greene at the time Jonathan died?

A. I only met her maybe one time. I mean it was fine, I guess. I never had words with her.

Q. Did you ever call her after Jonathan died?

A. I don't think so. I mean I kind of cut

ties, I'm pretty sure.

Q. Did you ever call and leave a voice mail on her cell phone?

A. I don't think so.

Q. Did you ever tell anyone that you gave blood pressure pills to Jonathan?

A. I've never gave any blood pressure pills to anybody.

Q. Other than Ryan Higgins with the Yancey County Sheriff's Office, did you ever talk to any other police officers about this case?

A. No.

Q. Did you ever speak to Chief Deputy Thomas Farmer on the phone sometime after you spoke to Ryan Higgins about this case?

A. I don't think so.

Q. Did you meet with any of the prosecutors prior to trial?

A. No.

Q. Did you talk to anyone or any attorneys prior to testifying at Mr. Pritchard's trial?

A. No.

Q. Did you ever meet with Mr. Pritchard's defense team?

A. No.

Q. His attorney?
A. No.
Q. Did you ever discuss this case with anyone else?
A. No.
Q. Why didn't you appear at the deposition that we had scheduled with you on September 22nd of this year?
A. That one was -- I didn't get served. I wasn't at home. My husband got the papers, and ended up throwing them away. And September the 23rd, that was at Yancey County?
Q. September 22nd. Yes.
A. I did go to Yancey County. And the three people I talked to said that you -- they didn't know who you was or that you was even there that day. It was Scott Rogers and Lynn Austin and Jeff Boone.
Q. What time did you go?
A. It was like 3:30, four o'clock time I got back through from Asheville.
Q. Did you receive text messages from me that day?
A. I did.
Q. So I was talking to you on the phone?
A. Yes.
Q. That phone you were sharing with your

husband at the time. Is that right?

A. Yes.

Q. So you did receive those text messages from me?

A. Yes.

Q. Is there anyone else that you think we should talk to who would have information about this case?

A. I'm trying to think. I guess not, I mean --

Q. Is there anything else you would like us to know about this case or that you think would be helpful for our investigation?

A. I can't think of any right now. I mean could I think later? I mean could I think when I leave and then I can get in touch with you?

Q. Sure.

A. Because I mean a lot of times -- a lot of times something will hit me later.

Q. Yeah. Absolutely. My phone number is on that subpoena there.

A. Okay.

Q. And you understand you're under subpoena to appear at the Commission hearing starting next Tuesday at 8:30 --

A. In Raleigh. Right.

Q. -- in Raleigh.
A. That's correct.
Q. And you understand that?
A. Yeah. So I need to be there for sure.
Q. If you bond, you have to be there.
A. Right.
Q. And if you have questions, you can call my number. That's our main office line.
A. Okay.
Q. Has anyone talked to you about what you have testified to at this deposition today?
A. No.
Q. Has anyone told you what to say?
A. No.
Q. Has anyone made you any promises about your testimony today?
A. No.
Q. Has anyone threatened you regarding your testimony today?
A. No.
Q. Has anyone put any pressure on you regarding your testimony today?
A. No.
Q. Were you completely truthful in answering my questions today?

A. Yes.

Q. Do you remember any additional information about the questions I have asked you?

A. Not so far.

Q. I'm going to conclude and end the deposition at this time. Time is 12:07 p.m.

[Deposition was concluded at 12:07 p.m. on December 8, 2021.]

STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
COUNTY OF YANCEY

STATE OF NORTH CAROLINA,
Petitioner,
-vs-
JOHN PRITCHARD,
Defendant.

File No. 11 CRS 304
File No. 11 CRS 305

DEPOSITION
STEPHANIE WHITSON RANDOLPH
December 8, 2021

I, June Robinson, having been assigned to transcribe the above-captioned deposition from December 8, 2021, do hereby certify that said deposition, pages 1 through 88, is a true, correct, and verbatim transcript of said proceeding to the best of my ability.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was heard; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, and am not financially or otherwise interested in the outcome of the action.

This 9th day of December, 2021.

June E. Robinson

June Robinson, transcriptionist
2304 Vail Avenue
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STATE OF NORTH CAROLINA IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
COUNTY OF YANCEY

STATE OF NORTH CAROLINA,
Petitioner,
-vs-
JOHN PRITCHARD,
Defendant.
_ _ _ _ _ _ _ _ _ _ _ _ _

File No. 11 CRS 304
File No. 11 CRS 305

DEPOSITION OF
STEPHANIE WHITSON RANDOLPH
December 8, 2021

ERRATA SHEET

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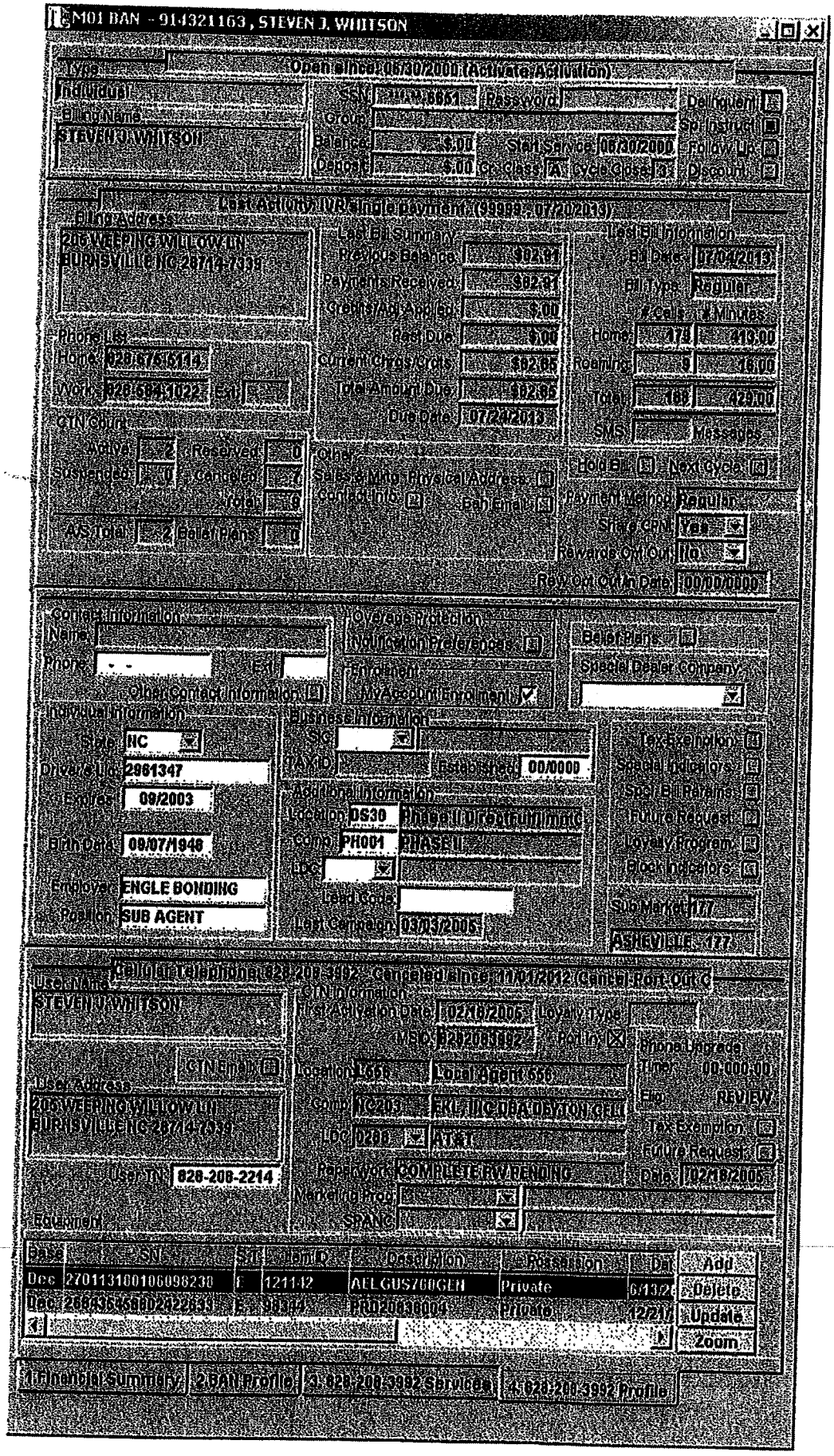
11-0151

Account Number: 914321163
Bill Date: 4/04/11
Invoice Number: 914321163-130
Bill Reprint

Detail of Local Usage - NATIONAL FAMILY 1000
STEVEN J. WHITSON 828-208-3992

Line	Date	Time	Calls To		Number Called	Feature	Period	Min	Airtime Charge	Toll Charge	Add'l Charge	Amount
7	3/05	12:20PM	MAIL	CL	828-208-3992		OP	3.00	0.00			0.00
8	3/05	12:24PM	MAIL	CL	828-208-3992		OP	3.00	0.00			0.00
9	3/05	12:34PM	CALL WAIT		828-208-3992	CW	OP	15.00	0.00			0.00
10	3/05	12:41PM	INCOMING	CL	828-208-3992		OP	1.00	0.00			0.00
11	3/05	12:42PM	BURNSVILLE	NC	828-678-0014		OP	2.00	0.00			0.00
12	3/05	6:13PM	INCOMING	CL	828-208-3992		OP	12.00	0.00			0.00
13	3/05	6:14PM	BURNSVILLE	NC	828-678-0014		OP	1.00	0.00			0.00
14	3/05	6:31PM	MICAVILLE	NC	828-675-5114		OP	3.00	0.00			0.00
15	3/05	6:40PM	INCOMING	CL	828-208-3992		OP	2.00	0.00			0.00
16	3/05	7:59PM	INCOMING	CL	828-208-3992		OP	2.00	0.00			0.00


M01 BAN - 914321163 , STEVEN J. WHITSON
Open since: 06/30/2000 (Activate/Activation)
Individual
Billing Name
STEVEN J WHITSON
SSN
Password
Group
Balance
Deposit
Start Service: 06/30/2000
Cycle Close: 3
Delinquent
Sp. Instruct
Follow Up
Discount
Last Action: IVR Single Payment (99999 - 07/20/2013)
Billing Address
206 WEEPING WILLOW LN
BURNSVILLE NC 28714-7339
Phone List
Home: 828 675 6114
Work: 828 684 1022 Ext:
CTN Count
Active: 2 Reserved: 0
Suspended: 0 Canceled: 7
Total: 9
AS Total: 2 Belair Plans: 0
Last Bill Summary
Previous Balance: $62.91
Payments Received: $62.91
Credits/Adj Applied: $0.00
Past Due: $0.00
Current Chrgs/Crdts: $62.65
Total Amount Due: $62.65
Due Date: 07/24/2013
Last Bill Information
Bill Date: 07/04/2013
Bill Type: Regular
Calls # Minutes
Home: 179 413.00
Roaming: 9 16.00
Total: 188 429.00
SMS: Messages
Other
Sales & Mktg Physical Address
Contact Info
Bill Email
Hold Bill
Next Cycle
Payment Method: Regular
Show CPNI: Yes
Rewards Opt Out: No
Rev Opt Out In Date: 00/00/0000
Contact Information
Name:
Phone: - -
Ext:
Other Contact Information
Overage Protection
Notification Preferences
Enrollment
MyAccount Enrollment
Belair Plans
Special Dealer Company:
Individual Information
State: NC
Driver's Lic: 2961347
Expires: 09/2003
Birth Date: 09/07/1948
Employer: ENGLE BONDING
Position: SUB AGENT
Business Information
SIC:
TAX ID:
Estab Since: 00/0000
Additional Information
Location: DS30 Phase II upgrade/ummotc
Comp: PH001 PHASE II
LDC:
Lead Code:
Last Campaign: 03/03/2005
Tax Exemption
Special Indicators
Spcl Bill Params
Future Request
Loyalty Program
Block Indicators
Sub Market: 177
ASHEVILLE - 177
Cellular Telephone: 828 208 3992 Canceled since: 11/01/2012 (Cancel Port Out C
User Name
STEVEN J WHITSON
CTN Email
User Address
206 WEEPING WILLOW LN
BURNSVILLE NC 28714-7339
User TN: 828-208-2214
CTN Information
First Activation Date: 02/08/2005
Loyalty Type:
MSID: 8282083992
Port In
Location: 1661
Local Agent 666
Comp: NC205
EKL, LLC DBA DEYTON CELL
LDC: 0200
AT&T
Paperwork: COMPLETE W/ PENDING
Marketing Prog:
SPANG
Phone Upgrade
Time: 00:000:00
Elig: REVIEW
Tax Exemption
Future Request
Date: 02/08/2005
Equipment
Base SN ST Item ID Description Restriction Dat
Dec 270113100106098230 6 121142 AELGUS700GEN Private 04/12/
Dec 268435600D2422853 E 98344 PRD20030004 Private 12/21/
Add
Delete
Update
Zoom
1 Financial Summary
2 BAN Profile
3 828-208-3992 Services
4 828-208-3992 Profile

NORTH CAROLINA STATE BUREAU OF INVESTIGATION
ADMINISTRATIVE SUBPOENA

TO: US Cellular

GREETINGS:

By the service of this subpoena upon you, you are hereby commanded and required to:

☒ Produce business records that disclose all subscriber information, date of birth, social security number, ESN, activation dates, and any accounts for telephone number **828-208-3992** for **March 5, 2011**

☒ Produce inbound/outbound local and long distance call detail records and the direct connect log for telephone number **828-208-3992** . The information being sought is for the date(s) **March 5, 2011**

PLEASE PROVIDE THE INFORMATION IN ELECTRONIC Excel Format .csv/.txt

AND EMAIL TO: pbyrd@ncdoj.gov

☐ Identify all phone numbers listed in the name of

☐ Identify all telephone numbers located at

You are hereby directed not to disclose to the subscriber or to any other person, the existence of this subpoena or inquiry. Disclosure could impede an ongoing criminal investigation.

Please email to: pbyrd@ncdoj.gov or fax to Analyst Pandora Byrd at 919-662-4483

Issued under the authority of North Carolina General Statute 15A-298.
I certify that this subpoena is issued in furtherance of a criminal investigation and the information sought is material to the said investigation.

Signature:

Title: Special Agent in Charge

SBI Case Number 2011-02340

Issued this 2nd day of January, 2014 Subpoena No. 36672

Return of service: Received _____

Served _____ on _____

By _____

FAX_20140102_1388692749_45

Handout 42

John Pritchard

Criminal History Chart

JOHN PRITCHARD

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
SECOND DEGREE MURDER	YANCEY	03/05/2011	04/17/2014
PWISD SCH II CS	YANCEY	03/05/2011	04/17/2014
MAINTAIN VEH/DWELL/PLACE CS (M)	YANCEY	03/05/2011	04/17/2014
MAINTAIN VEH/DWELL/PLACE CS	YANCEY	01/26/2010	01/31/2011
SELL/DELIVER SCH II CS	YANCEY	01/26/2010	01/31/2011
PWISMD SCH II CS (x2)	YANCY	01/26/2010	01/31/2011
FORGERY	SOUTH CAROLINA	UNKNOWN	07/31/1984
FORGERY	SOUTH CAROLINA	UNKNOWN	05/04/1984
RESISTING ARREST	SOUTH CAROLINA	07/04/1982	07/07/1982
OPEN CONTAINER OF ALCOHOLIC BEVERAGE IN PUBLIC	SOUTH CAROLINA	07/04/1982	07/07/1982

Handout 43

John Pritchard DPS Records Summary

Sealed by Order of the Court.

Handout 44

John Pritchard

Letters Handout

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
10/10/2016 **Mr. Belser** **(WFU File, pg. 1279-1282)**	• Dr. Brent Hall (Dr. Hall) was told that the Victim had been taking morphine which may have caused his death. Sgt. Ryan Higgins (Sgt. Higgins) and Deputy Thomas Farmer did not find any physical evidence to support morphine toxicity or overdose. They did not find any spoons or syringes. • Sgt. Higgins was related to the Victim's step-grandmother Christine Angel. Christine is the woman who stated the Victim died in her trailer, which is a lie. • Stephanie Whitson Randolph (Stephanie) stated that every time she and the Victim did drugs it was in the stepfather, Nathan Angel's (Nathan) trailer located behind Christine's home. This occurred for about six months, beginning in the summer. • Christine had her husband move into a trailer down the road from her so he could drink. Christine would not condone any alcohol or drug use from any of her family members in her home. • Christine 's relationship with the Victim was verbally abusive and she did not allow the Victim to come into her home. • The cousin who picked up the Victim from a gas station store early in the morning of 3/5/2011 stated he had dropped the Victim off at Christine's home at 1 am. The Victim informed the cousin that he (the Victim) was clean and sober and was going to stay that way. Nathan "assisted" the Victim's drug history since the Victim was 16 years old. The Victim went back into a using environment the Saturday and Sunday before his death. • Pritchard discusses issues with his trial counsel, Daniel Hockaday (Hockaday) and alleges ineffective assistance of counsel. • Pritchard alleges Hockaday, Sheriff Gary Banks and Michael Holmes were texting each other throughout the jury selection process. He also alleges that Sheriff Banks had pre-selected the jurors before trial began and dismissed about 50 jurors from the third row back. The clerk of court, Tammy McIntyre, stood and called people's names from the first two rows. • Sgt. Higgins stated he found no physical evidence of beer cans or alcohol in Christine's home on 3/6/2011 because the Victim was at Nathan's trailer.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
2/27/2017 **Mr. Belser** **(WFU File, pg. 1286-1288)**	• Pritchard discusses the issues he had with Robert Sirianni and lists numerous corrections he has for the trial transcript. • Stephanie bought Opana's (brand name of the oxymorphone) from Robbie Brown (Robbie), not from Pritchard. Stephanie was mad because the Victim tried to purchase drugs from Pritchard. Pritchard told the Victim he would not sell him drugs because Stephanie's father was the town bondsman, and she would turn the two of them in if she were arrested. Robbie sold the Victim and Stephanie drugs and Pritchard's medication for payment of doing yard work. • Pritchard not being a native of Burnsville is one reason he thinks Sheriff Banks prosecuted him "to the fullest extent of the law." • Pritchard has witnesses that will state the Victim was at Nathan's trailer and was moved early Sunday morning the Christine's home. The Victim and Stephanie were drinking and doing drugs at Nathan's trailer until Stephanie went home. The Victim continued to party at the trailer with Nathan and William Angel (William). • Pritchard discusses issues and questions he has around Dr. Hall's report. Pritchard adds "Stephanie shot the same amount as [the Victim] that night. Why didn't she die?" • William was never interrogated by the police and he received a prescription every month for 30mg morphine. • Sheriff Banks refuses to send Pritchard his cell phone records from the time of the trial.
April 2017 **Mr. Belser** **(WFU File, pg. 1289-1290)**	• Pritchard discusses the "power" of Sheriff Banks. • Both the Victim and Stephanie shared the morphine with the exception of 2 pills, which she traded for 2 "fake" 20mg of Oxycontin. The pills were counterfeit blood pressure pills that Stephanie got from "Bam Bam" at Hardee's. • The Victim was in a state of rigor mortis when Sgt. Higgins arrived at Christine's house.
8/7/2017 **Mr. Belser** **(WFU File, pg. 1291-1294)**	• Pritchard discusses an upcoming visit with David Belser and included brochures on the Matthew House.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
Unknown **Mr. Belser** **(WFU File, pg. 1295-1296)**	• Pritchard explains he is a recovering addict and therefore has knowledge on overdose issues. He alleges that the Victim went to bed after shooting drugs with his ex-girlfriend. Pritchard believes you cannot overdose 13 ½ hours after injecting drugs. • Danny Edwards (Danny) was a witness to the fact that the Victim was at Nathan's house after 1 am on 3/6/2011 drinking, shooting dope, and selling morphine with Nathan. • Nathan told Pritchard that he (Nathan) did wash the Victim's drug spoon after he discovered the Victim was dead. Nathan did this at his trailer behind Christine's home. • The Victim was washed to remove feces and changed into new clothes before he was placed on the couch at Christine's. • Robbie was the only one who sold to the Victim because she knew him. Pritchard denies selling the Victim drugs. • Stephanie admitted that she and the Victim shot drugs together. If Jonathan had drugs on him when he was leaving Pritchard's truck earlier that day, it was because he was dropped off at store well-known store for having drugs. Pritchard's medication was in a safe at his trailer where Aaron Collins (Aaron) was present.
3/15/2019 **Dr. Roberts** **(WFU File, pg. 1358)**	• Pritchard believes the Victim did not die from overdose. He alleges that the Victim and his ex-girlfriend injected 210mg of morphine between them. The first injection of three 30mg tablets was around 4:30 pm on 3/5/2011, then four 30mg tablets at 9:45 pm on 3/5/2011. Then the Victim allegedly overdosed at 10:30 am the next morning. • Sgt. Higgins took photos of the Victim's body on the couch in a state of rigor mortis. • The Victim also had an uncared-for abscess on his left arm larger than the upper part of Pritchard's leg. He was shooting drugs into this arm. • The Victim was running a high fever when detained in Madison County Detention Center and wasn't provided with medicine. The Victim then asked for a ride to the BP Station in Yancey County on 3/5/2011.
12/27/2019 **Commission** **(Correspondence Folder)**	• Pritchard indicates he has contacted Wake Forest School of Law's Innocence and Justice Clinic and is unsure if they will take his case. He will let the Commission know.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
1/14/2020 Commission **(Correspondence Folder)**	• Pritchard describes various accusations against Sheriff Banks, including that: Banks did everything possible to get Pritchard convicted, tried to get Pritchard to leave Robbie and sent confidential informants to illicit the sale of drugs from Robbie, that Pritchard received poor treatment from all staff while detained, and that Banks had Dr. Hall forge the autopsy report for the Victim. Pritchard also states he had ineffective counsel during trial. • "Whitson shot drugs up @ (9:30 with Girlfriend and died the following morning @ 10:45 am March 6, 2011. 13 ½ hours later ??? From overdose of morphine." (sic)
2/24/2020 Commission **(Correspondence Folder – 2/27/2020 Letter)**	• Pritchard states that Whitson was not in Christine's house when he died. Christine did not allow her husband to drink/possess alcohol in her home or allow her sons to sleep in her home, especially when using drugs. Christine allowing Nathan, the Victim and William to stay because it was cold is a lie. • Stephanie stated that she and the Victim used drugs and she would spend the night in Nathan's trailer. The two used drugs on 3/5/2011 in Nathan's trailer. • Pritchard gave the Victim a ride to Riddle's BP Station and dropped him off. Pritchard then went to the public dump to throw away trash and returned to pick up the Victim. The two then drove to Fred's store for chewing tobacco for Pritchard's roommate. The trip took 45 minutes. • The Victim asked if he could cut Robbie's grass as a way to deduct money from what he owed Pritchard. The Victim showed Pritchard the abscess on his (the Victim's) left arm. It was swollen and looked infected. The Victim said that as soon as he was feeling better he'd cut the grass. • Sunday morning, Annette "Ann" Whitson Greene (Greene) left Pritchard's trailer and went to Nathan's. Nathan and William changed the soiled clothes on the Victim and moved him to his step-grandmother's couch early that morning. Greene was afraid to tell this to police. Sgt. Higgins was investigating the case and he is a cousin of Christine's. • Stephanie stated her and the Victim shot four morphine tablets. They put the cooking spoons and 4 syringes in the bathroom vanity under the sink. Sgt. Higgins did not find the spoons or syringes under the sink. • Pritchard alleges that the bruises on The Victim's inner thighs were from where he was carried by Nathan and William. • Christine and her husband Wade went to the store early in the morning of the 6th so they were not home when the Victim was carried in. Christine thought the Victim was just on the couch sleeping when she returned.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
Cont.	• Danny informed Pritchard that when he (Danny) visited Nathan's trailer between 12:30-1 am, the Victim, William and Nathan were offering Danny liquor and trying to sell him drugs. • The Victim owed Pritchard money for morphine he bought from Robbie. The Victim and Stephanie did not care for the morphine Pritchard had because it was 30mg and that was generic. They bought brand name 30mg from William, Brian Silvers (Brian) and someone from the Riddles BP station • Stephanie's statements regarding where the Victim got the drugs and who from are lies and inconsistent. • Nathan claimed the Victim gave him (Nathan) one (1) pill of morphine and then Nathan left the Victim and Stephanie in his (Nathan's) trailer for "alone time" • Stephanie went to Hardee's to meet "Bam Bam" and left the Victim at the trailer. • "While Stephanie had 'Bam Bam' counterfeit 2 blood pressure pills to look like 15mg oxycodone tablets to give the Victim for the remaining 2 tablets of morphine which she gave to the Victim." • Floyd Ayers (Ayers) said he picked up the Victim at approx. 12:30 am on 3/5/2011 and dropped off the Victim at Christine's house around 1am on 3/5/2011. This was a lie because Christine would not let anyone in her home after 11 pm. Instead, Ayers dropped the Victim off at Nathan's trailer. • During Pritchard's trial his attorney, Hockaday, used his cell phone to text with Sheriff Banks and the DA Michael Holmes. The trial transcript was also doctored from the original statements made at trial. • Pritchard says he never gave or sold any morphine to the Victim because Pritchard did not know the Victim very well and his girlfriend (Stephanie) was the daughter of the county bondsman.
Unknown Unknown **(Bullock File, Pg. 176-179)**	• Pritchard's first trial was set for 12/2/2013 but was postponed until Feb. 2014 due to Christine being in the hospital. It was cancelled again and moved to 4/14/2014. Discusses the jurors lists he was given in February and April to pick from. Pritchard hear from his attorney that the Clerk would re-pick the jurors from a can. None of the jurors selected were from Pritchard's list. • During jury selection Pritchard saw Sheriff Banks texting Hockaday and Michael Holmes and alleges the three continued to text one another throughout the trial. • On 9/26/2011, before trial began, Nathan and "CR" were arrested for sale and distribution of 30mg morphine.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
Cont.	• Sgt. Higgins is related to the Angels and was the investigative detective for this case. • The Victim's biological mother, Greene, believed her son died in Nathan's trailer. But Pritchard's attorney refused to put her on the stand. Pritchard's attorney also did not put Nikki Angel on the stand. Pritchard discusses his thoughts about corruption between his attorney, the DA and Sheriff Banks including ineffective assistance of counsel issues. • Brian and "CR" were not questioned about the Victim's death because "CR" is related to Sheriff Banks. • Sheriff Banks has bad feelings about mental health and substance abuse agencies and does not support their teamwork to help "MH" and substance abuse clients. Banks refused to work with 3 mental health and substance abuse corporations causing the groups to close down. • The jurors selected were constituents of Sheriff Banks and he would visit their homes on a regular basis. Pritchard argues the same jurors serve consistently on trials in Yancey county. • Christine lied about the Victim staying at her trailer Friday and Saturday nights. Christine hates the Victim and his addictions. Christine's husband stays down the road in a trailer because of his drinking. The Victim died at Nathan's trailer not his stepmother's house. • Sheriff Banks made up Robbie's statement and Robbie never signed it. Pritchard does not understand why Robbie was accused of perjury. People in the jail felt like Banks and Robbie were more than acquaintances.
9/30/2019 Commission **(Questionnaire)**	• The Victim was found on the couch of Christine dressed in clean blue jeans and flannel shirt. Christine reported that the Victim was dead at 10:30 am on 3/6/2011. Pritchard was at his trailer with Greene (The Victim's biological mother). • Stephanie was the ex-girlfriend of the Victim and Pritchard considers her a possible suspect. She shared the morphine with the Victim and injected the same amount of drugs between her and the Victim. • On 3/5/2011 at approximately 1 pm Pritchard was getting his mail when he was approached by Nathan riding his four-wheeler. The two spoke for 15 mins. about Nathan cleaning Pritchard's trailer. Nathan then informed Pritchard that the Victim was getting out of jail and was at Nathan's trailer. Pritchard asked Nathan to have the Victim call Pritchard about doing some lawn work at Robbie's. Nathan said he would have the Victim call and then left.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
Cont.	• Pritchard went into his trailer and started collecting his garbage to take to the public trash containers on 19-23 bypass across from Riddles Store. Pritchard began driving when he received a call from the Victim. Pritchard drove to Nathan's trailer. • Pritchard told the Victim he was going to the dump and then to Fred's Store to pick up chewing tobacco for Aaron, Pritchard's roommate. The Victim said he needed to go to the store and asked if Pritchard could give him a ride. It was approx. 2:36 pm when the two left Nathan's trailer. • The Victim asked to be dopped off at the intersection of 19-23 Bypass. Pritchard continued on and took his trash to the public dump. Pritchard then headed to Fred's Store when he noticed the Victim standing near 19-23 Bypass Rd. and picked him back up. The two went to Fred's Store where Pritchard bought the chewing tobacco for his roommate. The Victim also purchased chewing tobacco. • They returned to Nathan's trailer at approximately 3:25 pm. Stephanie was at Nathan's trailer. Either the Victim or Stephanie said that as soon as the Victim's left arm abscess was better, he would cut Robbie's grass. The Victim then showed Pritchard his arm – it was black and blue and swollen to the size of Pritchard's thigh. Pritchard then left and did not see the Victim again. • On 12/1/2011 Sgt. Higgins arrested Pritchard and he remained in county jail for 2 years and 4 months until he was convicted. • Pritchard says he was framed by Sheriff Banks. Dr. Hall was forced to resign for giving wrong information concerning the Jenkins Family. • Pritchard never gave, sold, or traded any drugs to the Victim and Stephanie. The Victim always bought oxymorphone from Robbie. • Pritchard met the Victim and Stephanie in October 2010-December 2010 and was introduced to them via Robbie. • Dr. Hall stated he drew the toxicity of morphine out of the Victim's urine/bladder and registered 15mls of morphine. Pritchard had a forensic pathologist reevaluate the Victim's autopsy reports and concluded that the Victim died from sepsis. Dr. Hall fabricated his report so Sheriff Banks would drop Dr. Hall's DWI charges. • The Victim injected morphine at 9:45 pm 3/5/2011 and overdosed 13 ½ hours later on 3/6/2011 at 10:30 am.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
10/1/2020 Commission **(Documents received from Pritchard 10/2/2020, pgs. 2-4)**	• Pritchard describes his efforts to obtain documents about his case from the Clerk's office and law enforcement. He believes his paperwork was purposefully taken out of the box of documents given to his daughter at the end of his trial. • Pritchard discovered Stephanie made two different statements to police. In one statement, she claimed the Victim got out of Pritchard's truck at Nathan's trailer and showed her eight (8) pills of morphine when they went inside. Stephanie and the Victim went to Star Branch Rd, pulled over and shot 3 pills of morphine into their arms. Pritchard does not believe this is true because someone would have stopped to see if they needed help. In the second statement, Stephanie said they went to Christine's kitchen where the Victim showed Stephanie ten pills of morphine and the two got into Stephanie's jeep in the driveway and shot the three pills up there. The Victim got out of the Jeep and Stephanie drove to Hardee's to meet someone at 6:30 pm. Stephanie returned at 8 pm and crushed four pills of morphine with the Victim. The Victim and Stephanie shot each other up four times in Christine's home and in the bathroom. Pritchard argues this is all lies. • Nathan told Pritchard the Victim gave him one pill and then left the trailer, leaving the Victim and Stephanie alone. This was at approximately 4 pm. • One paper Pritchard looked over discussed body marks on the back inside of the Victim's legs and a blister on his right heel where the scab was rubbed off during the moving of the Victim's body. Nathan and William changed the Victim's clothes before placing him on Christine's couch because the Victim was covered in urine and feces.
3/22/21 Commission **(Correspondence Folder)**	• Stephanie gave three different statements during Pritchard's trial: - #1: Stephanie stated Pritchard called the Victim before picking him up at Nathan's trailer and drove him to Robbie's house. There Robbie gave 8 tablets to the Victim - #2: Stephanie said Pritchard called the Victim when Pritchard was traveling back from Marion and told the Victim that he (Pritchard) was going to pick up the Victim and give the Victim some pills - #3: Stephanie stated Pritchard called the Victim and told the Victim that he (Pritchard) would pick up the Victim and go to English Branch Rd for 15 minutes to give the Victim 10 pills of morphine. • Stephanie was not at Nathan's trailer when Pritchard picked up the Victim to discuss the Victim doing yard work at Robbie's house. They went to the BP Station (Riddles) and Fred Store to pick up chewing tobacco for Aaron. Then returned to Nathan's trailer 40 minutes later.

Letters Written by John Pritchard

Date/Recipient (Citation)	Description
Cont.	• Stephanie got to Nathan's trailer around 2:45 pm, about the same time Pritchard and the Victim arrived back to the trailer. • Pritchard's attorney did not ask Stephanie at trial about the counterfeit drugs she gave to the Victim • Pritchard includes handwritten notes taken while he was at Yancey County Jail: - When Nathan's brother went over to Nathan's trailer "they" were selling and doing morphine until late in the night. • Cookie Honeycutt stated he knew that Stephanie had taken 2 blood pressure pills and gave them to the Victim to shoot for 30mg oxys.
4/11/2021 Commission **(Correspondence Folder)**	• Pritchard makes complaints against Sheriff Banks and Hockaday, alleging ineffective counsel and corruption.
4/27/2021 NC Bar Association **(Correspondence Folder)**	• Pritchard provided a statement regarding his involvement to Hockaday. Pritchard then saw Hockaday give that statement to Sheriff Banks • The rest of this letter discusses ineffective assistance of counsel claims and ethical issues against Hockaday.

Handout 45

Dr. Brent Hall
Criminal History Chart

DR. BRENT HALL

CRIMINAL RECORD

Conviction	Jurisdiction	Date of Offense	Date of Conviction
DWI – LEVEL 5 (M)	WATAUGA	02/11/2018	02/21/2019

Handout 46

Dr. Hall Articles - Wake Forest File

Articles about hotel death, in relation to former medical examiner Brent Hall.

Charlotte Observer Jan 2014- Long before three deaths at a Boone hotel this spring, experts warned North Carolina officials that failings in the state medical examiner system posed a threat to the public. A 2001 legislative study group questioned whether medical examiners had the training to properly investigate suspicious and violent deaths. The study was triggered by an Observer investigation that uncovered a litany of problems in the state medical examiner system. But instead of hiring professional death investigators and making other reforms, state officials largely ignored the recommendations. The inaction left the state vulnerable to faulty death rulings and shoddy investigations, and inhibited researchers' ability to spot dangerous health threats. Now, the recent deaths at Boone's Best Western Plus Blue Ridge have provoked renewed debate about the competency of state-appointed medical examiners. A state medical examiner report existed three weeks ago showing that carbon monoxide might have killed an elderly couple in April but no one alerted local police and fire authorities until after an 11-year-old Rock Hill boy died in the same room. Authorities later determined that all three died from carbon monoxide poisoning. Experts say medical examiners should warn police and fire officials immediately after carbon monoxide poisoning is suspected, to prevent future deaths. Former N.C. Chief Medical Examiner Dr. John Butts acknowledged problems with the investigation into the hotel deaths. But he told the Observer that state lawmakers shoulder some blame because they failed to heed warnings about budget shortages and other problems that have dogged the agency for decades. "When you have a high volume of cases and part-time people, there's a risk of things slipping through the cracks," said Butts, who helped produce the legislative study. "It was a tragedy (in Boone). That was something we hoped would never happen." Dr. Marcia Herman-Giddens, who was a member of the 2001 medical examiner study group, said the mishandling of the Boone hotel deaths was "appalling," but hardly surprising. "There are huge holes in the system," said Herman-Giddens, who is now a professor at the UNC Chapel Hill School of Public Health. Some current and former state lawmakers said they did not recall the 2001 study. They said they were unaware of existing problems in the medical examiner system. "I don't remember hearing that it is a problem," said State Sen. Stan Bingham, a Davidson County Republican, who is listed as a sponsor of the bill that created the N.C. Study Commission on Medical Examiners in March 2001. "I am sure that will change now. ... Sometimes it takes a tragedy like this to correct (problems)." Ricky Diaz, a spokesman for the N.C. Department of Health and Human Services, did not respond directly to questions. Diaz emailed a statement, saying agency leaders have been "engaging local experts and actively pursuing opportunities for improvement." State Rep. Beverly Earle, a Charlotte Democrat who supported the legislative study in 2001, said the medical examiner system has been severely underfunded for years. "It's probably worse now," Earle said. "If anything, it's been cut." But she said that lawmakers likely have been unfairly faulted. DHHS has tremendous influence over how it spends money allocated from the General Assembly, Earle said. DHHS Secretary Aldona Wos has said the three deaths "should have never happened" and the state is reviewing its role in the troubled investigation. Missteps The public, law enforcement, insurance companies and researchers count on medical examiners to find the cause of death in shootings, drownings and other sudden deaths. Their work can help solve crimes, determine

insurance payouts, identify public health threats and ensure nothing is overlooked in a suspicious death. The Observer found a series of investigative missteps following the deaths of Daryl Dean Jenkins, 73, and his wife, Shirley Mae Jenkins, 72, both of Longview, Wash., and Jeffrey Williams of Rock Hill. The Jenkinses died of carbon monoxide poisoning on April 16 after staying in room No. 225 at the Best Western. Emergency workers found Jeffrey dead and his mother, Jeannie Williams, seriously injured in the same room on June 8. Reports show that Watauga County Medical Examiner Dr. Brent Hall did not view any of the three bodies at the scene – even though experts say it is a crucial first step in determining how someone died. Unlike states and counties with leading death investigation systems, North Carolina does not require medical examiners to visit scenes. The 2001 task force recommended mandatory scene investigations and professional investigators to do the work. Hall did not ask for an expedited carbon monoxide test of the bodies or the hotel, the state has said. It took nearly two months for the medical examiner's office to complete toxicology tests on the couple. That length of time is typical without a request to expedite the process. Hall listed an overdose as the probable cause of death in his request for the toxicology test. He also requested that the state screen for carbon monoxide poisoning, among other causes. The state says a June 1 report was sent to Hall from the state medical examiner's office showing Shirley Jenkins had a lethal concentration of carbon monoxide in her blood. It remains unclear why no one took action after that finding. The toxicology report for Daryl Jenkins wasn't completed until June 9, the day after Jeffrey died. It showed dangerous levels of carbon monoxide in his blood. Boone police have said the department renewed a request for the Jenkinses toxicology reports on May 29. They said they did not receive the lab results for the couple until June 10, after the child was dead. Through an open records request, the Observer obtained emails exchanged between Hall and current Chief Medical Examiner Dr. Deborah Radisch from June 10-14. Hall performed autopsies on the Jenkinses in April, but as of June 11 still had not completed their autopsy reports, email shows. The deaths of the Jenkinses and Jeffrey had been the subject of national attention for days by then. "Because of the many requests we are getting for the reports, can you please complete your autopsy reports on Mr. and Mrs. Jenkins as soon as you have the time, taking into account your primary responsibilities? Thank you!" Radisch wrote to Hall on June 11. State officials released the autopsy reports for the Jenkinses and Jeffrey two days later. Hall, who resigned as the county medical examiner June 14, declined comment.

Shortages-A pathologist, Hall is president and medical director of Pathology Associates of Boone, a private practice that conducts lab testing, according to the company website. He also is laboratory medical director for at least four western North Carolina hospitals, including Watauga Medical Center in Boone. Fellow medical examiners said he had earned a reputation for doing solid death investigations. They said he once completed a fellowship at the Office of the Chief Medical Examiner. "I was surprised that he was involved (in the hotel case)," said Butts, who retired in 2010. "I have a high opinion of his work. Something obviously went wrong."But Hall is professionally trained in the study of natural death and not suspicious death. Experts say it is preferable to have a certified forensic pathologist conducting autopsies. In North Carolina, Butts said, a significant number of autopsies are performed by doctors who are not certified forensic pathologists because there is a shortage. Diaz said state officials are worried about finding qualified candidates to fill the void. The N.C. Office of Chief Medical Examiner has openings for two pathologists in Raleigh but no one has applied, he said. States and counties with

nationally accredited systems, says states and counties should spend between $2.50 and $3.50 per capita. If going to the scene were a requirement, Radisch said, the state would have even fewer medical examiners. Not too long ago, Hall went to a greater percentage of death scenes than most of the state's roughly 350 active medical examiners. In 2002, state data show, he went to the scene in nearly half of the 57 cases he investigated. Only six medical examiners with caseloads at least the size of Hall's went more often. Over time, the Observer learned, Hall began showing up less and less. Since 2010, he visited only two of 323 death scenes in cases he agreed to investigate. As a medical examiner, Hall was called on to testify in court in criminal cases. On Jan. 28, 2010, he faced his own criminal charge. Hall was stopped at 1:27 a.m. on a Thursday morning for driving 50 mph in a 35 mph zone on rural Meat Camp Road not far from his house, according to court documents. The sheriff's deputy who pulled him over wrote in an affidavit that she detected a strong odor of alcohol and asked Hall to perform field sobriety tests. She said he performed poorly, so she arrested him. Court documents show that Hall's blood alcohol level was 0.19 – more than twice the legal limit. As required by law, he underwent a substance abuse assessment. Because Hall and local prosecutors worked together on criminal cases, a special prosecutor was brought in to try the case. In May 2011, Hall was found guilty in District Court of speeding and driving while intoxicated. The judge sentenced him to 30 days in jail but suspended the sentence and placed Hall on six months' unsupervised probation. Hall appealed the conviction to Superior Court, where the trial has been postponed at least 15 times in more than 21/2 years. It is now scheduled Feb. 3. The deadly signs of CO poisoning-Though Hall did not go to Room 225, he performed the autopsies on Daryl and Shirley. Several outside medical examiners said signs of carbon monoxide poisoning should be evident in autopsies. Daryl and Shirley's blood should have been bright red. Hall did the autopsy on Shirley's body on April 17, a day after they were found, and on Daryl's body on April 18, and made no mention of the color of their blood. He said that Daryl had severe coronary disease and that both had mild to moderate fluid in their lungs and congestion. While those symptoms could be markers of carbon-monoxide poisoning, they also could be signs of heart disease or overdose. If Hall wasn't looking for carbon monoxide, he might have overlooked the discoloration, said Dr. Gregory Davis, assistant state medical examiner for Kentucky. "There's an old saying in pathology," Davis said, "If you're not looking for it, you're not going to find it." Hall at least considered carbon-monoxide poisoning, documents indicate. When he mailed samples of their blood to the Office of the Chief Medical Examiner in Raleigh, he asked that it be tested for alcohol and drugs – but also for carbon monoxide. Hall then waited to get the results. 'Something seriously wrong'-The hotel immediately closed off Room 225. But closing the room didn't eliminate the danger. Three days after the deaths, Serene Solinski hosted a 13th birthday party at the Best Western for her daughter Levi. It was Friday, April 19. The party began around 4 p.m. at the pool, followed by cake in the lobby. About 7:30 or 8 that night, Solinski said she and 10 girls checked into Room 325 for a sleepover. Things started to go wrong about an hour later. Levi complained she didn't feel well, that the lights and noise bothered her. A little while later, another girl complained of the same symptoms. One girl threw up. Then another. And another. All but one girl ended up going home. Solinski, her two daughters and the one friend spent the night. Solinski opened a window to air out the room, which she said felt "warm and stuffy and sick." Le Beau speculated the open window may have saved them from serious harm. Solinksi said she complained to the front desk several times. "I went down and told them that night that there is something seriously wrong. Ten little girls don't fall out puking, passing out. That's not normal. They need to get someone in there to inspect the room." No

one at the hotel apparently made the connection with what happened earlier in the week one floor below in Room 225. The toxicology requests-The samples of Daryl and Shirley's blood had not even reached the toxicology lab in Raleigh by then. It took five days for the specimens to get to the Office of the Chief Medical Examiner. Shirley's arrived on April 22, Daryl's on April 23. The delay might not have mattered if Hall had completed the toxicology request forms that accompanied the blood. He did not do two things, the state said: Hall did not ask that results be expedited. He also did not fill out a section marked "pertinent history" in which medical examiners include background about a death – in this case, that two bodies were found in a hotel room. That information might have alerted toxicologists that the deaths were linked and that there could be a public health hazard. In an email two years earlier, Radisch had reminded medical examiners about the importance of filling out that section. The Observer reviewed toxicology request forms also submitted in April for carbon-monoxide testing and found that most included background information. Medical examiners wrote brief histories in 14 cases and the word "none" in one case. Hall left the section blank on each form he submitted. None of the requests were marked "urgent." Eight of the tests were completed in 10 or fewer days. Shirley's test would take four times as long, 40 days, and Daryl's, 47. Even the one case that had the word "none" under the history section took 19 days. At the time, the state didn't demand that local medical examiners fully complete the forms. On separate four-page investigative reports that Hall sent to Raleigh the same week, he did note that Daryl and Shirley were found together in a hotel room with "no evidence of foul play." But the reports would have been placed in the case files for later review by a pathologist, a state spokesman said, and it's unlikely the toxicologist ever saw them. In another unexplained decision, Hall indicated on the toxicology forms that the cause of each death might have been an overdose. "OD?" he scribbled. 'I just don't feel right'-Police and medics who went to the scene said they did not suspect an overdose and were surprised Hall noted that on the forms. Le Beau, the police captain, said investigators bagged up prescription medication found in the hotel room and had it delivered to Hall, but that's standard procedure. Rather than an overdose, Patsye Watts said, a police investigator suggested what is sometimes called "broken-heart syndrome," speculating that either Shirley or Daryl suffered a fatal heart attack and the other died from shock. The speculation took on the authenticity of fact the more it was shared. Two months later, after Jeffrey died, firefighters told the hazmat team the Jenkinses died of heart attacks, according to the hazmat incident report. Watts said family members never believed that theory. "If one had died, the other would have been able to handle it," Watts said. "We as a family did not feel that they died of natural causes." She said the family suspected carbon monoxide. Mark Brumbaugh, their attorney, said Daryl and Shirley's son and daughter shared their suspicions with "anyone who would listen." The response, no matter whom they talked with, was always the same, he said: We're waiting on toxicology results. Sullivan, of Watauga Medics, said he and co-workers speculated for days over breakfast about what might have killed the couple, including carbon monoxide. "We discussed a little bit of everything," Sullivan said. "We were all curious, waiting." There was enough uncertainty that the hotel didn't rent the room for six weeks. The lead police investigator also talked with Hall about carbon monoxide in the days immediately following the deaths, Le Beau said. He said Hall acknowledged the possibility, and also told the investigator that Daryl and Shirley each had enough heart disease to have killed them. The investigator remained so perplexed, Le Beau said, she went online May 29, six weeks after Daryl and Shirley died, and requested the toxicology results. Le Beau said she told him: "I just don't feel right about it." Police have a record of the request, but the state said it never

got it. A state spokesman said it wouldn't have mattered – an online request doesn't expedite toxicology tests. If police wanted the results sooner, they should have called. That was 10 days before Jeffrey died. Toxicology results not shared- It is the mission of the North Carolina medical examiner system to determine the cause of unexplained deaths and alert the public about health hazards. But the system doesn't always operate with the same split-second efficiency you might expect after watching forensic police dramas on television. It was not until Saturday, June 1 – 40 days after Shirley's blood arrived – that her toxicology report was completed. It would take seven more days in Daryl's case. Medical examiners in three states known for their expertise in investigating deaths said it would be rare for their tests to take so long. Maryland turns around most tests within three to five days, said Bruce Goldfarb, executive assistant to the state's chief medical examiner. In an urgent case, within 15 minutes. Others reported a two- to three-week turnaround. North Carolina's turnaround time depends on the complexity of the tests and the quality standards they require, said Ricky Diaz, spokesman for the N.C. Department of Health and Human Services, which oversees the medical examiner system. "Medical examiners can request a 'stat' test for the presence of carbon monoxide," he said. "In those cases, the toxicology lab will expedite the test." After the test was completed in Shirley's case, the state waited two days to notify Hall. Unless a request is expedited, Diaz said, the report is not emailed until normal business hours. "A positive carbon-monoxide result, by itself, does not point to a potential threat or emergent situation," he said. "Considering that the majority of positive carbon-monoxide tests are the result of house fires, car fires or suicides, additional facts are needed to reach that conclusion. ... The toxicology lab relies on the information it receives from the pathologist." Diaz said results were emailed to Hall on Monday, June 3. Jeffrey and Jeannie would not check into the Best Western until Friday. There was still time to save them. The biggest puzzle is whether Hall got the email, read it and did nothing. He has declined to comment. Reopening Room 225-The breakdown in communication might not have been fatal if Room 225 had remained closed. But the Best Western reopened the room May 31, Le Beau said. Why did the hotel manager think it was safe to reopen Room 225? Attorney Paul Culpepper of Hickory, who represents hotel management, said the hotel consulted with police and had a contractor inspect the pool heater and the fireplace in the room. Damon Mallatere, whose company manages the hotel, declined to comment. The hotel was under no legal obligation to keep the room closed. Police said they did not have authority to close the room or shut down the hotel. Firefighters and medics said they did not. A state spokesman said there's no single protocol for what a local medical examiner should do in the event of a potential threat to public safety. The building inspector said he might have been able to shut down the hotel, but he would have needed evidence of a violation. The evidence was in the toxicology report June 1, seven days before Jeffrey died. That night, two people stayed in Room 225 and "had a pleasant stay, no issues," Le Beau said. He speculated they escaped death because the swimming pool water heater wasn't running, or wasn't running often. The heater, he said, was controlled by a thermostat, but employees could manually adjust it based on the water temperature in the pool. No one stayed in the room again until Jeannie and Jeffrey checked in six days later. The day Jeffrey died-They arrived at the Best Western late in the evening on Friday, June 7. Their room smelled so much of cigarette smoke that around 9 p.m., Jeannie asked that they be moved. The clerk offered to upgrade them to one of the hotel's 11 luxury rooms, a family member said. It had a king-size bed, heart-shaped hot tub and gas fireplace. Room 225-Directly below them, as the pool heater worked to warm the water, it emitted a stream of deadly odorless gas that seeped into the room. Le Beau suspects an employee

likely cranked up the thermostat. He said the same thing might have happened the night Daryl and Shirley Jenkins died. Jeannie later told her family that she felt fine one moment, terrible the next. She and Jeffrey planned to get up Saturday morning, eat breakfast, then drive about 30 minutes to Banner Elk, where Jeffrey's sister, Breanne, 17, was at camp. The three of them were very close. Jeannie home-schooled both children on the family farm outside Rock Hill, where they raised cows, horses, chickens and pigs. Breanne had just completed 11th grade; Jeffrey, fifth grade. Later that day, they planned to hike at Grandfather Mountain. It would be a fun start to summer vacation. But Jeannie and Jeffrey never showed up. Breanne called her mother's cellphone and didn't get an answer, so she called her father. Jeff Williams owns Substation Concrete Services in Rock Hill and happened to be working in Hickory that morning, about an hour from Boone. He and Jeannie had met when they were studying at Mars Hill College near Asheville, where Jeff played defensive end on the football team. Jeffrey was named for him. Jeff called Jeannie and didn't get an answer either, so he telephoned the Best Western. An employee went to look for them and told Jeff they had checked out. Jeff then telephoned police who transferred him to the highway patrol. Had there been a car accident? Jeannie was always punctual and organized. It wasn't like her to leave Breanne stranded. He called the hotel a second time. After that call, the clerk realized they looked in the wrong room – the one that smelled of cigarettes. Jeannie and Jeffrey had moved into Room 225, where just two months earlier Daryl and Shirley also failed to show up for an appointment. 'Please come help us'-Again, an employee was sent to check on Room 225. Again, there were two bodies. The hotel clerk called 911 and went up to the room. A few minutes into the call, the dispatcher can be heard consulting with a colleague, then suddenly warning the clerk: "I'm going to need you to just go ahead and get out of that room." "Get out of the room!" the clerk called out. "Everybody get out of the room!" Her voice breaking, the clerk then told the dispatcher "Oh, ma'am, this is awful, please." The dispatcher tried to calm her. "I understand. I'm here with you, OK ... ." "You don't understand," the clerk said, and her voice broke a second time. "We just went through this." Once again, fire, police and medics rushed to the Best Western. This time, Sullivan, the owner of Watauga Medics, went, too. "We're a pretty small town," he said, "and bells and whistles were going off." Emergency responders carried Jeannie Williams out of the room and shut the door, leaving Jeffrey's body on the bed. Before re-entering the room, firefighters suited up in protective clothing and air masks. They tested for carbon monoxide and found potentially lethal levels. The hotel was evacuated. Jeff Williams was driving toward Boone to find his wife and child when his phone rang: Jeannie was in the hospital; they didn't know where Jeffrey was. Then another call-Jeffrey was dead. A standoff at the Best Western-It would take most of the afternoon and a standoff at the hotel before Jeff was allowed to see his son. He and Jeannie are still too distressed to talk publicly about what happened at the Best Western. Jeff's brother Darrell shared the story on behalf of the family. This is his account of the afternoon of June 8: He said family members who were gathered at the hospital, where Jeannie was in intensive care, sent word to police that they wanted to see Jeffrey's body. He said they were told that there might be a danger of contamination and that the body would not be removed from the hotel until a hazmat team determined what was wrong. Hours passed. Jeff Williams grew more distraught. His brothers, Darrell and Dennis, decided to drive to the Best Western. The parking lot was chaotic. Flashing lights. Yellow crime-scene tape. Fire. Police. Medics. Dozens of hotel guests wandering around, unable to get back into their rooms, some with a wedding to attend. Darrell pleaded for Jeffrey's body. He said a police officer told him that Hall, the medical examiner, had not given them permission to move it.

When a medical examiner is investigating a death, only he or she can authorize the body's removal. A short while later, Jeffrey's grandfather arrived from the hospital. Darrell said Jim Williams, 69, rarely shows a temper, but when they told him that Hall refused to release Jeffrey's body for fear of contamination, he became furious. He said Hall was at the hospital, consulting on Jeannie's injuries. "If there was any real danger," he said, "everyone in the ICU has already been exposed." Darrell called the hospital and asked to speak with Hall. By then, he said, police officers had gathered around them. He said his father got on the phone and warned Hall: "You either give the EMS the authority to remove Jeffrey's body, or my sons are going to walk into that hotel and remove his body." Hall relented, and medics took Jeffrey's body to the hospital. About six hours after Jeff Williams learned that his 11-year-old son was dead, he finally saw him. He hugged Jeffrey, rested his cheek on Jeffrey's cheek and laid with him. "I love you," he whispered. "I'll miss you." He told Jeffrey to go be with Jesus, that he would see him again someday. Then he kissed his son goodbye. Deadly levels of gas-Around 7 p.m., within an hour after Jeffrey's body was taken away, four members of a hazmat team arrived at the Best Western. They brought monitors capable of identifying and measuring 55 gases. After suiting up head to foot in protective clothing, they entered Room 225. They placed one gas identification pump on the nightstand and another near the bathroom sink. Sunday afternoon, June 9, after the rest of the team arrived from Asheville, they checked the monitors. No poison. They planned to test again for carbon monoxide, and also for chlorine gas, pesticides and possible residue from a methamphetamine or ricin lab. Though a toxicology test eight days earlier revealed that Shirley died of carbon-monoxide poisoning, none of the investigators on the scene knew of those results. At 1:35 Sunday afternoon, they called the Office of the Chief Medical Examiner in Raleigh and asked that tests on Daryl and Shirley Jenkins be expedited. Fifteen minutes later, they got the results: lethal levels of carbon monoxide. The hazmat team narrowed its focus. Enough to kill-When team members had surveyed the hotel earlier, they discovered that a metal pipe connected to the swimming pool water heater was severely corroded. The 10-inch diameter pipe was supposed to remove carbon monoxide from the heater to the outdoors, but it had gaping rusted-out holes. It was hidden in the dropped ceiling over the pool. Directly above was Room 225. The hazmat team tested the air at various locations in and outside the hotel while the water heater was off. No poison. A little after 4 p.m., they fired up the heater. After 28 minutes, the level of carbon monoxide at one location was so high they stopped testing there to prevent damage to the sensor. Four minutes later, they turned off the heater. It had been running for a little over half an hour. The level of carbon monoxide on a portable monitor placed on the nightstand inside Room 225 had soared to 343 parts per million, enough to make someone seriously ill. With longer exposure, the person would die. The reading on a monitor outdoors near the room's heating and air conditioning unit was nearly that high. And in Room 325 on the floor above, where the young girls became ill in April, the level of carbon monoxide was 56 parts per million, enough to make a person sick. Further investigation revealed that there were two ways the poisonous gas could have entered Room 225, Le Beau said. From inside the building, it rose through holes in the corroded exhaust pipe and up through a hole in the fireplace across from the bed. From outside the building, the gas could have been sucked back inside through the room's heating and air conditioning unit, or it could have seeped in through gaps around the unit. Instead of being directed safely outdoors, the gas drifted and flowed through openings. The corroded pipe didn't hold it. A ventilation fan designed to pull it through the pipe to the outside wasn't working. Still a little boy-The same day the hazmat team discovered the source of the carbon monoxide, Hall performed an autopsy

on Jeffrey. A written autopsy report typically includes clinical medical language, but it also provides a personal glimpse into the life of the deceased. Jeffrey was still a little boy, less than 5 feet tall and weighing 85 pounds. He wore braces. On his pajama top was a picture of a black dog and the words "North Pole 28 Challenge." Hall noted "red discoloration" in his organs and blood – the telltale sign of carbon-monoxide poisoning that experts said should have been evident during Daryl and Shirley's autopsies. Hall also noted vomit on Jeffrey's pajama top, a side effect of carbon-monoxide exposure. He noted a bluish-purple discoloration beneath his fingernails, caused by a lack of oxygen. Too much carbon monoxide diminishes a person's ability to absorb oxygen, causing headaches, dizziness, vomiting and confusion as well as discoloration of fingernails, nostrils and lips. At extremely high doses, it can cause loss of consciousness or death within minutes, similar to suffocation. The reason Jeannie Williams survived, her family believes, is because she collapsed beneath the exhaust fan in the bathroom. Shortcuts to tragedy-No one knows for sure when the carbon monoxide began leaking into Room 225, or how many other people were poisoned. Police said they heard from a few hotel guests who became sick in months past and suspected the flu. Two girls who attended the birthday party in Room 325 have possible side effects. Solinski said that her daughter's eyesight is damaged and that another girl has violent headaches. When the Best Western was built in 2000, original plans called for carbon-monoxide detectors in the 11 rooms with fireplaces, said Culpepper, the attorney who represents hotel management. Instead, he said, the contractor put in the wrong type of detectors, combustible gas monitors. The hotel didn't discover the mistake, he said, until after the deaths. An Observer investigation in June found multiple shortcuts and violations when the swimming pool water heater was installed in 2011. It was a used heater that hotel employees moved from a Sleep Inn hotel run by the same company, Appalachian Hospitality Management. The employees were not licensed to do the work and did not get a permit or an inspection, in violation of the North Carolina Building Code. Not only did they install the heater improperly, they also did not put a carbon-monoxide detector nearby despite explicit warnings in the owner's manual. In February 2012, the hotel hired a company to convert the heater from propane to natural gas. The company applied for a permit, as required, and the town inspected and approved the work. A town official declined to say whether an inspector examined the corroded exhaust pipe. After Jeffrey died, investigators with a state licensing board discovered multiple unseen dangers in the heating system. They took 325 photographs that illustrate the hazards in frightening detail: pipes with rusted holes, different-sized pipes improperly joined together with tape, vents covered by insulation, gashes in the drywall of the equipment room. Several gas lines appeared to have been modified, according to the Board of Examiners of Plumbing, Heating and Fire Sprinkler Contractors. In some places, the outer liner of the exhaust pipe had rusted away; in other places, the inner liner had deteriorated. An ice bucket was propped up under one pipe, apparently to catch condensation; a VHS videotape supported an elbow fitting on another pipe. '100 percent preventable'-Though carbon monoxide from the pool heater killed Jeffrey, Darrell Williams believes North Carolina's medical examiner system is to blame for his death. "It was 100 percent preventable and should have never happened," Williams said. "The (state) medical examiner's office was fully aware that there was carbon-monoxide poisoning involved in the Jenkinses' deaths a week before Jeffrey was sent to his death in that room." He faulted Hall for failing to pinpoint carbon monoxide during the autopsies of Daryl and Shirley Jenkins. Dr. Aldona Wos, the state secretary of health and human services, said in a written statement in June that the deaths "should have never happened." She said she instructed her

staff to work with local officials to prevent another such tragedy. She has declined repeated requests for interviews. Diaz, the spokesman, said department officials reviewed what happened and do not believe any state employee erred. He said Hall was not a state employee. The department is "actively pursuing opportunities for improvement and enhancement" of the medical examiner system, he said. He declined to be more specific except to say pathologists are now required to submit a written account of pertinent details about a death with any specimen mailed to the lab. If they don't include the information, he said, the lab will contact the medical examiner before testing for anything other than alcohol. In the past, filling out the section was considered "best practice." The new policy making it a requirement took effect June 11, three days after Jeffrey died. 'My side of the story' Despite public outrage over the deaths, it was not until four days after Jeffrey died, on June 12, and only after prodding from the chief medical examiner, that Hall completed the three autopsy reports. In the deaths of Daryl and Shirley Jenkins, Hall was paid $100 for each investigation and $1,000 for each autopsy. He also collected $1,100 for his work in Jeffrey's death. He resigned as a medical examiner on June 14. In a brief telephone conversation in September, Hall acknowledged that what happened has been difficult, but he declined to answer questions. "If and when it goes to court," he said, "I will tell my side of the story." Pressed to talk, Hall said: "I'd rather not say anything that I'm going to read in the paper tomorrow." Approached last month by certified letter, Hall did not respond. District Attorney Jerry Wilson said that during Hall's 20 years as medical examiner in and around Boone, he gave the rural mountain communities the same expertise urban areas expect. Wilson said Hall would hold him accountable in cases. "He would say, 'Jerry, that's just not right. That's not what happened.' He was such an excellent pathologist and such a fair pathologist, I hate to see him absolutely beat to death over a mistake." In Boone, some people believe Hall has been made a scapegoat, Grief and a slow recovery; the night before they buried Jeffrey, Jeannie Williams was released from the hospital. She was brought to the church the next day in a wheelchair. It was June 16, Father's Day. A screen in the sanctuary of Rock Hill's First Baptist Church projected photographs of Jeffrey at various stages of his childhood doing things he loved; surf fishing at the beach with his father, practicing violin, cuddling with his mother. Thanksgiving would have been Jeffrey's 12th birthday. With Christmas approaching, he would have been looking forward to this year's big surprise from his grandparents. One year, Jim and Flora Williams took all the grandchildren to Busch Gardens in Tampa, Fla.; another year, they bought them a golf cart to drive around their property. Each milestone without Jeffrey brings more anguish to his family. "I ask that every one of your readers say a prayer for my brother, my sister-in-law, my niece and my family on Christmas," Darrell Williams said. He said Jeannie will face serious health problems for the rest of her life. She can walk on her own, but she has a noticeable limp and has trouble climbing stairs. She finds it difficult to grip with her hands and perform simple tasks of dexterity. "She has reached a plateau that we believe may be her full recovery," he said. "The limited mobility will probably get exponentially worse with age." A bigger challenge, Darrell Williams said, is damage to her heart and brain caused by a lack of oxygen. "Jeannie was a very sharp and astute person before the accident," he said. "However this accident has caused cognitive impairment." Jeannie no longer home-schools her daughter. Breanne is finishing her last year of high school at a private academy. Lack of accountability-Police recently completed a six-month criminal investigation. Le Beau said it includes "the entire story" of what happened at the Best Western – from the installation and repair of the water heating system, to the response of fire, police and medics, to the role of the medical examiner. It will be up to Wilson, the district attorney, whether evidence is

further testing, and the state issued a report on June 1 that carbon monoxide poisoning might have killed Shirley Jenkins. Jeffrey Williams died in the same room on June 8, and his mother was hospitalized. It wasn't until June 10 that the Boone, N.C., police department issued a statement that said the state Medical Examiner had found lethal levels of carbon monoxide in Shirley and Daryl Jenkins' blood. On June 14, a police statement said that Hall had determined that Jeffrey's concentration of carbon monoxide in his blood was greater than 60 percent. The boy's carbon monoxide concentration level matched that of both Shirley and Daryl Jenkins, the news release stated. Elderly Couple and Boy Die in Same Hotel Room Months Apart North Carolina Department of Health and Human Services Secretary Aldona Wos called the three hotel deaths "a tragedy that should have never happened." "My heartfelt condolences go out to the families and loved ones of Shirley and Daryl Jenkins, and young Jeffrey Williams," Wos said in a prepared statement. "The Department of Health and Human Services is continuing to gather the facts. I have instructed my staff to work with local officials to identify measures to ensure tragedies like this never happen again." Boone Police Department Sgt. Shane Robbins told ABC News that he was unable to release information as a result of the ongoing criminal investigation. While Hall has resigned from his state-appointed position, it is unclear if he is still practicing medicine. Calls to his private practice were not immediately returned. The North Carolina Medical Examiner's office declined to comment to ABC News.

Medical Examiner Resigns- Our local Community Dec 2013-Dr. Brent Hall has resigned after performing autopsies on the three people who died at the Best Western Hotel in Boone. Dr. Hall, a Mitchell County native, has served as a regional pathologist for several years. New documents released show Daryl and Shirley Jenkins died on April 16. A request for a toxicology report was made April 22nd but it was not expedited by the state because Dr. Hall indicated probably cause of the Jenkins death to be an overdose. Boone police repeated their request May 29.The state completed its toxicology report proving carbon monoxide killed Shirley Jenkins on June 1. Daryl Jenkins report was completed June 9th. Dr. Hall contacted Boone Police with the reports on June 13th. Jeffrey Williams' died from carbon monoxide poisoning on June 8th. Officials in Boone said that the water heater that has been blamed for causing the deaths was replaced sometime after March of 2012 and was done without an inspection. The heater would not have met the town's codes for the hotel because the ventilation for that type of water heater required the exhaust to go out the top of the building not the side near the window for Room 225. It was also found that a fan used to suck the poisonous gas out the opening was broken. The three deaths at the hotel have sparked widespread concerns about carbon monoxide in hotels including a call for carbon monoxide detectors in each hotel room and stronger regulations.

New Reporting –Dec 2013- BOONE, N.C. — Open the door to Room 225 at the Best Western hotel. Jeannie Williams and her 11-year-old son, Jeffrey, are settling in after driving up from the family farm outside Rock Hill. It is a little before 10 on a rainy Friday evening in early June. They plan to pick up Jeffrey's older sister the following morning from a weeklong Christian youth camp. Jeffrey snuggles beneath the covers of the king-size bed, wearing his plaid pajamas. Jeannie later told her family she remembers sitting beside him, talking with her husband over the phone. She tells him goodnight, then begins her Bible study. Suddenly, she feels nauseated and confused. She rushes to the bathroom. She is so dizzy, she has to sit on the toilet. The last thing she remembers thinking is: I have to get my phone to

call someone. When a housekeeper finds them more than 14 hours later, around 12:25 the next afternoon, Jeffrey is dead in the bed. Jeannie, 49, is near death, lying unconscious on the bathroom floor, still in her clothes from the day before. "Please hurry!" a hotel clerk pleads in a chilling call to 911. "This just happened to us." Less than two months earlier in the same room on the second floor of the Best Western, Daryl and Shirley Jenkins of Longview, Wash., died overnight in much the same way. But despite the alarming circumstances of the first deaths – two bodies in a hotel room without any evidence of foul play – there is no indication that officials in Boone or anyone in the state's medical examiner system acted with urgency to understand what happened. Daryl and Shirley's son and daughter immediately suspected carbon monoxide and left for Boone that afternoon. They said they talked about the possibility of poisoning with the medical examiner, the hotel, police. Still, the investigation moved at a fatally slow pace. A toxicology test for carbon monoxide takes about 15 minutes to complete. After Daryl and Shirley died, it took the state 40 days to finish just one of the tests. It was only after Jeffrey's death that authorities recognized a public health hazard and evacuated the Best Western. A hazardous materials team discovered carbon monoxide spewing from the swimming pool water heater at levels so high in one location they worried it would ruin their detection equipment. Room 225 was a death chamber. Holding someone accountable-Three people died. Another person suffered debilitating injuries. Who is to blame? A prosecutor is now reviewing evidence police compiled during a six-month investigation and will decide after the new year whether to seek criminal charges. Both families have hired attorneys and are expected to file civil lawsuits. Possible targets include the hotel, Boone authorities, as well as any person or company that worked on the swimming pool heating system. The Williams family wants to hold another party accountable: North Carolina's medical examiner system. Jeffrey's death exposed faults within the system that the Observer first reported in 2001. The state pledged then to fix the problems but didn't. Even now, the chief medical examiner describes having to rely on "basically volunteers" to investigate unexplained deaths in North Carolina. The state knows medical examiners don't go to most death scenes. It knows some don't even view the bodies. It knows they sometimes provide inadequate investigative background about deaths. If there had been a more vigilant investigation into why Daryl and Shirley died, Jeffrey might be alive today, and Jeannie Williams might not be facing health problems for the rest of her life. The night Daryl and Shirley died-The multiple failures that led to that night in June can best be explained by stepping back to Sunday, April 14, when Daryl and Shirley Jenkins checked into the Best Western Plus Blue Ridge Plaza. High school sweethearts, married 53 years, they had come from across the country to visit cousins in the community of Todd, about 20 minutes north of Boone on the South Fork of the New River. Though news accounts after their deaths described them as elderly, family members did not think of them that way. Daryl, 73, was a retired counselor who had recently taken up snowboarding; Shirley, 72, a former office manager, was known for her distinctive laugh. They loved to travel. They had been to the Blue Ridge Mountains once before, in September 2011, and stayed at the same Best Western. With them again on this trip were Shirley's brother, Gary Watts, and his wife, Patsye. They drove up from the Atlanta airport Sunday and had an uneventful first night. They spent most of Monday seeing relatives. After dinner at Cracker Barrel, the couples returned to the hotel around 8 and agreed to meet Tuesday morning for breakfast. Daryl and Shirley never showed up. Worried, Gary and Patsye asked if the hotel would check on them. Shortly after 10 a.m. on April 16, a housekeeper entered the room. Shirley was lying on the carpet near the door, dressed in her pink and white nightgown. Daryl was lying nearby in the empty hot

tub. Frantic, the housekeeper called the front desk. The clerk called 911, and Patsye and Gary Watts raced to the room. Patsye said they thought Shirley might still be alive, so Shirley's brother got down on the floor and performed CPR. A health inspector, who happened to be in the hotel that morning on a routine inspection, jumped over Shirley's body and began doing chest compressions on Daryl. Over the next 53 days, authorities at multiple levels missed opportunities to protect the public, beginning when the bodies were first discovered and no one tested the room for carbon monoxide. Firefighters looked around, from the fireplace on one wall to the hot tub on the other, and the fire chief said they didn't find any obvious hazards. At the time, the town's fire engines were not equipped with monitors to check for deadly gas. (They have since been added.) The department's heavy-rescue truck had a monitor, but no one sent for it. It was not their job, the fire chief said, to determine the cause of the deaths. That was the job of the medical examiner. Clues to the deaths in Room 225- Deaths that are sudden, unexplained, accidental or violent are usually referred to medical examiners for investigation. So, a call went out to Dr. Brent Hall. Hall, 53, is well-known in and around Boone. He was medical examiner for Watauga and four other counties. Like most of the state's medical examiners, he had another full-time job. He works as a private pathologist, diagnosing disease and performing autopsies. As a medical examiner for 20 years, he worked closely with emergency responders and would occasionally have pizza delivered to the medics, said Craig Sullivan, director of the privately owned Watauga Medics. "I've always thought a lot of him," Sullivan said. On the morning of April 16, Hall did not take what some experts say is one of the most crucial first steps in investigating a suspicious death. He did not go to Room 225. It's a mistake not to go to the scene of a death, said Dr. Gregory Schmunk, president of the National Association of Medical Examiners. "To not go to the scene," he said, "is just inviting potential problems. ... You're just not getting the full picture." If Hall had driven to the hotel overlooking U.S. 421 and seen for himself where Daryl and Shirley collapsed, he might have gained a better sense of the mystifying circumstances. He could have looked into the bathroom and seen a possible clue: Shirley had thrown up. Or talked with emergency responders who wondered whether something bad was in the air. "If you have two people die in the same area with no obvious signs of foul play, it screams of an environmental cause," said Timothy Rohrig, director of the nationally accredited Sedgwick County Regional Forensics Science Center in Wichita, Kan. Boone Police Capt. Andy Le Beau, a 23-year veteran of police work, including several years in Charlotte in the mid-1990s, said he wasn't surprised Hall didn't show up. Hall rarely went to death scenes, Le Beau said. Not many medical examiners in North Carolina do. System of volunteers- Unlike some states, North Carolina does not require medical examiners to go to the scene. An Observer analysis of state data shows that local medical examiners did not go to the scene in about 9 of every 10 deaths they investigated since 2001. They did not even view the body in about 1 of every 10 cases. Dr. Deborah Radisch, the state's chief medical examiner, has told the Observer it is law enforcement's job to gather evidence at the scene and the medical examiner's job to look over the body. "There is little that the ME can add at the scene, especially with current investigative technology and extensive scene photography," Radisch said in January in an email response to questions on another Observer medical examiner story. Some rural areas of North Carolina don't have all the current investigative technology – Boone didn't have gas monitors on its fire engines at the time. Radisch, who declined to be interviewed for this story, said last year that medical examiners are "basically volunteers" performing a public service for a $100 fee for each death investigation. North Carolina spends less than $1 per capita on its medical examiner system. Dr. Victor Weedn, a George Washington University professor who has studied

leading medical examiner systems often hire trained professional death investigators. Herman-Giddens noted that North Carolina medical examiners are state appointees, paid $100 per case. Some medical examiners have little or no training because the state does not require it, she said. Current chief medical examiner Radisch "is between a rock and a hard place," Herman-Giddens said. "She has no real authority over the medical examiners because you can't require training." Radisch, who replaced Butts, did not return phone calls or respond to emails seeking comment. Recommendations ignored

A 2001 Observer investigation found: • Medical examiners failed to detect at least five homicides over a five-year period.• Errors and oversights jeopardized hundreds of investigations.• As many as 4,400 apparent suicides, drownings and fire deaths were not autopsied. State policymakers responded by forming a legislative study commission to find ways to improve death investigations. An expert panel made nearly two dozen recommendations, including calls for mandatory training for medical examiners, improved death scene investigations and the creation of trained death investigators who would assist medical examiners. Officials followed up by raising medical examiners' pay to $100 from $75 per case, but not by creating the more expensive model of using full-time professionals. The agency recently moved its central office into a new $52 million facility in Raleigh it shares with the North Carolina Laboratory of Public Health. But most of the major recommendations from the study were not implemented because the state refused to spend the money, medical examiners and pathologists said. Similar statewide medical examiner systems spend about $1.76 per capita, but North Carolina allocates less than $1 per capita, they said. In an interview last year, Radisch told the Observer that she wants to bolster training, but money is a roadblock. The Chief Medical Examiner's office offers annual free one-day training. Law enforcement officers are the primary attendees; relatively few medical examiners are present. Radisch said her office does not have the money to stage a full-fledged multi-day conference and she said it would be wrong to ask medical examiners to pay to attend. About two-thirds of North Carolina's 450 medical examiners are physicians, meaning they would likely miss work to come to training, Radisch noted. "We can't require them to shut down their practices for three days," she said. "That's a lot of lost income."

Watuga dem June 2013- The regional pathologist who conducted the autopsies of three people who died from carbon monoxide in Boone Best Western room 225 has resigned, Watauga Democrat has learned. "Dr. (Brent) Hall has tendered his resignation to the chief medical examiner, and it has been accepted," said Ricky Diaz, communications director for the N.C. Department of Health and Human Services, on Friday. Diaz did not provide additional information about the circumstances of the resignation. State toxicology results listed carbon monoxide toxicity as the cause of death for Daryl and Shirley Jenkins, who died in the room and at the hospital, respectively, on April 16, and Jeffrey Williams, an 11-year-old who died in the room June 8. Documents from the Office of the Chief Medical Examiner indicate the toxicology request for Shirley Jenkins was received April 22 and the report completed June 1 -- one week before Jeffrey Williams and his mother stayed in room 225. A DHHS spokesperson said the requests for toxicology results for Shirley and Daryl Jenkins were not expedited by the state office because the request forms indicated the cause of death was believed to be an overdose. No circumstantial information was shared with the department that communicated a need to expedite the request, he said. April 17 and 18 "Request for Toxicological Analysis" documents obtained by Watauga

Democrat shows that Hall indicated the probable cause of death of Shirley and Daryl Jenkins to be "?OD?" and that he requested tests for alcohol, organic bases and carbon monoxide for both cases. The state office's documents indicate the toxicology request for Daryl Jenkins was received April 23 and the report was completed June 9. The spokesperson said toxicology tests can take time because they test for hundreds of different parameters that require different levels of review. However, the spokesperson said the "need to be expedited was known" in the toxicology request for Williams. An Office of the State Medical Examiner document indicates the report for Williams was completed June 12. "If it has to be expedited, it is expedited," the spokesperson said. The Boone Police Department announced Friday that state toxicology results confirmed carbon monoxide toxicity as the cause of Williams' death, stating the department was contacted by Hall late Thursday afternoon. The blood concentrations of carbon monoxide were greater than 60 percent for Williams and the Jenkins couple, the toxicology reports indicated. "Twenty percent saturation of hemoglobin induces symptoms (headache, fatigue, dizziness, confusion, nausea, vomiting, increased pulse and respiratory rate)," according to a Mayo Clinic website. "Sixty percent saturation is usually fatal." Carbon monoxide poisoning occurs when CO binds to hemoglobin and prevents delivery of oxygen to the tissues. Police said earlier this week that the cause of death in the Daryl and Shirley Jenkins was not believed to be suspicious in April but that the cause was listed as undetermined pending state toxicology results. Police said they repeated their request for the results on May 29 but were told the results were unavailable. Police said on June 10 that they had received the toxicology results for Daryl and Shirley Jenkins "within the last 24 hours." Boone Police Department Public Information Officer Sgt. Shane Robbins reconfirmed this statement on Friday. Investigators on Wednesday said preliminary tests pointed to the hotel's swimming pool water heater as the source of elevated carbon monoxide levels in room 225, noting several deficiencies that led to carbon monoxide entering room 225 through the gas fireplace area and through the room's heating and air conditioning unit.

Abc News June 2013-

A North Carolina county medical examiner has resigned in the wake of three carbon monoxide poisoning deaths that occurred in the same North Carolina hotel room nearly two months apart, officials said. Watauga County medical examiner Dr. Brent Hall resigned from his state-appointed post Friday. The North Carolina Medical Examiner's office learned on June 1 that carbon monoxide might have killed an elderly woman in their Boone, N.C. hotel room, but failed to alert local authorities until after a young boy died in the same room one week later, according to a toxicology report from the Office of the Chief Medical Examiner obtained by ABC News. Hotel Room Where 3 Died Had Carbon Monoxide Leak. A toxicology report dated June 1 by the Office of the State Medical Examiner showed lethal levels of carbon monoxide in the blood of Shirley Mae Jenkins, 72. She and her husband, Daryl Jenkins, 73, of Longview, Wash., were found dead at Best Western Plus Blue Ridge Plaza on April 16. Jeffrey Williams, 11, of Rock Hill, S.C., died in the same hotel room a week later. An autopsy revealed that he died of asphyxiation. Following Jeffrey's death, police tested the room for carbon monoxide and ordered toxicology tests on the boy's body and on tissue samples from the elderly couple. Hall, the Watauga County medical examiner, conducted toxicology tests on the Jenkins shortly after they died, but the results were inconclusive, officials said. He sent the case to the state Medical Examiner's office for

Dr. Hall

The Patient Safety League

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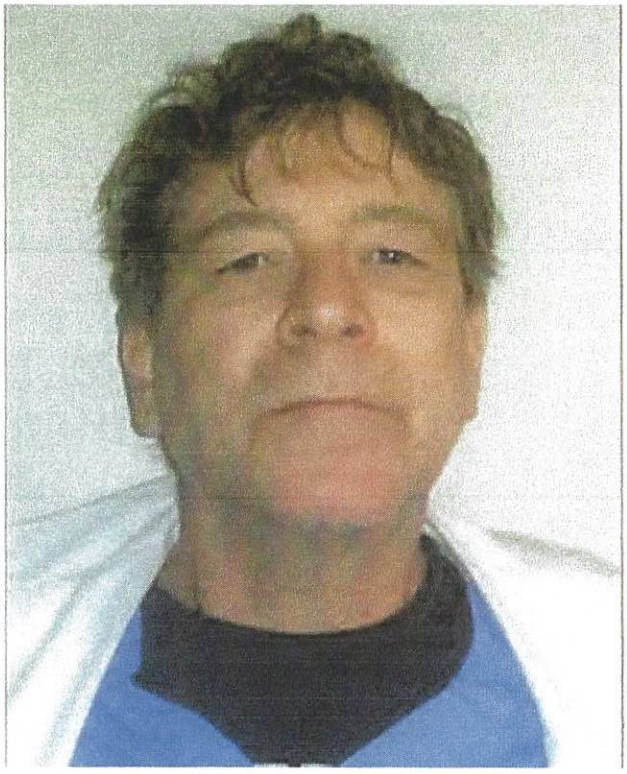
aka: Brent Dwayne Hall



Dr Brent Hall charged with DWI

NORTH CAROLINA MEDICAL BOARD RECORD— 34026
DISCIPLINARY ACTIONS—*License Active; Interim Non-Practice Agreement*

Medical Examiner Found Carbon Monoxide Danger Before Boy's Hotel Death

A North Carolina county medical examiner has resigned in the wake of three carbon monoxide poisoning deaths that occurred in the same North Carolina hotel room nearly two months apart, officials said.

Watauga County medical examiner **Dr. Brent Hall** resigned from his state-appointed post Friday. The North Carolina Medical Examiner's office learned on June 1 that carbon monoxide might have killed an elderly woman in their Boone, N.C. hotel room, but failed to alert local authorities until after a young boy died in the same room one week later, according to a toxicology report from the Office of the Chief Medical Examiner obtained by ABC News.

A toxicology report dated June 1 by the Office of the State Medical Examiner showed lethal levels of carbon monoxide in the blood of Shirley Mae Jenkins, 72. She and her husband, Daryl Jenkins, 73, of Longview, Wash., were found dead at Best Western Plus Blue Ridge Plaza on April 16.

Jeffrey Williams, 11, of Rock Hill, S.C., died in the same hotel room a week later. An autopsy revealed that he died of asphyxiation.

Following Jeffrey's death, police tested the room for carbon monoxide and ordered toxicology tests on the boy's body and on tissue samples from the elderly couple.

Hall, the Watauga County medical examiner, conducted toxicology tests on the Jenkins shortly after they died, but the results were inconclusive, officials said. He sent the case to the state Medical Examiner's office for further testing, and the state issued a report on June 1 that carbon monoxide poisoning might have killed Shirley Jenkins.

Jeffrey Williams died in the same room on June 8, and his mother was hospitalized.

It wasn't until June 10 that the Boone, N.C., police department issued a statement that said the state Medical Examiner had found lethal levels of carbon monoxide in Shirley and Daryl Jenkins' blood.

On June 14, a police statement said that Hall had determined that Jeffrey's concentration of carbon monoxide in his blood was greater than 60 percent. The boy's carbon monoxide concentration level matched that of both Shirley and Daryl Jenkins, the news release stated.

Elderly Couple and Boy Die in Same Hotel Room Months Apart North Carolina Department of Health and Human Services Secretary Aldona Wos called the three hotel deaths "a tragedy that should have never happened."

"My heartfelt condolences go out to the families and loved ones of Shirley and Daryl Jenkins, and young Jeffrey Williams," Wos said in a prepared statement. "The Department of Health and Human Services is continuing to gather the facts. I have instructed my staff to work with local officials to identify measures to ensure tragedies like this never happen again."

Boone Police Department Sgt. Shane Robbins told ABC News that he was unable to release information as a result of the ongoing criminal investigation.

While Hall has resigned from his state-appointed position, it is unclear if he is still practicing medicine. Calls to his private practice were not immediately returned.

The North Carolina Medical Examiner's office declined to comment to ABC News. (LINK)—6/17/2013

Former Watauga medical examiner's DWI case goes to court

A Superior Court judge heard pretrial evidence this week in a DWI case against **Dr. Brent Hall**,

the former medical examiner at the center of three carbon monoxide deaths in a Boone hotel.

Aside from details of Hall drinking Glenlivet Scotch in his barn around midnight one evening, the hearing provided a rare glimpse of the man whose decisions in the 2013 deaths at the Best Western have been criticized.

Hall, 54, has never spoken publicly about the deaths. This week was no exception. "Believe me, I would like to sit down and tell my side of the story," he said during a break in the DWI hearing. He said lawyers have advised him not to talk.

Hall is a tall man with a lumbering gait. He speaks softly with a mountain drawl, drawing out his vowels.

On the witness stand, he limited most of his answers to questions from attorneys to "Yes, sir" and "No, sir." But occasionally, he interjected colloquial expressions. Asked if he saw two deputies following him on the roadway the night he was arrested for DWI, Hall said, "I was as nervous as a cat. Yes, sir."

Hall resigned as medical examiner in June 2013, a week after 11-year-old Jeffrey Williams died of carbon monoxide poisoning in Room 225 at the Best Western. Two months earlier, Daryl and Shirley Jenkins of Washington state had died in the same room.

The deadly carbon monoxide was eventually traced to a swimming pool water heating system.

An Observer investigation revealed a series of errors and decisions that led to the tragedies – from the actions of maintenance workers hired by the hotel to the inaction of the medical examiner.

The state took nearly six weeks to determine that carbon monoxide killed the couple. The results were emailed to Hall on Monday, June 3. Even then, no one alerted the public. The next weekend, the poisonous gas leaked into Room 225 again, killing Jeffrey and seriously injuring his mother, Jeannie.

At the time, Hall was medical examiner for Watauga and four other counties. Like most of the state's medical examiners, he had another full-time job. He works as a private pathologist in Boone, diagnosing disease and performing autopsies.

A 5-year-old case

Hall's arrest for DWI took place three years before the deaths at the Best Western.

Defense attorneys contend that the deputies worked together to "set up" Hall for arrest. Judge

Gary Gavenus indicated that he would rule later this week on the motion to dismiss the charge.

Court documents show that Hall's blood alcohol level was 0.19 – more than twice the legal limit. That fact was not part of the evidence in the pretrial hearing. Hall said he has not drunk alcohol in more than four years.

Hall was pulled over in rural Watauga County at 1:28 a.m. on Jan. 28, 2010, a Thursday morning. He was convicted in District Court in 2011 and appealed to Superior Court, where the case was postponed 20 times before being called for motions Monday.

In the past, it was former prosecutors who did not want the case resolved, according to attorney Robert Speed, who represented Hall in District Court. If Hall was convicted in Superior Court, Speed said prosecutors worried that defense attorneys would make sure that fact was known to jurors in criminal cases where Hall testified as medical examiner. Prosecutors worried, Speed said, that jurors would discount Hall's testimony because of a DWI conviction.

But when newly-elected District Attorney Seth Banks attempted to have the case heard earlier this year, it was Speed who fought for a continuance. Then on Monday, defense attorney Jay Vannoy asked that the charge be dismissed. He argued that Hall's arrest amounted to an illegal seizure.

Watauga County Sheriff's Deputy Aaron Billings testified that he was preparing to stake out a narcotics suspect when he spotted a white Toyota 4Runner outside a barn in rural Watauga County and saw a man pacing in front of the headlights. He said he thought it might be a break-in and stopped to investigate.

The man identified himself as Hall and said he owned the property. Billings testified that Hall had bloodshot eyes, slurred speech and appeared intoxicated. He said he told Hall not to drive on public roads.

Billings and another deputy testified that later that evening Hall drove by while they were staking out the narcotics suspect. They said Hall was speeding, crossed the center line several times and crossed over the fog line twice. When he was pulled over, they said, Hall slurred his speech, had bloodshot eyes and stumbled when he walked. He failed field sobriety tests, they said. (LINK)—4/07/2015

Former Watauga Co. medical examiner charged with DWI, bribing officer

WATAUGA COUNTY, N.C. – A former Watauga County medical examiner was arrested after police said he was driving drunk Sunday in Boone.

Authorities said a Boone police officer encountered an SUV sitting stationary at the intersection of King Street and Highway 105 Extension. The officer said the driver, identified as **Dr. Brent Hall**, appeared to be intoxicated, and also had a loaded handgun and an open bottle of tequila inside his SUV.

According to police, Hall wouldn't get out of his vehicle and offered to pay them money to let him out of the DWI charge.

"He didn't obey the officer's commands and then there was a brief struggle during that process of getting him out of the car," Boone Police Lt. Chris Hatton said.

"And at one time, he offered a bribe?" reporter Dave Faherty asked.

"He is charged with offering a bribe and he did at some point offer a bribe to the officer," Hatton answered.

Hall faces several other charges, including driving while impaired and carrying a firearm after consuming an impairing substance.

Channel 9 tried to reach Hall at Pathology Associates of Boone, which has a picture of Hall on its website. Police were called to have Channel 9 removed from the property.

Hall resigned as medical examiner in Watauga County in 2013 after the deaths of Daryl and Shirley Jenkins and 11-year-old Jeffrey Williams. All three died at the Best Western in Boone within a six-week period.

State officials said they sent the results of the Jenkins' toxicology to Hall, showing they died from carbon monoxide, a week before Jeffrey and his mother checked in to the motel and were overcome by fumes. Police said they didn't receive that crucial information until two days after Jeffrey died.

The police chief told Channel 9 at the time that officials would have been able to find the source of the carbon monoxide in the Best Western motel room before Jeffrey and his mother checked into it.

Channel 9 checked with the state medical board and Hall is still licensed and working at the Watauga Medical Center. (LINK)—2/13/2018

Ex-medical examiner who handled Best Western autopsies facing charges

A Boone physician and former medical examiner for five Northwest North Carolina counties has agreed to temporarily stop practicing medicine under an agreement with the N.C. Medical Board.

The agreement signed by **Dr. Brent Dwayne Hall**, 56, went into effect Feb. 21. He is not permitted to practice medicine until the medical board president gives permission.

Hall was the medical examiner who oversaw autopsies for three people who died from carbon monoxide poisoning at a Boone Best Western hotel in 2013. His investigations have drawn criticism, including from state health officials for lacking key historic information in the toxicology reports.

Hall, of Meat Camp Baptist Church Road, was arrested Feb. 11 by Boone police after his 2015 Toyota Land Cruiser was found stopped in the intersection of U.S. 421 and N.C. 105 at 7:51 p.m. Watauga sheriff's deputies assisted in the arrest.

Hall faces five charges: misdemeanor driving while impaired, resisting arrest, misdemeanor possession of an open container of alcohol in a vehicle, misdemeanor carrying a firearm after consuming an impairing substance, and felonious offering bribes to Boone police officers.

Hall reportedly offered money to the arresting officer in exchange for having the charges dropped, according to Boone Police Sgt. Shane Robbins.

Hall reported the arrest to the board Feb. 12. He is set for a March 16 appearance in Watauga District Court. He was released on a $25,000 bond.

In the agreement, Hall acknowledged his alcohol dependence and unprofessional conduct. The board said that if Hall fails to comply with the agreement, his license could be suspended or revoked.

Hall received his medical license in May 1991. He has practiced pathology and immunopathology in Boone.

The agreement with the medical board lists Hall as having been arrested and convicted of driving while impaired in January 2010. He appealed the conviction, which was dismissed in April 2015.

In June 2011, the board ordered that Hall have a physical examination by the N.C. Physicians

Health Program, which diagnosed him with alcohol dependence. He agreed at that time to a non-practice agreement that lasted from Aug. 5, 2011, to Jan. 15, 2012.

The board sent Hall a formal warning in December 2011 in which it said "repeated arrests for such (DWI) conduct could form the basis for the board charging you with unprofessional conduct or the inability to practice medical acts safely."

Hall served as medical examiner for Ashe, Avery, Mitchell, Watauga and Yancey counties until resigning in 2013.

In June 2013, 11-year-old Jeffrey Williams and his mother, Jeannie Williams, of Rock Hill, S.C., stopped for a night in Boone and stayed at the Boone Best Western. Jeffrey died from carbon monoxide leaking from a swimming pool heating system, while Jeannie suffered serious injuries.

Six weeks earlier, Daryl and Shirley Jenkins of Washington state had died in the same room, but officials did not immediately identify carbon monoxide as their cause of death.

Both families filed wrongful death lawsuits, seeking damages from Best Western International; the hotel's owners and its former manager, Damon Mallatere; as well as from companies and individuals who worked on the swimming pool heating system where the deadly gas originated.

In January, The Charlotte Observer reported the Williams family agreed to settle wrongful death and injury suits against the hotel chain and other parties for $12 million.

An Observer investigation into the deaths uncovered a series of errors and decisions by many different people, including hotel management, town employees and Hall.

The investigation found no indication that officials in Boone or anyone in the state's medical-examiner system acted with urgency to understand what happened following the Jenkinses' deaths.

As it involved Hall, he failed to list in the pertinent history section that the Jenkinses died in the hotel room with no sign of foul play.

In 2014, the N.C. General Assembly adopted a law aimed at preventing such tragedies. That law requires hotels and other lodging establishments to install carbon monoxide alarms near fossil-fuel-burning heaters, appliances and fireplaces.

A subsequent Observer investigation found that state medical examiners routinely skipped basic steps when investigating suspicious deaths — a problem that can cause widows to be

cheated out of insurance money and allow killers to go free.

State lawmakers responded by doubling pay for the state's medical examiners and, for the first time, setting aside money for mandatory training. (LINK)—3/01/2018

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Transcript of Interview of Dr. Jerri McLemore

STATE OF NORTH CAROLINA

COUNTY OF YANCEY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION

STATE OF NORTH CAROLINA	)	
	)	
	)	FILE No. 11 CRS 304
Vs.	)	11 CRS 305
	)	
JOHN PRITCHARD,	)	
	)	
Defendant	)	
	)	

INTERVIEW OF JERRI MCLEMORE, M.D.

TUESDAY, JULY 27, 2021

APPEARANCES:

JULIE BRIDENSTINE, STAFF ATTORNEY

Julie Bridenstine, Staff Attorney
North Carolina innocence Inquiry Commission
Post Office Box 2248
Raleigh, North Carolina 27602

Also Present:

Beth Tanner, Associate Director

_____

BRIDENSTINE: Hello. This is Julie.

TANNER: Julie. I think I have her on hold. Let me see if I can merge y'all.

BRIDENSTINE: Okay.

TANNER: Julie and Dr. McLemore, can you guys hear me?

BRIDENSTINE: Yes.

MCLEMORE: Yes.

TANNER: Awesome. Okay. I'm gonna let Julie get started.

BRIDENSTINE: Hi. Dr. McLemore, how are you doing?

MCLEMORE: Hello.

BRIDENSTINE: Hi. I had quite a few questions to go through with you, but I first want to let you know that we are recording the call just we know what everybody says, and we are as accurate as we can be. Some of these terms are very confusing for me in particular.

MCLEMORE: Okay.

BRIDENSTINE: Okay. First, can you just briefly describe what it means to be a forensic pathologist? You hear that term a lot, but does that mean you have to be board certified in something?

MCLEMORE: So, to be a forensic pathologist preferably you're going to graduate from an accredited ACGME medical school and residency and finish or complete a fellowship in the field of forensic pathology. And then, preferably, you will pass a standardized test by the American Board of Pathology that is specifically for forensic pathology.

BRIDENSTINE: Okay.

MCLEMORE: So, there's your certification. Now, can you do forensic pathology work without being -- without doing a fellowship in forensic pathology and without being board certified? Unfortunately, in a lot of states you can.

BRIDENSTINE: Is that something you can do in North Carolina?

MCLEMORE: Actually, yes. We have general pathologists who are not forensic pathologists, and we have forensic pathologists who are not board certified performing some of these autopsies in the state.

BRIDENSTINE: Okay. Do you know what Dr. Hall is or was at the time of this case?

MCLEMORE: He was -- he had completed a fellowship, I believe in forensic pathology, but I do not -- but he is not board certified.

BRIDENSTINE: Okay. All right. We provide a lot of material to you through email and obviously I dropped off the slides to you. Did you review everything that we provided?

MCLEMORE: Yes, I did.

BRIDENSTINE: And, first, what are you findings in this case?

MCLEMORE: I can tell you for the microscopic -- looking at the microscopic slides the pneumonia that is -- that this person has is consistent with an aspiration pneumonia meaning that he swallowed and -- vomit and basically bacteria from the mouth that went into his lungs. So, the bronchopneumonia is actually more specific. It's -- it's -- it's a -- it's a type of pneumonia that I would deem -- it has all the features of aspiration pneumonia. So, that is not sepsis from like say an ulcer that he might have had somewhere else on his body. This is -- this is backwash from

the mouth going into the lungs.

BRIDENSTINE: Okay. What -- is that the cause of death?

MCLEMORE: So, the cause of death is actually -- yeah. He's got a -- he's got a pretty florid aspiration pneumonia going on there. Now, the causes of aspiration pneumonia can be a number of things like mental alteration from any etiology.

BRIDENSTINE: Wait. Sorry. What is that?

MCLEMORE: Mental alt -- mental alteration. You know, you can -- you can have an altered mental status for a large number of reasons. Unfortunately, one of -- one of the reasons is drug intoxication. Drug intoxication and hasp -- and aspiration pneumonia actually go, very frequently, hand in hand.

BRIDENSTINE: Okay. What other types of mental alterations can lead to aspiration pneumonia?

MCLEMORE: So dementias of -- so, chronic -- chronic diseases like chronic nervous systems diseases of the -- or chronic diseases of the brain. So, things like dementia can cause aspiration pneumonias. People in coma, they have to protect the airways because you can get aspiration pneumonia if you're not careful. So, those kind of things where you're not protecting your airway, right?

TANNER: So, Dr. McLemore, I'm sorry. I'm gonna touch in really quick. So, when you say this is aspiration pneumonia, I just want to be clear. That is your opinion as to his actual cause of death?

MCLEMORE: No. I would cert -- I would have certified his cause of death as one of -- a variety of ways, actually. I would have -- I

could have said aspiration pneumonia due to obtundation due to morphine or heroine toxicity or morphine toxicity or whatever narcotic toxicity. It could be -- I -- it could be one line, complications of a drug toxicity.

TANNER: So --

BRIDENSTINE: Well, what would you have said then in this case?

MCLEMORE: What's that?

BRIDENSTINE: So, what would you have written in this case?

MCLEMORE: I probably would have said aspiration pneumonia due to morphine tox -- morphine intoxication.

TANNER: So, I just want to make sure I'm understanding. What gets you to the opinion that the aspiration pneumonia was due to morphine toxicity?

MCLEMORE: Because it doesn't look like there's any other reasons for him to aspirate.

TANNER: Okay.

MCLEMORE: He didn't -- he did have dementia as far as we know. He had nothing mechanical wrong with his esophagus or anything like that that would preclude that. Now, the fact of the circumstances that he was, by witness accounts, using narco -- using a narcotic or an opioid or an opiate, you know, also plays into this. And the fact that, yes, even though it's only a trace amount, it's there.

TANNER: Okay. And then I have another question and I -- I'm sorry, Julie, you may have these as well. In a case where there is aspiration pneumonia like you have identified here, at what point would the

vomiting have to have occurred in order for the aspiration pneumonia to be the reason he actually died?

MCLEMORE: At what point?

TANNER: Yeah. Like, did he need to vomit 20 minutes before he died? Did he need to vomit that afternoon? Did he need to vomit two minutes before he died?

MCLEMORE: So, at some point when he -- when he was unresponsive, whether he's sleeping or whether he took another dose, and he basically could not protect his airway and vomited or aspirated, that's the point. Can I tell you when that happened during that interval? No, but it was long enough that -- and when you're doing this, you know, you're developing the pneumonia, you're still metabolizing what's in your bloodstream.

TANNER: Got it.

BRIDENSTINE: So --

TANNER: So, I'm just unclear. So, he would -- how long could he have had the aspiration pneumonia before he actually died? It sounds like what you're saying to me is like you vomit, you aspirate the pneumonia, and boom you die. Like all within a few minutes. Or is it --

MCLEMORE: No. I mean it takes a while to -- it takes a while to develop that mu -- I mean he had pretty de -- it was florid. It was well established. Now, how long does that take? Well, good question, but rip-roaring pneumonia like that can occur -- start occurring pretty quickly, but it still takes some time, you know. A couple of hours. That's probably as good as I can get.

TANNER: Does it ever take more than a couple of hours to develop aspiration pneumonia that would kill you?

MCLEMORE: It depends on the person's immune system. It depends on whether they're getting treatment, medical treatment, you know, getting thrown antibiotics. Left unchecked, I mean, it -- it can develop in just a few hours.

TANNER: Okay. Yeah. So, I mean, my question would then be, could he have vomited the day before and --

MCLEMORE: No.

TANNER: -- developed this -- okay.

MCLEMORE: That's a little too long.

TANNER: Okay. That's too long. Okay. So, it would have had to have been within the -- the day -- I mean I guess he died -- theoretically, he was found dead the next day, but it would have had to have happened --

MCLEMORE: Same day.

TANNER: Uh-huh. So, it would have had to have happened sometime -- would you say that evening while -- that evening? So, he was found -- and I'm sorry, Julie, I don't have the dates in front of me. I think he was found like 10:30 in the morning.

MCLEMORE: Yeah. I would say -- I would say during the time he was asleep.

TANNER: In the evening? Like overnight?

MCLEMORE: Or overnight. It could -- it could have happened in the early morning.

BRIDENSTINE: So, Dr. McLemore, a question I have is that would you have seen evidence he is vomiting and, you know, suffering like that in places other than the slides? Like, for instance, would he have vomit on his mouth or would you see it in his, I don't know, in his throat? Like during the autopsy, would you see evidence that someone was swallowing their own vomit and aspirating into the lungs?

MCLEMORE: You could. It depends on -- it depends on what was in his stomach. If it is just -- if he -- if he's basically processed the food stuffs in his stomach and it's just gastric juice, I mean, it may just be, you know, fluid that can easily be wiped off or inadvertently when the bo -- when moving the body into the body bag and you might not see that. Oftentimes we do see vomit. I mean it's all over the face or it's down the -- the -- the esophagus and windpipe, but sometimes we don't and then there's aspiration pneumonia.

BRIDENSTINE: Okay. So, what specifically did you see that made you determine that it was aspiration?

MCLEMORE: So, in the lungs there are huge colonies of bacteria, and the bacteria are basically they look -- they're round. We call them cocci, and they're also in kind of fourchettes if you look at them really closely. So, this is typical for species of bacteria in the mouth. Now, there's no culture that was done, you know, and typically we don't do cultures. So, you know, it would be probably a mixed, you know, oral flora if it -- if -- if they -- if cultures were done. But there are huge colonies sprinkled, you know, around the bron -- the airways, the bronchioles, and the bronchi where the major inflammation is. And that -- like I said, that is

typical -- a typical appearance for aspiration pneumonia.

BRIDENSTINE: Could it be indicative of something other than aspiration pneumonia?

MCLEMORE: I don't know what. Even a sepsis, if you have that much overgrowth of your bacteria, you should be seeing it in vessels in other organs like the liver and the kidney if it is that overwhelming as far as if it is from sepsis.

BRIDENSTINE: And did --

MCLEMORE: I didn't. There's --

BRIDENSTINE: Did you -- did --

MCLEMORE: -- the other organs are clean.

BRIDENSTINE: Okay. So, out of the slides that you looked at -- well, first of all, which slides did you look at? Can --

MCLEMORE: All of them.

BRIDENSTINE: And what parts of the body were those taken from?

MCLEMORE: So, they were from the lungs. There was -- there was quite a few slides of the heart muscle. There were -- let me pull this up. There was a section of brain tissue from the hippocampus. There is a section of liver, section of kidney, section of spleen. There were one, two, three -- it looks like three sections from lungs, which had -- some had multiple sections on them. And then there were six sections of heart muscle.

BRIDENSTINE: Okay. So, you said heart, brain, liver, kidney, spleen, and lungs?

MCLEMORE: Yeah. Mm-hmm.

BRIDENSTINE: Okay. Wh -- did you notice any issues in anything other than the lungs?

MCLEMORE: Actually, no, I didn't. Let me look real quickly but the brain was fine. The -- the section of liver had some very small, scattered fat -- fat droplets within some of the liver cells. There was also some sparsely scattered chronic inflammation within some of the portal triads, which is pretty nonspecific. Kidney, there was early autolysis or postmortem breakdown of some of the -- of the tubules, but there was nothing else going on with any of the other structures within the kidney. The spleen basically looked fine. Oh, and the other thing about the spleen, if this guy is -- is fighting a rip-roaring sep -- is septic, you might see, if his immune system is intact, you might see his white pulp or the lymphocytes the -- the cells that help fight off infection kind of kick into high gear and there might be formation of reactive germinal centers, which none were present in the spleen section. The lung stuff -- the lung had the sec -- had the stuff that I -- I mentioned and then the heart muscle itself, or all the sections that were taken actually, there wasn't anything of significance in the -- in the muscle -- in the heart muscle sections.

BRIDENSTINE: Now, if somebody was septic, would you expect to see similar to what you saw in the lung sections that made you think that it was aspiration bronchial pneumonia?

MCLEMORE: If someone were -- if -- if someone had pneumonia because of sepsis from another site, I actually see -- expect to see just inflammation. I wouldn't expect to see the huge colonies of bacteria unless the person was so immunosuppressed, they couldn't fight it

off and the bacteria were left to proliferate unchecked. If that were the case, I would expect to see bacterial colonies then in the vessels of the liver, the vessels of the spleen.

BRIDENSTINE: Okay.

TANNER: Doctor -- Dr. McLemore, I'm sorry, I just have a couple of questions I want to follow up on. How many cases where aspiration pneumonia is the cause of the death is there no evidence of vomit seen?

MCLEMORE: How many cases?

TANNER: Yeah.

MCLEMORE: I have no -- I -- I don't think I could answer that question. I'm not sure.

TANNER: In your experience, how many times has a patient died or, I'm sorry, anyone, I guess. I -- I don't know that I'd call them patients for you, but you can correct me. How many times have you examined a case where someone died, the cause of death was aspiration pneumonia, and there was no evidence of vomit?

MCLEMORE: That -- that or residual vomit.

TANNER: Sure.

MCLEMORE: And I would probably say 50/50.

TANNER: Okay. Because I want to make sure because I think before what I understood you to stay is that usually you would see that evidence, not always.

MCLEMORE: I mean -- not always, yeah. I mean it's about 50/50 because sometimes if there's nothing in the stomach, it's just gastric

juice.

TANNER: So -- okay. So, you would say, in your experience, 50% of the time someone expires from aspiration pneumonia, there's no evidence of residual vomit?

MCLEMORE: Yeah. I -- yeah. And that -- that's just a ballpark guess because getting -- first of all, getting to this degree of florid aspiration, I mean this is -- this -- this cooked for a while. Getting to this degree there could be continual clearance as best as possible. So, it's not the vomit just sits there.

TANNER: Okay. And when you say --

MCLEMORE: So, if you vomit and die -- if you vomit and die pretty quickly, it sits there.

TANNER: I get it. So, when you say it cooked for a while, do you have any idea how long that is?

MCLEMORE: That's why -- that's what I said, it -- it's -- it's at least a couple of hours and that's probably as best as I can get it.

TANNER: Got it. Now, how would alcohol impact someone who's -- who's -- I mean could that cause someone to vomit --

MCLEMORE: If the -- if --

TANNER: -- like that?

MCLEMORE: -- if the alcohol is a true, indicative value of ingestion of exogenous alcohol, then, you know, any amount of alcohol is not gonna help the -- because that's a depressant too.

TANNER: Okay. Explain what you mean by that. So this victim had alcohol present in his system. It looked like --

MCLEMORE: Yes. No. No.

TANNER: -- what was about (inaudible) --

MCLEMORE: I wouldn't say that. I wouldn't even go that far. Alcohol was detected in the sample.

TANNER: Okay.

MCLEMORE: Now --

TANNER: So, what would be the difference in that?

MCLEMORE: -- is that a true indicative result from alcohol -- from him ingesting alcohol? I'm not sure. I don't know. I -- I will tell you what I told -- so what Dr. Hudson doesn't know, since he was not here during that time -- when I first came here the regional offices and anyone -- some of the offices that were doing cases for the state were mailing their tox specimens through USPS. There was no -- there was no control over the conditions that those samples were being transporting in. This is why we actually now send ours through FedEx and with tracking and -- and trying -- trying to minimize samples being stored in harsh environments.

TANNER: So, it could have created alcohol in the mailing is what you're saying?

MCLEMORE: Blood is -- blood that -- that starts to decompose and -- and ever liver tissue that starts to decompose, yes, it -- it will start producing alcohol and -- and you cannot tell the difference between alcohol and that you drink and alcohol that you make.

BRIDENSTINE: So --

TANNER: So, it is possible that he -- that the mailing created alcohol in the blood, but it is also possible that he ingested

alcohol and that created alcohol in the blood?

MCLEMORE: Right.

BRIDENSTINE: Is that point --

TANNER: If he had --

MCLEMORE: There's no way -- there's no way to tell because this level is low and that's the level that we typically see -- that range that we typically see when it's fermenting -- when the tissue is fermenting.

TANNER: Okay. And I'm sorry, I just want to ask if he had ingested alcohol and he was suffering from this -- or at some point vomited or -- and had nothing in his stomach and had these hours of aspiration pneumonia, could alcohol be a contributor to why you don't get rid of your vomit the normal way so that you don't --

MCLEMORE: Yes.

TANNER: -- could it be a reason -- it could?

MCLEMORE: Yes.

TANNER: And if alcohol was the reason for that, if he then took several hours to develop this aspiration pneumonia, is it possible his body would have continued to get rid of the alcohol so that the readings would be different?

MCLEMORE: Yes.

TANNER: Okay. So, it basically works the same way as the drug, right?

MCLEMORE: Yes.

TANNER: So, that could be the cause of him not vomiting

appropriately --

MCLEMORE: Well --

TANNER: -- he aspirates into his lungs --

MCLEMORE: -- not clearing his vomit appropriately. Let's just say --

TANNER: Not -- right. Not clearing his vomit appropriately. He aspirates that in his lungs and that -- that grows for a little while and that's ultimately his cause of death. Is that -- am I understanding it correctly? Because I'm not a scientist for sure.

MCLEMORE: No, I mean -- yeah. If -- if that -- if that alcohol is -- is from ingested alcohol, yes.

TANNER: Do you have any way of knowing whether it was the alcohol or the drugs that caused him to not be able to get rid of his vomit such that he would aspirate?

MCLEMORE: Again, this is based on what witnesses say. No one saw him drink anything. They say him do -- they saw him take the -- the opiates. So, you know, in that case that raises the concern that that alcohol result is artificial.

TANNER: So, like --

MCLEMORE: Do we have a way of knowing that absolutely? No I don't.

TANNER: Okay. And -- and I'm sorry. Also witnesses -- help me understand a little bit because I think there was some discussion of him snoring. How can that -- or does it matter in your opinion and how?

MCLEMORE: Oh, yeah. That's a bad sign.

TANNER: Okay.

MCLEMORE: If you take drugs or you drink a lot of alcohol, if you're snoring that's a bad sign. You're not protecting your airway.

TANNER: So, the snoring just means you're not protecting your airway. Does it have anything to do with whether you're aspirating at that moment or not, or does it just mean --

MCLEMORE: No.

TANNER: -- you're not protecting your airway?

MCLEMORE: I mean you could be or not. You could be or not. I mean that -- the snoring is just -- is -- is basically a sign you're just not protecting your airway.

TANNER: Okay. If he's snoring, he's alive presumably.

MCLEMORE: If he's snoring, he's alive. Yep.

TANNER: Okay. Okay. And Julie, I'm sorry. I don't know the time, and maybe you can help me with this. The last time someone saw him doing drugs. Do you know what that time might be?

BRIDENSTINE: Probably between 9:00 and 10:00 p.m.

TANNER: Okay. Does that make a difference for you, Dr. McLemore, in your opinion? I know you reviewed some of these witness statements.

MCLEMORE: Yeah. No, not really.

BRIDENSTINE: What do you mean by not really?

MCLEMORE: Well, I mean, yeah, he took -- if someone saw him take drugs at that time, he could have taken some more when no one was

around. I mean it -- it -- that's hard to -- that's hard to -- that's hard to -- yeah, that's -- that's, you know, a possibility. He could have fallen asleep right after that and it was enough to, you know, to get him obtunded where he couldn't protect his airway and then this all started developing overnight. So, yeah, I mean -- yeah.

BRIDENSTINE: So, are you saying that the -- the morphine causes somebody to basically vomit and then that gets into the lungs and you call that aspiration? Is that right?

MCLEMORE: So, the morphine is a depressant. It's a respiratory depressant. It's a CNS depressant and, yeah, one of the problems is you -- you -- if you -- especially -- and let's say you have reflux, you know, usually you protect your airway because your body is not suppressed. If you're drinking a lot or you -- you take drugs and are obtunded, that mechanism gets shut down. It -- it no longer works.

BRIDENSTINE: So how long after someone takes morphine would you expect them to start basically aspirating? How much time passes?

MCLEMORE: And it depends. There is no specific time. I mean somebody could fall asleep immediately after taking morphine and then -- uh -- uh -- you know they're -- they're -- they can't protect their airway and at any point they can aspirate.

BRIDENSTINE: So you -- you're saying you can take -- you can take some about of morphine, fall asleep and then even like 10 year -- 10 hours later start aspirating?

MCLEMORE: Probably not. I mean probably it -- it's gonna be, again, within a couple of hours where you have this, and then you have a

smoldering aspiration pneumonia.

BRIDENSTINE: And when you talk --

MCLEMORE: Like I said this is --

BRIDENSTINE: Oh, go ahead.

MCLEMORE: -- none of this is -- this isn't immediate and so if you're asking me did it happen at 2 or 3 o'clock, there's no way I'm gonna be able to tell you that.

BRIDENSTINE: Okay. Looking at Dr. Hall's cause of death and how he listed it, are you in agreement with Dr. Hall?

MCLEMORE: Well, unfortunately, I -- I -- am in agreement that the opiate use, you know, had a -- had a hand in his death with the aspiration going on. I would not have -- I would not have worded the cause of death like he did.

BRIDENSTINE: And why is that?

MCLEMORE: Because it's not acute. It really isn't. And I -- I read Dr. Robert's affidavit and -- and I -- I do -- I don't agree with her -- with her saying that this is sepsis leading to pneumonia. I -- but I do agree that this would be, again, not an a -- not a death from an acute toxicity, but it's a complication of taking the drug. So, there's a little bit of chronicity to this. You know, it -- it's not immediate.

BRIDENSTINE: Okay. So, on -- when he lists cause of death as morphine toxicity, you would list it as you know what you stated before, which --

MCLEMORE: I -- yeah. I would -- I would li -- it would be a longer worded. I would -- I would basically say aspir -- the cause of

death is the aspiration pneumonia due to, I -- and I would -- I'd probably throw in obtundation due to -- and that just means, you know, mental altern -- alteration, you know. So, obtundation due to the morphine intoxication.

BRIDENSTINE: So, his final anatomic diagnosis, he lists some things. I'm just gonna go one by one and ask you about those. Where he says pulmonary edema and congestion, severe, do you agree with that finding?

MCLEMORE: So, I don't agree with the way he does his diagnosis list. Pulmonary edema, to me, in my -- in my opinion is not a diagnosis. It's a sign, but it's not a diagnosis.

BRIDENSTINE: And what's it a sign of?

MCLEMORE: It's a sign of fluid backup for -- for whatever reason in the lungs and there's a ton of reasons that can happen.

BRIDENSTINE: Now, would -- would that -- could it be something other than the aspiration bronchial pneumonia that was going on?

MCLEMORE: Well, histologically, he had aspiration pneumonia and that causes edema.

BRIDENSTINE: And, so, you just talked about this, but where he says acute bronchial pneumonia, moderate, do you agree with that?

MCLEMORE: So, I probably would have classified it an aspiration pneumonia.

BRIDENSTINE: And where he says pulmonary emphysema, mild, do you agree with that?

MCLEMORE: So, that's interesting, I -- I'm not sure where he got the diagnosis of emphysema. Histologically, I didn't see any signs that would lead me to emphysema.

BRIDENSTINE: Now one thing I noticed is that you're basically reviewing, you know, the paper documents and the slide, but Dr. Hall was also doing an internal examination. Is -- is that right?

MCLEMORE: Mm-hmm. Yep.

BRIDENSTINE: And, so, what are the limitations for you, the fact that you weren't present during the autopsy when it was performed?

MCLEMORE: Well, there could have been something that he saw that of course I don't see, right? There could have been something he missed that, you know, I don't know whether he did or not. So, let's -- so -- yeah. I mean, he could have seen vomit in the airways and just didn't note it. I don't know. So, yeah, there's some -- there's somethings, of -- of course, that the -- that he might have seen that I don't -- I w -- I don't have privy to.

BRIDENSTINE: Okay. So is that pulmonary emphysema, mild, is that an example of something he might have seen during the internal examination that you can't see now because you were not there?

MCLEMORE: Well, possibly, if he didn't take his sections in the areas he thought he saw emphysema, but still histologically, I'm not seeing any evidence of emphysema.

BRIDENSTINE: All right. And then the last thing he noted was cardio -- and I'm not gonna say this right. Cardiomegaly?

MCLEMORE: Cardiomegaly?

BRIDENSTINE: Yes. Mild with left ventricular hypertrophy. What is that?

MCLEMORE: Okay. So, I'm gonna -- and -- and that

probably explains why he took six sections, but I am going to -- I'm going to bring up his report and see that because I need to look at this guy's size. So his -- this is a -- this is a tall guy. Tall, thin guy, right?

BRIDENSTINE: Mm-hmm.

MCLEMORE: He's 71 inches and he's 150 pounds. So he's tall and thin, and his heart weight is 420 grams. That is not that heavy for his height. That's, you know, when we -- we look around 400, you know, going over 400 grams, okay maybe, but it depends on your height and weight. Even though he's thin, he -- he's 71 inches. So, that 420 grams, I -- that's -- that's -- that's -- I would say that's still within the normal range. Now, he says mild concentric left hyper -- ventricular hypertrophy, but he doesn't give any measurements of the walls. So, I can't assess that, but I have a feeling there is, you know, for men, especially young men, they can have physiologic left ventricular. It looks enlarged. It's looks thickened, but it's normal. It's normal physiologic state. So, with the heart weight that I'm not overtly or -- or not extremely impressed about and would argue that it's still within the normal range for his height. There's not much I can say about it.

BRIDENSTINE: Is there anything there that he noted with the heart, and that you saw on the slides, that would lead you think anything was wrong with Mr. Whitson's heart that led to his death?

MCLEMORE: No.

BRIDENSTINE: And if you look also on the internal examination on the respiratory tract, lungs, he wrote that sectioning demonstrates marked edema and congestion, mild emphysematous change is --

MCLEMORE: Em -- emphysematous.

BRIDENSTINE: Emphy -- okay.

MCLEMORE: That's where he's getting the emphysema.

BRIDENSTINE: Okay. So, is that --

MCLEMORE: And who knows. He could have seen little blebs on the pleura or something like that. I don't know.

BRIDENSTINE: He also notes that the lower trachea and major bronchi are unremarkable. Is that something that you would expect to see in aspiration/bronchopneumonia? That those things are -- are -- nothing special is noted about them?

MCLEMORE: Yeah, you could. Again, there's so much fluid coming up from the lungs who knows what's been flushed up or down.

BRIDENSTINE: In aspiration/bronchopneumonia, does it usually affect the lower trachea and major bronchi of the lungs?

MCLEMORE: Like I said, if there's a lot of fluid in the lungs, and it sounds like there was, and by the weights of the lungs, they were heavy. You can have a lot of -- you can have fluid kind of pouring backwash into the -- into the airways.

BRIDENSTINE: Okay. So, do you make anything of the fact that Dr. Hall said that those two things were unremarkable?

MCLEMORE: Not really.

BRIDENSTINE: Do you think morphine proximately caused death in this case?

MCLEMORE: So, what do you mean by proximately? I --

BRIDENSTINE: So --

MCLEMORE: -- think that's the crux here.

BRIDENSTINE: -- in North Carolina, morphine does not have to be the immediate cause of death. You just only need to show that the drug ingested caused or directly contributed to the death.

MCLEMORE: So, that -- okay. I'm not sure how I can answer that. Did I -- did I -- do I think that the drug use contributed to death? Yes, I do.

BRIDENSTINE: Now, do you think that if you had taken the morphine out completely, if he had never ingested it, that he would have not died?

MCLEMORE: Let's see. I would have no other reason for him to be dead.

BRIDENSTINE: So, Dr. Hall testified that, but for the morphine in Mr. Whitson's system, there is no other explanation for why he would have died. That's basically what he testified to. Do you agree with that?

MCLEMORE: I -- I would prob -- I would agr -- I would agree with that. Yeah. I mean I don't have any other thing in any of the or -- other organs --

BRIDENSTINE: So --

MCLEMORE: -- that would explain why this guy all of a sudden developed the florid aspiration pneumonia.

BRIDENSTINE: Um --

TANNER: And I'm sorry, Dr. McLemore, I'm gonna let Julie tell you again because I -- I understand the difference. There's like

a legal definition of the, you know, cause of death, and then there's, of course, the scientific definition of the cause of death. And I think -- I think we probably understand though we may have some follow-up questions about this scientific piece, but I am curious and want to really understand if you would have been comfortable opining based on the legal definition, as to whether the morphine would have caused the death? So, Julie, do you mind reading that back and then my question would be, would you be comfortable or would you testify, would your opinion be, that the morphine was the cause of death as to the legal piece?

BRIDENSTINE: So proximate cause means it does not have to be the immediate cause of death. You only need to show that the drug caused or directly contributed to the victim's death.

MCLEMORE: Yeah. And -- and that would be a yes. I mean that's why it's in my cause of death statement.

TANNER: Okay.

BRIDENSTINE: The medical records that we provided for Mr. Whitson where he was at the hospital, you know, a couple m -- basically a couple months before he died. Did you take a look at that?

MCLEMORE: Yes.

BRIDENSTINE: All right. And I just noted that from his medical records, he had a diagnosis of left arm cellulitis with superficial vein thrombosis following a street injection into the left antecubital fossa.

MCLEMORE: Uh-huh.

BRIDENSTINE: What does that mean?

MCLEMORE: Probably used dirty needles to inject and it

got infected.

BRIDENSTINE: So, is that an abscess?

MCLEMORE: It could be. It -- it's -- the -- it sounds like -- like I said, they used the word cellulitis than abscess, but cellulitis can evolve into an abscess.

BRIDENSTINE: All right. So, that just basically means infection. Is that right?

MCLEMORE: Uh-huh. Uh-huh. Yep.

BRIDENSTINE: Okay. And the discharge notes also said that a CT performed suggested a probable small, subcutaneous abscess in antecubital region with an associated cellulitis and venous thrombosis. That's basically the same thing, right? That --

MCLEMORE: Yeah. Yep.

BRIDENSTINE: -- that's what they're talking about?

MCLEMORE: Yep.

BRIDENSTINE: So, a question that I had is that, you know, Dr. Hall noted that he had needle marks on that left arm. Is that right?

MCLEMORE: Yep.

BRIDENSTINE: Is it possible that he had some sort of an abscess there that you just couldn't see?

MCLEMORE: It's possible. I mean it probably would have had to be a deep-seated abscess, but still abscesses, if they're gonna make problems, and they're -- they're there they -- he should be ab -- I mean, you're -- you're likely going to be able to see them.

BRIDENSTINE: Okay.

TANNER: I have a quick question about this. My daughter had cellulitis one time. It was like a random thing on her chin. And honestly the only thing -- the only way we noticed it was because I looked at her one morning and her whole neck looked swollen. And I'm not a scientist, but they were very concerned about how that could impact her internal system, her lungs, and all that. We had some pretty aggressive treatment. So, I mean an abscess -- I do think of an abscess as like some huge thing you'd see on somebody. You know what I mean? Like -- I mean that -- if it is a problem.

MCLEMORE: I mean us -- usually. If it's gonna be a problem, you're gonna be able to see it. I mean --

TANNER: Is cellulitis the same thing then?

MCLEMORE: -- you should unless it's -- cellulitis, you still -- well, you saw it on your daughter. Her -- she started swelling up.

TANNER: Yeah.

MCLEMORE: It's like right at the neck. So, I mean that's -- and yeah, of course that's concerning. Cellulitis usually, you know, you should see some redness. You should -- you -- you -- there might be some swelling that you can actually see. I mean the forearm might be bigger than the other forearm. It could look -- start getting red because of all of that inflammation and -- and the vessels dilating so that all the cells that fight off the infection can get to that area.

TANNER: Okay. And with what you're seeing in the lungs, is there any relationship between -- let's say there was cellulitis or an abscess, even if it wasn't big, does that contribute to his condition at

all?

MCLEMORE: I -- you know, anything's possible, but I think it's highly unlikely.

TANNER: Okay.

BRIDENSTINE: Why do you think it's highly unlikely?

MCLEMORE: Again, the bacterial colonies I saw in the lung are classic for aspiration, not from sepsis from another site.

BRIDENSTINE: But if he -- if he did have an abscess in that arm, you wouldn't know unless Dr. Hall had done a culture of it or even taken a photo of his arm?

MCLEMORE: As far as -- as far as whether there was an abscess there or not?

BRIDENSTINE: Correct.

MCLEMORE: So, yeah. Since I'm not at the autopsy, I don't know whether there was an abscess there or not, but the findings I'm seeing on the lungs are not consistent with sepsis leading to pneumonia from a site like the arm.

TANNER: Got it. So --

MCLEMORE: Not only that -- not only that, there's -- the, you know, the blood travels through the heart first. Okay? Heart was normal. Valves were normal. No other -- no other organ system looked like it was sick if you -- at least histologically.

TANNER: And can you help me understand. I just want to make sure I'm understanding. I think I get it, but I want to make sure I'm understanding it. What would -- if an abscess or cellulitis was related to

the cause of death, you would expect to be seeing internally, one, other damaged organs. Is that right?

MCLEMORE: Mm-hmm. Right.

TANNER: And -- and two, what that would cause to cause your death would be sepsis --

MCLEMORE: That --

TANNER: -- that then caused pneumonia?

MCLEMORE: -- because that is. It's -- it's -- it's traveling to other organs and it could be the lungs too, but it's traveling through the blood. That's what sepsis means.

TANNER: Okay. But in order to make these skin conditions cause death, they have to have sepsis first and then you have pneumonia second?

MCLEMORE: Uh-huh. Uh-huh.

TANNER: Okay.

MCLEMORE: Because it's -- because it's -- that's how it -- that's how it travels to other organs, through the blood. That, by definition, is sepsis.

TANNER: Got it.

BRIDENSTINE: Now --

TANNER: And those things without sepsis, could they just cause pneumonia? I mean, could an abscess just cause pneumonia without the sepsis activity?

MCLEMORE: Yeah. It could, but again usually you don't see these huge colonies of bacteria unless you're immunosuppressed, but then

I should see it -- I should see bacterial in the vessels in -- in the other organs.

TANNER: And I have the same question about cellulitis. Could cellulitis just cause a pneumonia without seeing anything else?

MCLEMORE: So, cellulitis, that's a little different. I mean that -- that's in the tissues. It's -- it's not sp -- you know, it's not making a big, you know, dollop of -- of -- of pus in -- in the organs and stuff like that. Now, it depends on where you get cellulitis. Like your daughter, you know, that was -- you know, that is -- that is an emergency, right?

TANNER: Right.

MCLEMORE: In the arm, it's a little more protected. So, it's not as likely to, you know, get sepsis or pneumonia from cellulitis. It usually goes into also -- if it's untreated, I mean, it usually goes into forming an abscess and then -- but, you know, it's possible. It's just not as -- it's not as likely.

TANNER: Okay. I'm sorry, Julie.

BRIDENSTINE: Oh, no. That's -- that's fine. Just moving quickly onto Dr. Roberts, and you said you reviewed her affidavit.

MCLEMORE: Mm-hmm.

BRIDENSTINE: What did you think of her opinion?

MCLEMORE: I think -- I think she -- I mean, her affidavit, she was, of course cautious because she because -- she states in her affidavit, she has not reviewed the histology slides. And I think that's a huge part of this, is being able to see the histology slides. So, I would

have to disagree with her about what she -- her point 16 about what she would call the cause and manner of death.

BRIDENSTINE: Okay. And point 16, I'm just gonna read it. It's based on the information available to me at this time, with the limitations of the autopsy performed, the cause of death would be better listed as acute bronchial pneumonia with pulmonary emphysema as a contributing factor. The manner of death would, therefore, be listed as natural. That's what you're talking about?

MCLEMORE: Yes.

BRIDENSTINE: She also ta -- discussed in her affidavit that for the cause of death to be called a death by acute toxicity of morphine, there must be an appreciable level of morphine in the blood, which is not the case here. Do you agree with her assessment there?

MCLEMORE: So we're getting into semantics, but again I would not have called this an acute morphine toxicity per se. There's -- there's some time that has elapsed. So -- and yes, there -- he -- you know, there's some metabolism that has gone on. So, again, I probably would not have listed it as acute. I do agree kind of with her on that, but again, the way I -- my cause of death would still point a finger at the morphine intoxication.

BRIDENSTINE: So, how often is it that a person can take a drug, get aspiration pneumonia, die, and then the blood levels show either no drug or a trace amount like it is in this case?

MCLEMORE: Well, it's, you know, granted we -- what we see, especially with fentanyl now it's -- you know, it -- it -- it happens

rapidly.

BRIDENSTINE: What do you --

MCLEMORE: So, you know, yeah. I mean death happens rapidly. Y -- you're -- you're dying of the acute effects of the drug, you know, like fentanyl. So, granted, we don't -- I -- I have not seen maybe but a handful of cases this last 10 years where they were, you know, took just enough to be obtunded to start snoring, not protect their airway, and then to develop bronchopneumonia aspiration pneumonia prior to death. So, at some point, it's not the morphine anymore that's acting on the body, it's the complications of taking the morphine, which is the aspiration pneumonia.

BRIDENSTINE: Looking at the toxicology test, you kind of have addressed the alcohol portion of it, but can you just briefly explain the difference between the -- the blood samples of the test. What's the difference between the aorta blood test on this toxicology screen and the femoral blood?

MCLEMORE: I would -- I would probably defer to Dr. Hudson on that, but it -- it's a matter of the procedures that the toxicology lab have. Because there is postmortem distribution of drugs that occurs -- well, unlike living patients where you draw blood and you -- or you catch urine and you -- you know, you look at the levels and, you know, all that kind of stuff and, you know, you got the person right there telling you how they feel, you know, we're only -- or -- or you can follow your patient and -- and keep tabs of their levels when you draw it from time to time, we can't do that, right? They're dead. And, so, drug levels -- certain drugs in the system can actually redistribute after death. They can leak out of the tissue. They

can settle. So, you know, looking at drug lev -- looking at levels in the postmortem period is not the same as looking at levels in a living person. So, to try to combat some of those problems, the toxicology lab -- forensic toxicology labs will often want different types of specimens from different areas. They also have to confirm their -- anything they see on the screen. So, typically for the a -- right now for the aortic blood, they'll do a screen. If anything is positive, they'll do a confirmation, which means having to look at the blood levels at a different site, so the femoral blood. And then, you know, urine, if you got it, or -- well, frankly for situations like this where it's kind of like, gee, this person has -- you know, they're getting information from investigation that this person may have used narcotics or opiates, and he's got as -- florid aspiration pneumonia and you're not seeing anything in the blood, what's in the urine?

BRIDENSTINE: Okay.

MCLEMORE: Because you're -- yeah. It's -- it's -- it's -- so, urine is more the chronicity. If worst comes to worst, they can use it as a screen. And then we have liver tissue. We typically send liver tissue. So, those are our kind of -- and the fluid out of the eye. So, those are kind of our five standard specimens that we usually take on all of our cases and send to the tox lab. And -- and Dr. Hudson can expound on this.

BRIDENSTINE: Okay. Okay. But is it pretty typical that the aorta is used as a screening test?

MCLEMORE: If -- if we've got all of our samples. Now, if -- if for some reason we can't get all of our samples, then there has -- you know, there has to be some changes in the procedure. So, again, Dr. Hudson

can tell you more on that.

BRIDENSTINE: Okay. So, I'm just curious. Why is the test -- so morphine and cocaine are opiates, is that right?

MCLEMORE: So, morphine is an opiate.

BRIDENSTINE: Okay.

MCLEMORE: Cocaine is a stimulant.

BRIDENSTINE: Stimulant. All right. So, why is morphine separated out from the other opiates and opioids?

MCLEMORE: It may be because they saw that peak. Again, that would be a question for Dr. Hudson.

BRIDENSTINE: All right. So, do you know what the lowest level is reported in the femoral vessel for morphine?

MCLEMORE: As far as the -- so, all of those would be toxicology procedures.

BRIDENSTINE: Okay. So -- but what does the trace tell you in the femoral blood of morphine?

MCLEMORE: That it was there. That it's there. It's low, but it is there.

BRIDENSTINE: But trace suggests that it is a low amount?

MCLEMORE: I w -- that -- that would be my interpretation. Yeah.

BRIDENSTINE: So, Dr. Hall testified that the 15 mg/L of morphine that was found in Mr. Whitson's urine was a toxic amount. Are you in agreement with that?

MCLEMORE: So, if it -- so, this is -- first of all this

is in the -- the urine, and urine levels and blood levels may not be that interchangeable.

BRIDENSTINE: What do you mean by that?

MCLEMORE: So, as far as -- if 15 mg/dl is high -- is a high morphine level in the blood, that means it's gonna be a high level in the urine and it -- you treat it like apples and apples. It's not quite like that. You gotta kind of -- they're different -- they're different substrates. What's -- I mean one's blood, one's urine. So, 15 mg/dl in the urine may not be the same as 15 mg/dl in the blood.

BRIDENSTINE: Is there an amount in the urine in which you can rule in a case that it's an automatically toxic amount?

MCLEMORE: I would be very hesitant to do that.

BRIDENSTINE: He --

MCLEMORE: And again -- and again, when you're talking about urine morphine levels and interchangeable -- you know, what does it mean for the blood and everything, Dr. Hudson would probably be able to explain that more easily. 15 mg, you know, 15 mg/dl -- if that were in the blood that's incredibly high and that would be, you know, depending -- that's -- that's incredibly high.

BRIDENSTINE: Okay.

MCLEMORE: -- if -- yeah.

BRIDENSTINE: Well, what does it mean if it's --

MCLEMORE: What does it mean in the urine?

BRIDENSTINE: -- urine? Yeah.

MCLEMORE: Yeah. It means that the guy had morphine at

one point in his sys -- in his blood, and he's --

BRIDENSTINE: So when Dr. --

MCLEMORE: -- met -- he's metabolized it.

BRIDENSTINE: So, Dr. Hall, he actually testified that the cutoff point for toxicity resulting in death is 14 mg/L. That's from the trial testimony. Do you agree with that?

MCLEMORE: So, 14 ml and you're gonna make me -- make me do conversions. Okay. So, he -- he's at 14 mg/L, right?

BRIDENSTINE: Yeah.

MCLEMORE: In the blood -- in blood, morphine -- morphine that is toxic, the range would be the upper range would be 5 mg/L. Okay?

BRIDENSTINE: Mm-hmm.

MCLEMORE: So, you know, that's -- but that's blood. Lethal, of course, is gonna be higher than that. And these, you know, they're taking these -- making these charts from, you know, what they see. You know, there's gonna be overlap with the -- the lethal levels. So, the upper level of five could also not only be toxic it could be lethal. Okay? So -- but that's blood, right?

BRIDENSTINE: Mm-hmm.

MCLEMORE: What is 15 mg/L in the urine mean? Well, there was a heavy burden of morphine at one point that accumulated in the urine.

BRIDENSTINE: Okay. So, do you agree that the -- there's a cutoff point for toxicity resulting in death in the urine and that is 14 mg/L?

MCLEMORE: I don't know where's he's getting that

information.

BRIDENSTINE: That was my next question. Do you have any idea where he got that information?

MCLEMORE: No. I mean he may have grabbed a -- a -- results, but again -- but again, it's really hard to make absolute statements based on a drug level.

BRIDENSTINE: And he also testified that the levels of morphine found in Mr. Whitson's system were fatal. Do you agree with that statement?

MCLEMORE: The what?

BRIDENSTINE: He testified that the --

MCLEMORE: The levels in the urine?

BRIDENSTINE: No. I think he just says levels of morphine found in his system were fatal.

MCLEMORE: Well -- so, if he's referring to the trace, it depends. If you're just looking at the -- at the morphine -- trace morphine in a vacuum --

BRIDENSTINE: Mm-hmm.

MCLEMORE: -- disregarding everything else about the autopsy and investigation, no, trace -- a trace amount of morphine shouldn't kill you.

BRIDENSTINE: Earlier --

MCLEMORE: As you --

BRIDENSTINE: Go ahead. Sorry.

MCLEMORE: Yeah. But if you're looking at the entire --

you know, the -- the -- the entire findings, then, you know, we're not talking about the levels and whether or not they can kill you, we're talking about the effects.

BRIDENSTINE: Earlier when you talked about how you had -- you've seen a handful of cases in your career in which somebody took a drug and I guess went to sleep and then eventually got aspiration --

MCLEMORE: In the la -- in the last 10 years.

BRIDENSTINE: In the last 10 --

MCLEMORE: The last 10 years --

BRIDENSTINE: Okay.

MCLEMORE: -- I've seen a handful of cases because fentanyl is so much pot -- more potent that what we're seeing is acute toxicities with that. They don't get a chance to develop aspiration pneumonia. Now, back in the 1990s when it was heroin, and we didn't have fentanyl or all these designer analogs, you know, yeah, I actually did see quite a bit of aspiration pneumonia in my cases.

BRIDENSTINE: And was that with -- with morphine ever or was it other drugs?

MCLEMORE: So, heroin metabolizes into morphine.

BRIDENSTINE: Okay. So it was with --

MCLEMORE: And --

BRIDENSTINE: -- heroin cases?

MCLEMORE: Yeah. Yeah. I mean the -- it -- it -- at that point it's almost the same thing except mor -- heroin isn't QC'd on the street. So, you really don't know how much you're getting.

TANNER: Okay. And I'm -- I just want to make sure I'm understanding. So, what you are saying is that what you're seeing with fentanyl is because that's just so much more potent. We just don't see this anymore.

MCLEMORE: Yeah.

TANNER: But this obviously isn't fentanyl. This is morphine instead.

MCLEMORE: Yeah, this is morphine.

TANNER: It appears to be some version of a prescription drug, though we don't know that for sure.

MCLEMORE: Yes. Yeah.

TANNER: So how does that factor into your opinion?

MCLEMORE: I would -- I would say it is. It's -- it's probably from crushed pills.

TANNER: Okay.

MCLEMORE: And the reason why is there was another finding I saw that wasn't mentioned in Dr. Hall's report, but in the heart -- in the lung also there are basically clusters of foreign body, nonpolarizable material, that's surrounded by the inflammation. That is probably from components of crushed up tablets or pills.

TANNER: You've seen that, is what you're saying? You are seeing that?

MCLEMORE: I -- I am seeing that.

TANNER: Okay. And -- I -- I don't -- I don't know very much, again, about this, but what happens when a pill is crushed up? Does

that change it's timeline from potency or for metabolization?

MCLEMORE: It could especially because you're not taking it in the pre -- how it was formulated. You know, they -- they make pills, you're supposed to -- you're supposed to take them by mouth, right? Crushing up a pill, first of all, may -- may remove the protective barrier, you know, as far as a timed release in your stomach or in your intestines so that you have a controlled release. When you crush cert -- certain pills up, well, there goes -- there goes that, right? So, a lot of these extended-release type of -- not this one, but a lot of extended release that's what they rely on. You know, you crush that -- you -- you -- all bets are off. Not only that, but if you're injecting it, you're injecting that right into the blood stream.

TANNER: Now, I have a question about seeing those in the lungs though. In order to see that in the lungs, would he have had to had swallowed the crushed pills --

MCLEMORE: No. No.

TANNER: -- as opposed to injecting them? Okay.

MCLEMORE: If you see it -- if you see it in the lungs, it's injection.

TANNER: Oh, okay.

MCLEMORE: It could be inh -- it could be inhalation like snorting, but usually I'm not see -- this -- these -- these things look large and they look like they came out of -- I mean these look large. So, I typically see that with -- with -- because no matter how -- how much you crush a tablet up and how much you try to strain it, you know, there's gonna

be some of those bigger chunks getting through.

TANNER: And there -- and when you say bigger, I just want to put this in perspective. I mean they went through a needle and into his blood stream.

MCLEMORE: Yeah. I -- I'm sorry. I mean when I'm looking at histology, I -- it -- it -- I can see it under the microscope and -- and actually it -- it's a big field in my microscope, so to me that's big.

TANNER: Okay. I got it.

MCLEMORE: (Inaudible).

TANNER: Okay. Yeah. I'm like I'm not really sure how you got big pieces of lung (sic) in his --

MCLEMORE: Sorry.

TANNER: But since you're seeing that, though, it wasn't that he was aspirating those pills, it was that what you're seeing is foreign bodies that you believe came in through the blood stream from injection?

MCLEMORE: Yeah. Yep.

TANNER: Got it. Did that relate at all to his pneumonia development?

MCLEMORE: No because this was -- this was actually being walled off by a different kind of inflammation cell elsewhere again around the bronchioles, around the airways. That was -- that's where most of the inflammation and the worst inflammation was with all of those bacterial colonies.

TANNER: Okay. Got it.

BRIDENSTINE: Going quickly back to the aspiration bronchial

pneumonia, what kind of symptoms does a person usually experience when they have that?

MCLEMORE: Well, if you're awake, you're basically -- and you aspirate and you're starting to develop an aspiration pneumonia from it, then all of the symptoms are similar to symptoms from any other pneumonia. You're gonna start running a fever. You're gonna probably not feel too well. You could develop a cough. You know, same -- same things with -- with your typical pneumonia.

BRIDENSTINE: So, in this case, we don't have any evidence that Mr. Whitson was doing those things. There was evidence that he was snoring. And I think you said earlier that snoring is a symptom of aspiration bronchial pneumonia?

MCLEMORE: Yeah. We -- or it's a symptom of you're not protecting your airway.

BRIDENSTINE: Okay.

MCLEMORE: Okay.

BRIDENSTINE: So, the -- would you have expected to see, you know, someone in Mr. Whitson's position if he is developing aspiration bronchial pneumonia to get up, to not feel well, to -- to start coughing on the couch, to run a fever? Things like that?

MCLEMORE: Yeah. If -- if you're not -- if you're not basically being obtunded.

BRIDENSTINE: Now what do you --

MCLEMORE: Okay.

BRIDENSTINE: -- what does obtunded mean?

MCLEMORE: If you're -- if you're mec -- if you're not being suppressed. This is what -- this is what people who are intoxicated for whatever reason develop aspiration pneumonia and can die from it. Their mechanisms are suppressed.

BRIDENSTINE: So they can't wake up. Is that what that means?

MCLEMORE: Yep.

BRIDENSTINE: Is there any way to --

MCLEMORE: Because usually if I -- if I start choking in the middle of the night, I hope -- I hope my body jerks awake, right?

BRIDENSTINE: But would a person who is experiencing aspiration bronchial pneumonia, would -- would they still be doing those things just not be awake? Like, for instance, would someone else in the house maybe hear Mr. Whitson coughing or, you know, experiencing some sort of --

MCLEMORE: If -- if he --

BRIDENSTINE: -- distress on the couch?

MCLEMORE: -- if he -- if he's not obtunded enough maybe he'll cough, but if you're obtunded, you're obtunded, you may not be coughing.

BRIDENSTINE: And when you do an autopsy, is there a way to tell if someone had a fever right before they died?

MCLEMORE: Not really. I -- I think -- probably the only way to do that is if someone found someone dead and took their temperature. And then if it were -- you know, it'd be elevated, but by the time, you know,

people get called out or -- or if EMS arrives, if they took a temperature and usually they don't. If they're there and he's dead, they pronounce them. So, you know, that would be the only time. There's nothing I can do at autopsy. Now, if there were a high fever, you might see some accelerated decomposition of the organs.

BRIDENSTINE: Okay. And did you see anything like that?

MCLEMORE: No. All the organs looked o -- I mean pretty well. I mean the -- the -- the only -- uh -- the kidney section had some early postmortem breakdown but that's typical no matter what.

BRIDENSTINE: And how confident do you need to be until you issue a cause of d -- cause of death after you do an autopsy?

MCLEMORE: Depends on the situation, but for this one, I mean it -- it's more likely.

BRIDENSTINE: So, in your opinion, this is a more likely than not?

MCLEMORE: Yep.

BRIDENSTINE: So, you're not 100% sure?

MCLEMORE: You can never be 100% sure about most anything, especially when you're having to rely on piecemeal information and investigations and witness statements and those kind of things. But with everything put together, yes, this is -- this is -- uh -- I would be very comfortable with this --

BRIDENSTINE: All right. But it's a more like --

MCLEMORE: -- cause of death.

BRIDENSTINE: -- your -- by your standards, it's a more

likely than not conclusion?

MCLEMORE: Yep.

BRIDENSTINE: Would you have done anything different in this case from Dr. Hall?

MCLEMORE: I would -- well, we already talked about I -- I would disagree with how he worded his cause of death.

BRIDENSTINE: Would you have obtained any additional samples?

MCLEMORE: Probably not. Not for histology. I mean he did sample the lungs pretty well and he's got the major organ systems. In all -- in all practical purposes, no, probably not. It seems like I -- I -- I'm not sure what I'm trying to see if he's got a list of the -- I'm trying to find the tox report here so I can see what list of toxicology he sent, what specimens. Let's see. Where is it? It looks like he did vitreous testing too.

BRIDENSTINE: And what's that? What's vitreous testing?

MCLEMORE: So, under chemistry where he did additional procedure, he has chemistry. That's glucose, chloride -- that's typically done -- in the postmortem period that's done from the fluid in the eyes.

BRIDENSTINE: What's that testing?

MCLEMORE: So, he's looking -- he's just looking at the -- the glucose in the -- in the eye after death and different electrolytes. So, the saltwater -- potassium and sodium, urea and nitrogen, which would just be -- would actually be vitreous nitrogen, just to see if there is any postmortem irregularities.

BRIDENSTINE: Okay.

MCLEMORE: And from the looks of it, the sodium is a little on the high side, but that -- who knows where that's coming from, but really there doesn't look to be -- well, that's weird. They don't do creatine, but there doesn't really look to be any, you know, outstanding abnormalities for a postmortem metabolic screen.

BRIDENSTINE: You know, Dr. Roberts suggested in her affidavit that Dr. Hall could have taken blood, lung, or viral cultures.

MCLEMORE: Yeah. He could have, but I can tell you we don't take cultures of our drug ov -- or suspected drug overdoses.

BRIDENSTINE: And why not?

MCLEMORE: Well, because we can -- if it's aspiration pneumonia, we can see it histologically.

BRIDENSTINE: Um -- going back real quickly to that idea that he was -- you keep using this word. I'm not super familiar with it, obtunded.

MCLEMORE: Obtunded.

BRIDENSTINE: Okay. So, when you say that, that just means that you are not able to wake up. Is that right?

MCLEMORE: Obtunded. You're mentally and respiratorally (phonetic) suppressed. You're -- you're -- yeah. You may not be able to wake up very easily. You're not easily arousable. Yeah.

BRIDENSTINE: Is that something -- or I guess let me ask it this way. How much morphine would you -- um -- expect someone to take where they would get into that stage where they're obtunded?

MCLEMORE: It depends on the person.

BRIDENSTINE: Is there any way to know how much that amount is?

MCLEMORE: Not for -- not for a -- not for if we are talking about a person, no. I can't -- it depends on tolerance. It depends on loss of tolerance. It depends on potency of the morphine. It depends on route of intake.

BRIDENSTINE: And now there this idea or there was this notation in the autopsy that there was an ulcer on -- on Mr. Whitson's heel.

MCLEMORE: Mm-hmm.

BRIDENSTINE: Would you have taken a culture of that?

MCLEMORE: No.

BRIDENSTINE: And why would not -- why wouldn't you have?

MCLEMORE: Typically we don't t -- it costs money. To be honest.

BRIDENSTINE: Okay.

MCLEMORE: And it -- you know, the ulcer is there. You know, we will look at the organs, you know, histologically if we need to, but if it looks bad enough, the -- and I won't -- and I won't say we don't ever do it. If it looks bad enough that it looks like it might -- it might be able to cause problems, yeah, we might take a -- even a section and look at it under the microscope and we might culture. If I open up the -- uh -- uh -- the body and the liver looks like it -- you know -- there -- there's septic emboli all over, yes, I'm gonna take a culture. So, it depends on what we're seeing.

BRIDENSTINE: And is there anything that was noted by Dr.

Hall on -- anywhere else on Mr. Whitson's body that indicated to you that he could have had say an infection somewhere else on the body?

MCLEMORE: So, you know, from what -- from what was -- what he saw and from what he documented, no, I'm not seeing anything else that is standing out to me. Now, I will say his external exam is awfully sparse.

BRIDENSTINE: And what about it is sparse? What do you mean?

MCLEMORE: Well, I mean as -- as far as what he's describing when he's looking on the outside of the body that -- there's not a lot of information there.

BRIDENSTINE: And why do you think that is?

MCLEMORE: I have no idea.

BRIDENSTINE: Would you have given -- provided more information if you had done this autopsy?

MCLEMORE: So, we have a standard template, and yes, we have a flushed out external exam.

BRIDENSTINE: And wh -- what do you mean by flushed out? What does this standard template ask you to do that was not present in Dr. Hall's autopsy?

MCLEMORE: So, we go from top to bottom. We look and we -- we document the eye color. We document the condition of the teeth if we remember to look at it. We document, you know, the color of the scalp hair. So we -- we provide also, you know, pertinent physical characteristics documentation. You know, so color of the hair. We may look at the condition of the fingernails. We look at the arms and -- the extremities. You know,

are they symmetrical? Are they, you know, are there any of -- abnormalities? Are there any identifying marks or scars? We look at are there any significant lesions or, you know, identifying marks otherwise. So, we gotta -- we look -- is there -- what is the condition of the genitalia even? So, yeah, we -- we go from top to bottom.

TANNER: When you say we have a standard form, who is we?

MCLEMORE: Oh, the -- my office. Now, is my standard form the be all and end all? No. There is no standard autopsy template.

TANNER: Got is. So, Dr. Hall's standard form may have looked different?

MCLEMORE: Standard for him. .

TANNER: The standard for him --

MCLEMORE: Yes.

TANNER: -- or that form. We don't know, but that form could have been standard for him but it looked different than yours. I guess my question is OCME is not sending you a form and saying when you do an autopsy for us, this is what you gotta do?

MCLEMORE: Right. And there is no standard template across the United States.

TANNER: Got it. Okay. Thank you.

BRIDENSTINE: Was there anything that was sparse about his internal exam?

MCLEMORE: Let's see. Um -- it's -- you know, it's okay. Overall, Dr. Hall's template is much more -- is -- what's the word I want to

use? It's -- he does not waste a lot of words. He's -- it -- it's short. It's brief. Overall, I would say that his description and documentation is brief.

BRIDENSTINE: Now, there were only three photographs that came with the autopsy and they were all of Mr. Whitson's head. Did you see those photographs?

MCLEMORE: Uh-huh.

BRIDENSTINE: Would you have taken additional photos of Mr. Whitson's body?

MCLEMORE: Not necessarily.

BRIDENSTINE: And what --

MCLEMORE: He did -- he did the standard -- he did -- he did what is standard or as close to standards as we nationally have, and he did an ID -- identification photo.

BRIDENSTINE: Is that what those three photos are?

MCLEMORE: Yes.

BRIDENSTINE: Okay. Well, who decides what photographs are taken during an autopsy?

MCLEMORE: The pathologist doing the case.

BRIDENSTINE: And what makes you take more photos than just those ID photos during an autopsy?

MCLEMORE: If I see something of particular that I want to note. So, usually in trauma cases, we take it of major injuries. Do I take every single injury, every single scratch and bruise? No, I may not.

BRIDENSTINE: But it is not standard to do a full-length body

photo during an autopsy?

MCLEMORE: Nope. Nope. There are no -- let me make -- let me make this very clear. There are no national standards.

BRIDENSTINE: Okay. And in this case, would you have gone to the death scene?

MCLEMORE: Not necessarily.

BRIDENSTINE: And w -- why would you go to the scene or why do you go to the scene in some cases and not in others?

MCLEMORE: So, I will go to the scene when I -- if I am requested by law enforcement.

BRIDENSTINE: Okay.

MCLEMORE: Or sometimes EMS, then I will go to the scene. I will go to the scene on homicides if there is something about the scene that may make interpretation of what I see at autopsy more clear. Do we go on every scene? No, we do not have the resources.

BRIDENSTINE: All right. Have you talked to anyone else about this case?

MCLEMORE: No, I haven't.

BRIDENSTINE: Did you ever --

MCLEMORE: No, except you guys.

BRIDENSTINE: Okay. And so you never talked to Dr. Hudson?

MCLEMORE: No. Uh-uh. No.

BRIDENSTINE: All right. I want to turn -- just kind of the last thing to talk to you about is something that you brought up when I met with you when I dropped off the autopsy samples. You were talking about your

employment contract.

MCLEMORE: Oh yeah.

BRIDENSTINE: All right. Can you explain to me again what your ow -- what your contract says?

MCLEMORE: So I can -- I can actually read to you verbatim what the contract says. And -- this was -- this was a decision made by the state. I can tell you there's a lot of people at the different regional offices who are not happy with it, but there it is in our contract. Let me find it for you. Where's my contract. Here we okay. Okay. Yearly contract this last year. Here is -- okay. I'm sorry. I'm just going through all this stuff on my computer. Okay. So, under the scope of work in our contract that is issued every -- the full contract is issued every other year. It's every two years. But it -- one of the -- one of the scope of the works items -- if I can find scope of work here through all of this. Let me see. What page am I on? Okay. I'll get there.

TANNER: While you're looking, Dr. McLemore --

MCLEMORE: Oh I got it.

TANNER: Oh, you got it. Okay. Go ahead.

MCLEMORE: I knew as soon as you started talking, I'd find it.

TANNER: See, it's just magic.

MCLEMORE: Yeah. Okay. So, it's point 16, and I will read that to you. Ensure that any pathologist employed by vendor, and that would be -- does not -- that vendor would be us, the Wake Forest, does not enter into any contract or accept any additional employment to act as an

expert witness in opposition to the OCME. This includes publishing a report for litigation and/or offering testimony that conflicts with the report or testimony of, one, a professional staff member of the OCME, another pathologist under contract with OCME, or another local medical examiner in the North Carolina Medical System. Now --

TANNER: So do you --

MCLEMORE: -- yeah.

TANNER: Oh, I'm sorry.

MCLEMORE: Now, this -- this is a very grey area right here. First of all, I'm not entirely disagreeing with Dr. Hall, and Dr. Hall is no longer employed as a medical examiner in the North Carolina Medical Sys -- Examiner System, but this work that we are discussing was performed when he was an employee. So, I think the problem is, is this retroactive? And I haven't a -- I haven't gotten a response on that.

TANNER: Okay. So, I have a couple quick follow-up questions for you. Is your vendor contract -- it's with the state, correct?

MCLEMORE: Yeah. Correct.

TANNER: So, that's --

MCLEMORE: The Department of Health -- yeah, the Department of Health and Human Services really.

TANNER: It's with the Department of Health and Human Services. So, that's -- that's of public record?

MCLEMORE: Yes.

TANNER: Okay.

MCLEMORE: It should be.

TANNER: Yeah. So, I'd like to see a copy of that scope of work and if you -- and listen, I don't care what they're paying you, so if you want to like block out, you know, what they're paying you or whatever, it doesn't much matter to me.

MCLEMORE: They don't pay -- they don't pay us. They don't pay us.

TANNER: Okay.

MCLEMORE: What we -- what we get is we get paid for the performance of the work.

TANNER: Yeah. If you don't mind shooting us an email on that, that'd be great just that attaches that so we know. And --

MCLEMORE: Could I -- could I -- could I request that you actually ask for it through the Department of Health and Human Services?

TANNER: I certainly am happy to do that.

MCLEMORE: Yeah. I just -- yeah, I don't want to kind of get in the way of -- or bring misery down on my head if I --

TANNER: Of course.

MCLEMORE: -- ov -- overstep somebody.

TANNER: So when did this provision start appearing in your contract?

MCLEMORE: Yeah. When did it -- when did it start? It actually -- I think it started -- let me find it. I think it act -- this was this past year that it showed up. I want to say it was before the current chief medical examiner -- it was before she took the position as chief. I -- I want to say it was during Dr. Radish's tenure.

TANNER: Okay. So like this past -- so, you've had this contract that you're under right now, are you in your first year of it or your second year?

MCLEMORE: So, this current con -- contact is a -- this is the first it was -- the new one was done just this year.

TANNER: Okay. And has this provision only ever been in this contract or was it in the contract prior to this?

MCLEMORE: No. No. It's been -- it's been prior.

TANNER: Okay.

MCLEMORE: Because we did raise the issue and, you know, warn people that this was -- these contracts have these now. Let me see what it actually was. I'm gonna look up -- she came in -- let me try 2016 and see if it's there.

TANNER: So, what are you supposed to do if you review a case and the -- and the medical examiner got it wrong?

MCLEMORE: Well, I can do just exact -- that's why -- that's why when I was talking to Julie, I was going, you know what, yeah, I need to check on this, or early on when I was talking to you, I said I need to check on this. I did bring it up with the current chief and her legal, and I did -- I did not hear -- I have not heard an answer back from them. If I had - if I -- if I had completely disagreed with what Dr. Hall had said -- um -- I still don't know whether or not this covers this particular type of activity. Again, I don't know if it's retroactive or not because the way it's read, to me, it's if they're currently employed.

TANNER: Okay. And --

MCLEMORE: But that's my interpretation. I'm not a lawyer.

TANNER: Sure. And, well, you worked with us on the Williams' case and there was a question there. I don't know if you remember the gentleman was either knocked down or fell down. I don't know if anybody could have ever answered that question and hit his head on -- hit his head. Well -- and who knows. I'm not --

MCLEMORE: Yeah.

TANNER: -- (inaudible) sidewalk. Nobody seems to really know.

MCLEMORE: Oh I -- I still -- I still say that one that caught my eye was the clothesline one. I mean the guy probably had a vertebral artery dissection.

TANNER: So, in that case, I just don't remember this being an issue at all. So, what would you say the difference is?

MCLEMORE: Because -- because was from the 70s. That guy was never a -- that was even before the system was established.

TANNER: Okay. So, in your mind because that case was so far back this didn't matter.

MCLEMORE: It was so far back. Yeah.

TANNER: Okay.

MCLEMORE: Let's see. This was -- this was not -- this was not here in 2016.

TANNER: Okay. So, sometime after 2016 the provision shows up.

MCLEMORE: Right. Right.

TANNER: At this point, with your current opinion, do you believe -- I know you're not an attorney, but for yourself, do you believe that you are violating your contract based on your current opinion in comparison to Dr. Hall's?

MCLEMORE: I don't believe I am.

TANNER: Okay. Would you feel comfortable issuing a report in this case of your findings?

MCLEMORE: I -- yeah, I feel com -- I feel comfortable issuing a report. Like I said, I -- I -- isn't really -- it's not really -- yeah. It's interpretation but I -- I would feel comfortable. I would say.

TANNER: Okay. And I want to be really clear because I do have this concern a little bit sort of after understanding the situation with your contract. And I -- I don't know anything about your contract. I haven't read it and obviously I don't represent you. But do you feel any pressure to provide any kind of opinion to the Commission at all?

MCLEMORE: Do I feel any concern you mean?

TANNER: Well, yeah, I mean -- and I do mean pressure. I mean, did you ever feel pressured by us to provide any kind of an opinion?

MCLEMORE: No.

TANNER: Okay. So I -- I would -- we will be happy to contact DHHS. I do think it's a public record. It's the state's contract. You know, our records no matter who we hire, they are of public record. Our contract with you is a public record. It's just a public record, but I'd be happy to sort of go through to DHHS for that. And Julie, I'm sorry. I

didn't mean to interrupt. I'm sure you may have other questions.

BRIDENSTINE: I guess when did you realize that there was potentially this conflict due to your contract?

MCLEMORE: Oh, I'm not sure. It was short -- I mean it was shortly after we started and -- and materials were sent to me and it just popped up as like, oh yeah, I forgot about that. Because I don't -- I don't really do a lot of consults period. So, it was kind of out of sight, out of mind, but something -- something jarred me. Speaking to one of you, either you or -- or -- or Beth, that oh, yeah, we do have this clause in our contract.

BRIDENSTINE: So, I'm just curious, why didn't give us a call and tell us about, you know, this potential conflict that you had due to your employment contract?

MCLEMORE: I did. I did.

BRIDENSTINE: And then when you --

MCLEMORE: I mentioned it to -- I mentioned it to you as soon as I f -- or remembered it.

BRIDENSTINE: When I dropped of the autopsy samples?

MCLEMORE: Yep.

BRIDENSTINE: Okay.

MCLEMORE: That's exactly when I remembered it.

BRIDENSTINE: So is that when you realized there was a conflict?

MCLEMORE: No, that's when I realized there might be a conflict.

BRIDENSTINE: Okay.

TANNER: The fact that -- and I know that you haven't received an answer from legal, and we've discussed this.

MCLEMORE: Yeah.

TANNER: Do you believe realizing the existence of this provision in your contract impacted your opinion here?

MCLEMORE: No. I'd al -- I'd already -- I -- I -- in fact, I was actually verbalizing my opinion to Julie when I remembered about this.

TANNER: Okay.

MCLEMORE: I can -- oh, I -- I found it. So, 2018 was the first time it showed up in the contract.

TANNER: Okay. 2018 is the first time you see it. Got it. And I'm sorry, I'm just gonna follow up on it one more time. So, I know you said you voiced a concern, and I'm not trying to -- I -- I really am not trying to get you in the middle of anything for sure, but you voiced a concern. Did you voice that concern within your agen -- or within your group over at Wake Forest?

MCLEMORE: No, they don't know that -- I -- this case has nothing to do with casework or anything like that and -- and Wake Forest doesn't care. This is -- I did voice it and asked about their interpretation to the state, meaning the chief medical examiner and her legal.

TANNER: Got it. And this particular provision, you had mentioned that other people had concerns about it. Do you mean other like folks like you that are in private practice that work on contact for OCME?

MCLEMORE: So, yeah. I mean like for instance, Tom Owens, over at Charlotte-Mecklenburg, the Mecklenburg Regional Office. He was not very happy about this because he does a lot of consulting work.

TANNER: Of course. And have you been made aware that anyone has been able to communicate with DHHS about this concern and maybe removing this portion out of the contract?

MCLEMORE: I do remember back in 2018 there was concern. For instance, Dr. Lance here was concerned about it. He did reach out to someone to let them know, hey, this now in our contract, and I don't know what -- obviously nothing came out -- out of that.

TANNER: Okay. And I -- I think -- and I think I understand in this case you contacted somebody about it. Has it come up for you before that you have had a disagreement with a medical examiner where you think that that might implicate this portion of the contract besides potentially this current case? I know what we're not sure that this is even a disagreement, but you know what I'm saying? So, besides right now.

MCLEMORE: Yeah. This hasn't come up because I -- like I said, I just -- I don't really do a lot of consult work at all.

TANNER: Got it. Okay.

BRIDENSTINE: D -- Doctor, do you have any idea why they put this in the contract?

MCLEMORE: Well, like I said a lot of us do not agree with this being in there. I mean one of things about -- to me, having somebody like another consultant take a look at their work, you know, I'm not perfect. I may -- my interpretation may not be right. They may have a -- you know,

they may have something else. You know to me, I think it -- it's helpful. And I -- I can tell you, the -- the state wasn't the -- the state system wasn't the only one that tried this. When I was from Iowa under that cha -- chief, she also tried to ins -- institute something like this, and it -- I, you know, it -- it kind of goes back to appearances.

BRIDENSTINE: What do you mean?

MCLEMORE: Or in -- you know, like in-fighting. That never looks good.

BRIDENSTINE: All right. Is there anything else --

MCLEMORE: And that -- that's my own opinion, you know, like I said I -- I'm not in their heads. So, I don't know, you know, why -- why this -- this comes up, but that -- that would be my -- that would be my opinion as to why this was put in there.

BRIDENSTINE: And I understand why that might affect your consulting work if you are consulting in cases but is it ever the case where you are reviewing someone else's work as a pathologist like an autopsy situation just in general, I'm just trying to think of circumstances where, you know, maybe in a criminal case, one local ME makes some sort of finding and then someone else from the state takes a look at it. Does that ever happen?

MCLEMORE: Yes. That's happens all the time.

BRIDENSTINE: So, in that scenario, the second medical examiner or pathologist who is looking at the first person's findings, is precluded from testifying against that person?

MCLEMORE: Because we're a system. And -- and here's the

big switch. We're not -- you know, for 30 years before, you know, this last decade, or 20 -- 25 years before this last decade, we were kind of four separate fiefdoms. So, yeah, that might have happened more, but, you know, technically we are supposed to be a -- somewhat of a state system. So, what usually happens is our reports are reviewed by pathologists at the state office. If there is a disagreement, then it's -- we don't take it to court, it -- it's basically consultation on the phone saying, oh, how -- you know, how did you come to these conclusions. And it's basically a discussion. So, it's kind of a QA -- you know, QA/QC type of situation. Not a litigation one.

BRIDENSTINE: Okay. So, if I'm understanding you correctly, somebody reviewed Dr. Hall's autopsy report at the state level?

MCLEMORE: I would -- I would assume so, but don't -- don't quote me on that because I don't know if they had the same system of -- of -- back then. Oh, yeah, they did. This is 20 -- they had to of. So, somebody probably did review his -- his report.

BRIDENSTINE: So is that a forensic pathologist employed by the state?

MCLEMORE: I think so. Now, again, I don't know all the ins and outs of it back in 2020 -- when was that?

BRIDENSTINE: 2011.

MCLEMORE: 2011, and frankly I just got here. You know, I came here in 2010.

BRIDENSTINE: Okay.

TANNER: And I'm sorry. Just to make sure I'm clear.

When they're doing a review, they're doing a paper review of what's been written in the paper autopsy?

BRIDENSTINE: It's -- it's a paper review.

TANNER: Yeah. Nobody's going like what you just did for us, which is pulling tissue slides, cutting off the samples, looking under the microscope and seeing if they see the same thing? It's literally like I read the paper.

MCLEMORE: It -- it -- the way it is right now, yes, they're just reading the paper.

TANNER: Okay. Got it.

BRIDENSTINE: And do you know is -- is the intent in that scenario just to make sure that whatever someone is saying makes logical sense?

MCLEMORE: It's -- yeah. I -- I -- yeah, I would say overall that is -- I mean it's part of the QA, you know. They're catching, you know -- they can even, you know, catch misspellings that may alter the whole mood, if you will, or the meaning, you know. So they -- they are reading over it, yes. Does this make sense or the -- are the conclusions logical?

BRIDENSTINE: And do you know, is this something that happens soon after the report is finalized? Does it happen before it's finalized?

MCLEMORE: So, the way we -- yeah. The -- the report cannot be made public until it's gone through a review.

BRIDENSTINE: Okay. And do you -- are you aware of Dr. Hall? Like were you familiar with him before you looked at this case?

MCLEMORE: Yes, I was.

BRIDENSTINE: Did you have any concerns about Dr. Hall as a medical examiner? Hello?

MCLEMORE: I -- yeah.

BRIDENSTINE: Oh, sorry.

MCLEMORE: I don't -- I don't know him personally enough. Um -- all I know is what I have read in the papers and the fallouts for -- because the Boone, you know, the Boone carbon monoxide thing that was in the papers that was nat -- that was international. That was, you know, in national papers. So, you know, I -- I have never met him personally.

BRIDENSTINE: Okay. And that Boone case, did that raise any concerns for you?

MCLEMORE: So, it's unfortunate. I can see how it happened, but it's unfortunate that it happened. It -- that case, in my opinion, was not so much a marker of he's a bad forensic pathologist because he or -- you know, he ordered the appropriate tests, so it's not -- it wasn't a question of whether or not he was capable of forming a hypothesis and doing the appropriate tests.

BRIDENSTINE: Okay. And is there anything else that you think we should know that we haven't gone over yet during this call?

MCLEMORE: No, I think -- I think we covered most everything.

BRIDENSTINE: All right. I don't have anything more, but Beth do you have any -- sorry, you were going to say something Doctor?

MCLEMORE: Yeah. Yeah. I was gonna say, we do have a

Regional Autopsy Center meeting this Friday, and I will ask -- I will ask the chief medical examiner again and her legal will be there. So, I will ask them again if they've made any determination about this. I would be highly surprised if they said oh, no, you can't by the contract. Because to me it just doesn't fit in that -- in that wording. But I -- I will ask them Friday about this again.

TANNER: Yeah. I think that'd be great. And Dr. McLemore I think you have my contact and Julie's contact information, so certainly if they have any questions. And I've called you today, I'm thinking you saw it. That's my cellphone number. My personal cellphone number. We can certainly explain kind of who we are as an agency and that kind of thing, but I think that would be great. And I don't have any other questions and I think what we would like to do is sort of talk amongst ourselves based on what we found and then kind of touch back with you.

MCLEMORE: Okay. I'll let you know what they say on -- right after the meeting. I -- like I said, I would be shocked if they interpreted that to mean, oh this fits in this and you can't do it. To me it just doesn't fit, but --

TANNER: Okay.

BRIDENSTINE: I'm sorry. I did have one quick question and it's just about Dr. Hudson because we're gonna talk with him too. Do you have any questions for him that you think should be answered?

MCLEMORE: Oh, you know, Dr. Hudson is a relatively new chief.

BRIDENSTINE: Mm-hmm.

MCLEMORE: And relatively new in this position. I've talked to him on the phone. He's -- he's taken our fellows the last two y -- you know, the last two years anyway. He's taken our fellows for a tour of the lab and talked to them about toxicology, but that's about the extent that I know of him.

BRIDENSTINE: Mm-hmm.

MCLEMORE: Like I said, the one thing that I -- you know -- the one thing that I -- crossed my mind that he may not know because he wasn't here, is, you know, oh, well I'm not sure this alcohol is real or not and here's why because at the time this is what we were doing.

BRIDENSTINE: Okay.

MCLEMORE: And it wasn't uncommon for us to get low level alcohols back because they sat in a hot carrier getting transported or whatever or it literally -- it wasn't also uncommon for us to get notes back from toxicology basically saying there's leakage or seepage because the liver build up enough gas it popped the lid off. So -- and that -- those problems actually became almost nonexistent when we went to overnight -- using FedEx. So, he may not know that that was the situation back in 2011.

BRIDENSTINE: Okay. All right. That's it. That's all I have.

MCLEMORE: Okay.

BRIDENSTINE: All right.

TANNER: Thank you so much. Thank you for your time.

MCLEMORE: Sure. I -- and I'm sorry about as far as any confusion with the contract and literally as I was talking to Julie that

popped into my head and I will -- I will try to get that clarified as soon as possible.

TANNER: Awesome. Thank you so much. We really appreciate it.

BRIDENSTINE: All right. Thanks, Dr. McLemore.

MCLEMORE: Sure.

TANNER: All right. Bye-bye.

MCLEMORE: Okay. Bye.

BRIDENSTINE: Bye.

*** OFF THE RECORD ***

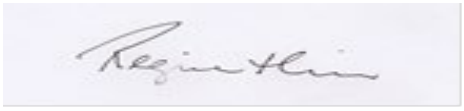
* * *

C E R T I F I C A T I O N

I, Regina Harris, having been assigned to transcribe the above-captioned interview from July 27, 2020 do hereby certify that said interview, pages 1 through 68, inclusive, is a true, correct, and verbatim transcript of said proceeding to the best of my ability.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was heard; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, and am not financially or otherwise interested in the outcome of the action.

This the 6th day of August 2021.



Regina Harris
Transcriptionist

Handout 48

OCME Wake Forest Universities Health Sciences Contract

STATE OF NORTH CAROLINA
Department of Health and Human Services

Refer *ALL* Inquiries regarding this RFQ to:	Request for Quote # 30-21439
	Quotes will be publicly opened: June 28, 2021, 2 PM (ET)
Marsha K. Harrington	Contract Type: Agency Specific Term Contract
Contract Specialist	Commodity No. and Description: 952-09 Autopsy Services
Marsha.Harrington@dhhs.nc.gov	Using Agency: DHHS – Department of Public Health
	Requisition No.: N/A

EXECUTION

In compliance with this Request for Quote, and subject to all the conditions herein, the undersigned Vendor offers and agrees to furnish and deliver any or all items upon which prices are quoted, at the prices set opposite each item within the time specified herein. By executing this quote, the undersigned Vendor certifies that this quote is submitted competitively and without collusion (G.S. 143-54), that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934 (G.S. 143-59.2), and that it is not an ineligible Vendor as set forth in G.S. 143-59.1. False certification is a Class I felony. Furthermore, by executing this quote, the undersigned certifies to the best of Vendor's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal or State department or agency. As required by G.S. 143-48.5, the undersigned Vendor certifies that it, and each of its sub-contractors for any Contract awarded as a result of this RFQ, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system. G.S. 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By execution of any response in this quote, you attest, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

Failure to execute/sign quote prior to submittal shall render quote invalid and it WILL BE REJECTED. Late quotes cannot be accepted.

VENDOR: **Wake Forest University Health Sciences**			
STREET ADDRESS: **Medical Center Blvd.**		P.O. BOX:	ZIP:
CITY & STATE & ZIP: **Winston-Salem, NC 27157-0001**		TELEPHONE NUMBER: **336-716-2382**	TOLL FREE TEL. NO:
PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE (SEE INSTRUCTIONS TO VENDORS ITEM #11):			
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF VENDOR: **Sara Stanley, Director, Office of Sponsored Programs**		FAX NUMBER: **336-716-4480**	
VENDOR'S AUTHORIZED SIGNATURE: Angela Horton acting for	DATE: 6/24/2021	EMAIL: **awards@wakehealth.edu**	

Offer valid for at least 60 days from date of quote opening, unless otherwise stated here: _____ days.

ACCEPTANCE OF QUOTE

If any or all parts of this quote are accepted by the State of North Carolina, an authorized representative of Department of Health and Human Services shall affix his/her signature hereto and this document and all provisions of this Request for Quote along with the Vendor response and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Vendor(s).

07/08/21 | 8:50 PM EDT

FOR STATE USE ONLY: Offer accepted and Contract awarded this _____ day of _____, 20___ as indicated on the attached certification, by _____

(Authorized Representative of the Department of Health and Human Services, Division of Public Health)

DocuSigned by:
Mark T. Benton/jp
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Table of Contents

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PURPOSE AND BACKGROUND

The purpose of this Request for Quote (RFQ) is to establish an Agency Specific Term Contract with a Vendor to provide Medical Examiner Services in North Carolina through professional staff, technical staff and suitable facilities for death investigations and autopsies. The quantity of services is undetermined, and no quantities are guaranteed. An estimated quantity based on past history or other means may be used as a guide but shall not be a representation by the State of any anticipated work volume under any contract made pursuant to this RFQ.

Pursuant to N.C.G.S. 130A-383, any death resulting from sudden, unnatural, violent, or suspicious causes; occurring in a jail, a prison or a state operated facility; or unattended by a physician must be reported to a county Medical Examiner (ME). County Medical Examiners, appointed by the Chief Medical Examiner, investigate the circumstances surrounding the death and certify the cause and manner of death. If the Medical Examiner decides that an autopsy is needed, the Chief Medical Examiner or a pathologist designated by the Chief Medical Examiner conducts the autopsy examination.

North Carolina General Statute 130A-377 authorizes establishing district or regional offices to provide appropriate personnel and facilities for postmortem medical-legal examinations. Appropriate personnel would include board-certified forensic pathologists who conduct inspections and autopsy examinations, file death certificates, confer with and advise county medical examiners and law enforcement officers in medical-legal death investigation matters, and communicate with the decedents' families. Appropriate facilities would be staffed with the necessary technical, investigative and administrative support staff capable of providing 24 hours/day, seven days/week support of the death investigation system, including storage of bodies awaiting examination.

Quotes shall be submitted in accordance with the terms and conditions of this RFQ and any addenda issued hereto.

1.0 GENERAL INFORMATION

2.1 REQUEST FOR QUOTE DOCUMENT

The RFQ is comprised of the base RFQ document, any attachments, and any addenda released before Contract award. All attachments and addenda released for this RFQ in advance of any Contract award are incorporated herein by reference. Vendor may attach its quote to this RFQ for submission; however, any and all additional, modified or conflicting terms and conditions submitted on or with Vendor's quote shall be disregarded and shall not be considered a part of any contract arising from this RFQ. Any attempt to delete or avoid the force of the previous sentence shall render Vendor's quote invalid, and it shall not be considered.

2.2 E-PROCUREMENT SOLICITATION

ATTENTION: This is NOT an E-Procurement solicitation. Paragraph #17 of Attachment D: North Carolina General Contract Terms and Conditions, paragraphs (b) and (c), do not apply to this solicitation.

2.3 MAILING INSTRUCTIONS

Instructions: Quotes, subject to the conditions made a part hereof and the receipt requirements described below, shall be received at the address indicated in the table below, for furnishing and delivering those items as described herein. **Deliver one (1) signed copy of the offer via e-mail, to Marsha K. Harrington at Marsha.Harrington@dhhs.nc.gov.** Offer must be submitted on the forms provided herein and Vendor must return all the pages of this solicitation with its offer as provided in Section 2.4. below. The subject line of the e-mail should read ***RFQ #30-21439 – Medical Examiner Services.***

If confidential and proprietary information is included in the quote, *also* submit **one (1) signed, REDACTED copy** of the offer to **Marsha K. Harrington at** Marsha.Harrington@dhhs.nc.gov. Such information may include trade secrets defined by N.C. Gen. Stat. §66-152 and other information exempted from the Public Records Act pursuant to N.C. Gen. Stat. §132-1.2. Vendor may designate information, Products, Services or appropriate portions of its response as confidential,

consistent with and to the extent permitted under the Statutes and Rules set forth above. By so redacting any page, or portion of a page, the Vendor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions determined to be confidential and proprietary and redacted as such, meet the requirements of the Rules and Statutes set forth above. ***However, under no circumstances shall price information be designated as confidential.***

It is the responsibility of the Vendor to deliver the offer in this office by the specified time and date of opening.

Prices and any other entry made hereon by the Vendor shall be considered firm and not subject to change.

The **maximum size limit for e-mails**, including the header, content, and attachments may not exceed **25MB**. If the quote is expected to exceed this size limit, submit separate e-mails and label "1 of X", "2 of X", etc. or as otherwise appropriate.

2.4 QUOTE CONTENTS

Vendor shall populate all attachments of this RFQ that require the Vendor to provide information and include an authorized signature where requested, as outlined below. Vendor Responses shall include the following items and they should be arranged in the following order:

a) Completed and signed version of EXECUTION PAGE, along with the body of the RFQ, and signed receipt pages of any addenda released in conjunction with this RFQ.

b) Completed version of ATTACHMENT A: PRICING FORM

c) Completed version of ATTACHMENT B: LOCATION OF WORKERS UTILIZED BY VENDOR

d) Completed version of ATTACHMENT C: INSTRUCTIONS TO VENDORS

e) ATTACHMENT D: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS

f) ATTACHMENT E: ADDITIONAL CONTRACT TERMS AND CONDITIONS

g) ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION

h) ATTACHMENT G: DATA PROTECTION

i) ATTACHMENT H: CERTIFICATION OF FINANCIAL CONDITION

2.5 DEFINITIONS, ACRONYMS, AND ABBREVIATIONS

a) **BUYER:** The employee of the State or Other Eligible Entity that places an order with the Vendor.

b) **CONTRACT ADMINISTRATOR:** Representative of the Department of Health and Human Services who corresponds with potential Vendors in order to identify and contract with that Vendor providing the greatest benefit to the State and who will administer the contract for the State.

c) **DHHS:** North Carolina Department of Health and Human Services

d) **DPH/DIVISION:** Division of Public Health

e) **E-PROCUREMENT SERVICES:** The program, system, and associated services through which the State conducts electronic procurement.

f) **HIPAA:** Health Insurance Portability and Accountability Act

g) **MEIS:** Medical Examiner Information System

h) **OCME:** Office of the Chief Medical Examiner

i) **RFQ:** Request for Quote.

j) **SERVICES:** The tasks and duties undertaken by the Vendor to fulfill the requirements and specifications of this solicitation.

k) **STATE AGENCY:** Any of the more than 400 sub-units within the executive branch of the State, including its departments, boards, commissions, institutions of higher education and other institutions.

l) **THE CONTRACT:** A contract resulting form or arising out of Vendor(s) responses to this solicitation.

m) **VENDOR:** Supplier, bidder, proposer, company, firm, corporation, partnership, individual or other entity submitting a response to a Request for Quote.

2.6 NOTICE TO VENDORS REGARDING TERMS AND CONDITIONS

It shall be the Vendor's responsibility to read the Instructions, the State's terms and conditions, all relevant exhibits and attachments, and any other components made a part of this RFQ, and comply with all requirements and specifications herein. Vendors also are responsible for obtaining and complying with all Addenda and other changes that may be issued in connection with this RFQ.

If Vendors have questions, issues, or exceptions regarding any term, condition, instruction or other component within this RFQ, those *shall* be submitted as questions to the Agency prior to submission of a Quote. If the State determines that any changes will be made as a result of the points raised, then such decisions will be communicated in the form of an addendum. Other than through this process, and subject to the provisions of section 2.1, the State rejects and shall not be required to evaluate or consider any additional or modified terms and conditions or Instructions to Vendor submitted with Vendor's response. This applies to any language appearing in or attached to the document as part of the Vendor's response that purports to vary any terms and conditions or Vendors' instructions herein or to render the quote non-binding or subject to further negotiation. Vendor's response to this RFQ shall constitute a firm offer. **By execution and delivery of a response to this RFQ, Vendor agrees that any additional or modified terms and conditions, including Instructions to Vendors, whether submitted purposely or inadvertently, or any purported condition to the offer shall have no force or effect, and will be disregarded. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject Vendor's Quote.**

2.0 METHOD OF AWARD AND QUOTE EVALUATION PROCESS

3.1 METHOD OF AWARD

Contracts will be awarded in accordance with G.S. 143-52 and the evaluation criteria set out in this solicitation. Prospective Vendors shall not be discriminated against on the basis of any prohibited grounds as defined by Federal and State law.

The State may obtain quotes from one or more potential Vendors. All quotes will be evaluated and award will be based on lowest responsive quote meeting specifications.

3.2 PERFORMANCE OUTSIDE THE UNITED STATES

Vendor shall complete ATTACHMENT B: LOCATION OF WORKERS UTILIZED BY VENDOR. In addition to any other evaluation criteria identified in this RFQ, the State may, for purposes of evaluating proposed or actual contract performance outside of the United States, also consider how that performance may affect the following factors to ensure that any award will be in the best interest of the State:

a) Total cost to the State
b) Level of quality provided by the Vendor
c) Process and performance capability across multiple jurisdictions
d) Protection of the State's information and intellectual property
e) Availability of pertinent skills
f) Ability to understand the State's business requirements and internal operational culture
g) Particular risk factors such as the security of the State's information technology
h) Relations with citizens and employees
i) Contract enforcement jurisdictional issues

3.3 QUOTE EVALUATION PROCESS

a) Quotes are requested for the items as specified, or item(s) equivalent in design, function and performance. The State reserves the right to reject any quote on the basis of fit, form and function as well as cost.

b) The State shall review the responses to this RFQ to confirm that they meet the specifications and requirements. The State reserves the right to waive any minor informality or technicality.

c) For all responses that pass the initial review process, the State will review and assess the Vendors' pricing. The State may request additional formal responses or submissions from any or all Vendors for the purpose of clarification or to amplify the materials presented in any part of the quote. Vendors are cautioned, however, that the State is not required to request clarification, and often does not. Therefore, all quotes should be complete and reflect the most favorable terms available from the Vendor. Prices quoted cannot be altered or modified as part of a clarification.

d) Quotes will be evaluated, based on the award criteria identified in Section 3.1 METHOD OF AWARD.

Award of a Contract to one Vendor does not mean that the other quotes lacked merit, but that, all factors considered, the selected quote was deemed most advantageous and represented the best value to the State.

Vendors are cautioned that this is a request for quote, not a request or an offer to contract, and the State reserves the unqualified right to reject any and all offers at any time if such rejection is deemed to be in the best interest of the State.

CONFIDENTIALITY DURING PROCESS: During the evaluation period and prior to award, all information concerning the quote and evaluation is confidential, and possession of the quotes and accompanying information is limited to personnel of the issuing agency and any third parties involved in this procurement process, and to the committee responsible for participating in the evaluation. Any attempt on behalf of a Vendor to gain such confidential information, or to influence the evaluation process (e.g., contact anyone involved in the evaluation, criticize another Vendor, offer any benefit or information not contained in the quote) in any way is a violation of North Carolina purchasing law and regulations and shall constitute sufficient grounds for disqualification of Vendor's offer from further evaluation or consideration in the discretion of the State.

3.4 INTERPRETATION OF TERMS AND PHRASES

This Request for Quote serves two functions: (1) to advise potential Vendors of the parameters of the solution being sought by the Department; and (2) to provide (together with other specified documents) the terms of the Contract resulting from this procurement. As such, all terms in the Request for Quote shall be enforceable as contract terms in accordance with the General Contract Terms and Conditions. The use of phrases such as "shall," "must," and "requirements" are intended to create enforceable contract conditions. In determining whether quotes should be evaluated or rejected, the Department will take into consideration the degree to which Vendors have proposed or failed to propose solutions that will satisfy the Department's needs as described in the Request for Quote. Except as specifically stated herein, no one requirement shall automatically disqualify a Vendor from consideration. However, failure to comply with any single requirement may result in the Department exercising its discretion to reject a quote in its entirety.

4.0 REQUIREMENTS

This Section lists the requirements related to this RFQ. By submitting a quote, the Vendor agrees to meet all stated requirements in this Section as well as any other specifications, requirements and terms and conditions stated in this RFQ. If Vendor is unclear or has any question about the specifications, requirements and terms and conditions herein, it is urged and cautioned to contact the issuing agency Contract Lead as specified in this RFQ.

4.1 CONTRACT TERM

The Contract shall have an initial term of one (1) year, beginning June 1, 2021 (the "Effective Date") and terminating on May 31, 2022.

At the end of the Contract's current term, the State shall have the option, in its sole discretion, to renew the Contract on the same terms and conditions for up to a total of **two (2) additional one (1) year terms**. The State will give the Vendor written notice of its intent whether to exercise each option no later than thirty (60) days before the end of the Contract's then-current term. In addition, the State reserves the right to extend a contract term for a period of up to 180 days in 90-day-or-less increments.

4.2 PRICING

Quote price shall constitute the total cost to the State for providing the services described herein. Vendor shall not invoice for any amounts not specifically allowed for in this Quote.

4.3 INVOICES

Vendor shall invoice the Agency monthly. The Vendor shall submit to the Division Contract Administrator, Nikki Marshall, a monthly invoice, for services rendered the previous month, by the 10th of the following month. **Invoices shall be submitted via email to Nikki.Marshall@dhhs.nc.gov and include detailed line-item information to allow Division Contract Administrator to verify services rendered and pricing match Division records.** At a minimum, the following fields shall be included on all invoices:

Vendor's Billing Address, NC Contract Number, Date of Invoice, Unit Price and Extended Price.

The final invoice must be submitted no later than June 10th of the current state fiscal year which runs July 1st through June 30th.

4.4 FINANCIAL STABILITY

Each Vendor shall certify it is financially stable by completing the ATTACHMENT H: CERTIFICATION OF FINANCIAL CONDITION. The State is requiring this certification to minimize potential performance issues from Contracting with a Vendor that is financially unstable. This Certification shall be deemed continuing, and from the date of the Certification to the expiration of the Contract, the Vendor shall notify the State within thirty (30) days of any occurrence or condition that materially alters the truth of any statement made in this Certification.

4.5 PAYMENTS

Prior to payment of funds, Vendor shall submit a monthly autopsy log detailing autopsies performed as outlined in Section 6.2.

The Division will issue payment to the Vendor the statutory fixed cost rates of either $1,050 as the State's portion when the subject of the autopsy becomes deceased in their county of residence or $2,800 as payment in full when the subject of the autopsy becomes deceased within the state outside their county of residence, in accordance with N.C.G.S. 130A-389(a). For instances of shared compensation responsibilities between the County of Residence and the State, the Division will issue payment to the Vendor the State's portion ($1,050) of the fixed cost autopsy fee upon receipt of the CER. For the remaining fees, the portion attributed to the county of residence the Division will attempt to ensure Vendor is paid an amount equal to the statutory fixed cost rates for each autopsy by either billing the appropriate county and directing it to pay the Vendor or initiating payment by the state pursuant to N.C.G.S. 130A-389(a) upon accepting a completed autopsy report.

4.6 PERSONNEL

Vendor shall not substitute key personnel assigned to the performance of this Contract without prior written approval by the Contract Lead. Vendor shall notify the Contract Lead of any desired substitution, including the name(s) and references of Vendor's recommended substitute personnel. The State will approve or disapprove the requested substitution in a timely manner. The State may, in its sole discretion, terminate the Services of any person providing Services under this Contract. Upon such termination, the State may request acceptable substitute personnel or terminate the contract Services provided by such personnel.

4.7 SUBCONTRACTING

The Vendor shall not subcontract any of the work contemplated under this contract without prior written approval from the Division. Any approved subcontract shall be subject to all terms and conditions of The Contract. Only the subcontractors specified in the contract documents are to be considered approved upon award of the contract. The State shall not be obligated to pay for any work performed by any unapproved subcontractor. The Vendor shall be responsible for the performance of all of its subcontractors.

5.0 SCOPE OF WORK

5.1 PERFORMANCE REQUIREMENTS

The Vendor shall:

1. Serve as the Regional Medical Examiner Center for up to 33 designated counties in western North Carolina, advising local medical examiners who conduct medical-legal death investigations;
2. On an annual basis, perform up to 1,399 medico-legal autopsies (recognizing such number is not inclusive of mass casualty, disaster or other emergencies as discussed in the prior Section) that are advisable and in the public interest for the designated counties. Payment for these autopsies shall be in the amount and method as set forth and statutorily defined in N.C.G.S. 130A-389(a);
3. Maintain a professional staff of at least (3) three full-time, board-certified Forensic Pathologists;
4. Maintain sufficient investigative and technical staff for 24 hours/day, seven days/week support and backup coverage for advising local medical examiners in all 33 counties in the region;
5. Assure that autopsy examinations and inspections are scheduled and completed in a timely and efficient manner, generally within two to three calendar days;
6. Submit toxicology samples to the Office of Chief Medical Examiner (OCME) with a complete history and appropriate orders for analysis;
7. Complete/submit autopsy reports in entirety, to include a statement of the cause of death;
8. Certify and file the supplemental death certificate for all pending death certificates for all drug-related fatalities from Buncombe and Henderson Counties performed at the facility;
9. Submit a copy of the supplemental death certificate along with the autopsy report;
10. Submit monthly autopsy data report(s). Data elements will be defined in advance by the Chief Medical Examiner;
11. Submit a monthly log of the number of autopsies performed, the decedent's name and the date of service;
12. Confer with local medical examiners and the OCME to assess opportunities to contribute to the Mass Fatality Incident plans in the event of a natural or man-made disaster in the designated counties to effectively integrate the functions of the Vendor and OCME;
13. Secure at Vendor's cost a suitable facility in the designated catchment area capable of storing and examining decomposed remains and managing multiple fatality incidents;
14. Deploy professional and technical staff as surge capacity at another regional medical examiner center as needed in the event of a multiple fatality incident, as directed by the Chief Medical Examiner, with expenses for such deployment to be submitted to OCME for consideration as soon as practicable thereafter;
15. Upon request, provide information and communication to family members of the deceased, law enforcement officials and other branches of the judicial system;
16. Ensure that any pathologist employed by Vendor does not enter into any contract, or accept any additional employment, to act as an expert witness in opposition to the OCME. This includes publishing a report for litigation and/or offering testimony that conflicts with the report or testimony of (i) a professional staff member of the OCME, (ii) another pathologist under contract with OCME, or (iii) another local medical examiner in the North Carolina Medical Examiner System;

17. Testify in court and depositions concerning cause of death findings for autopsies performed by Vendor's pathologists at this location;
18. Work collaboratively with the OCME to fully utilize the new medical examiner information system (MEIS) and manage integration of the system into daily operation in compliance with OCME guidance and direction; and
19. Designate two (2) "super users" (one primary, one secondary) to serve as liaisons with the OCME regarding operation and support of the new MEIS. Liaisons shall oversee and manage access rights of Vendor's staff with the MEIS in coordination with the OCME Operations Manager. Liaisons shall also serve as key points of contact for all systems related training and will service in a train-the-trainer capacity, as necessary.

5.2 PERFORMANCE AREA

The Vendor will provide services to the following North Carolina Counties under this contract: Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cherokee, Clay, Davidson, Davie, Forsyth, Graham, Haywood, Henderson, Iredell, Jackson, Lincoln, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Stokes, Surry, Swain, Transylvania, Watauga, Wilkes, Yancy, Yadkin.

The Vendor may on occasion be asked by Division or Regional Medical Examiners to provide services to other counties. Such requests are hereby anticipated and authorized for Vendor's performance under this Scope of Work.

5.3 PERFORMANCE STANDARDS

The Vendor shall:

1. Maintain regional presence in Western North Carolina so bodies can be examined locally;
2. Conduct medico-legal autopsies in accordance with established OCME guidelines;
3. Complete autopsy reports within 180 calendar days per 10A N.C.A.C. 44. 0202;
4. Submit monthly data reports to the OCME Epidemiologist via electronic mail; and
5. Submit a hard copy of the monthly autopsy log with the corresponding monthly invoice to the Office of the Chief Medical Examiner.

5.4 PERFORMANCE MONITORING/QUALITY ASSURANCE PLAN

This contract will be monitored according to the following plan:

1. The Chief Medical Examiner and OCME staff will monitor the Vendor's performance by conducting peer reviews of medical examiner autopsy and investigation reports to assure that the content and conclusions meet OCME requirements and forensic pathology best practice standards;
2. The Chief Medical Examiner and OCME staff will monitor the Vendor's performance by reviewing concerns raised by family members of the deceased, local medical examiners, funeral homes, transportation service providers, law enforcement officials and attorneys; and
3. The Chief Medical Examiner will consult directly with Vendor's pathologists when the peer reviews reveal instances where report content and conclusions do not meet program and professional standards.

5.5 ACCEPTANCE OF WORK

In the event acceptance criteria for any Services, work or other deliverables is not described herein or in contract documents or work orders hereunder, the State shall have the obligation to notify Vendor, in writing ten (10) calendar days following completion of such Services, work or other deliverable described in the Contract that it is not acceptable. The notice shall specify in reasonable detail the reason(s) it is unacceptable. Acceptance by the State shall not be unreasonably withheld; but may be conditioned or delayed as required for reasonable review, evaluation, installation or testing, as applicable of the Services, work or other deliverable. Final acceptance is expressly conditioned upon completion of all applicable assessment procedures. Should the work or deliverables fail to meet any requirements,

acceptance criteria or otherwise fail to conform to the contract, the State may exercise any and all rights hereunder, including, for deliverables, such rights provided by the Uniform Commercial Code as adopted in North Carolina.

5.6 TRANSITION ASSISTANCE

If this Contract is not renewed at the end of this term, or is canceled prior to its expiration, for any reason, Vendor shall provide, at the option of the State, up to three (3) months after such end date all such reasonable transition assistance requested by the State, to allow for the expired or canceled portion of the Services to continue without interruption or adverse effect, and to facilitate the orderly transfer of such Services to the State or its designees. If the State exercises this option, the Parties agree that such transition assistance shall be deemed to be governed by the terms and conditions of this Contract (notwithstanding this expiration or cancellation), except for those Contract terms or conditions that do not reasonably apply to such transition assistance. The State shall pay Vendor for any resources utilized in performing such transition assistance at the most current rates provided by the Contract for performance of the Services or other resources utilized.

5.7 VENDOR'S REPRESENTATION

a) Vendor warrants that qualified personnel shall provide all services that may be required under The Contract in a professional manner. "Professional manner" means that the personnel performing the services shall possess the skill and competence consistent with at least the prevailing business standards in the industry. Vendor agrees that it shall not enter any agreement with a third party that may abridge any rights of the State under The Contract. Vendor shall serve as the prime contractor under The Contract and shall be responsible for the performance and payment of all subcontractor(s) that may be approved by the State. Names of any third-party Vendors or subcontractors of Vendor may appear for purposes of convenience in Contract documents; and shall not limit Vendor's obligations hereunder.

b) If any goods, services, functions, or responsibilities not specifically described in The Contract are required for Vendor's proper performance, provision and delivery of the goods and services under The Contract, or are an inherent part of or necessary sub-requirement included within such goods and services, they will be deemed to be implied by and included within the scope of the contract to the same extent and in the same manner as if specifically described in the contract. Unless otherwise expressly provided herein, Vendor will furnish all of its own necessary management, supervision, labor, facilities, furniture, computer and telecommunications equipment, software, supplies and materials necessary for the Vendor to provide and deliver the goods and services.

c) Vendor warrants that it has the financial capacity to perform and to continue perform its obligations under the contract; that Vendor has no constructive or actual knowledge of an actual or potential legal proceeding being brought against Vendor that could materially adversely affect performance of The Contract; and that entering into The Contract is not prohibited by any contract, or an order by any court of competent jurisdiction.

6.0 CONTRACT ADMINISTRATION

6.1 PROJECT MANAGER AND CUSTOMER SERVICE

The Vendor shall designate and make available to the State a single point of contact for contract related issues and issues concerning performance, progress review, scheduling and any service required.

6.2 MONTHLY STATUS REPORTS

The Vendor shall provide the following Performance Management Reports to the designated Division Contract Administrator on a monthly basis. These reports shall include, at a minimum, information concerning the work accomplished during the reporting period (e.g., number of autopsies performed); work to be accomplished during the subsequent reporting period; problems, real or anticipated, and notification of any significant deviation from previously agreed upon work plans and schedules. These reports shall be well organized and easy to read. The Vendor shall submit these reports electronically using Microsoft Excel and, as needed, either Microsoft PowerPoint or Microsoft Word. The Vendor shall submit the reports in a timely manner and on a regular schedule as agreed by the parties.

Within fifteen (15) business days of the award of the Contract the Vendor shall submit a final work plan and a sample report, both to the designated Division Contract Administrator for approval.

6.3 DISPUTE RESOLUTION

The parties agree that it is in their mutual interest to resolve disputes informally. A claim by the Vendor shall be submitted in writing to the State's Contract Lead for resolution. A claim by the State shall be submitted in writing to the Vendor's Project Manager for resolution. The Parties shall negotiate in good faith and use all reasonable efforts to resolve such dispute(s). During the time the Parties are attempting to resolve any dispute, each shall proceed diligently to perform their respective duties and responsibilities under The Contract. If a dispute cannot be resolved between the Parties within thirty (30) days after delivery of notice, either Party may elect to exercise any other remedies available under The Contract, or at law. This term shall not constitute an agreement by either party to mediate or arbitrate any dispute.

6.4 CONTRACT CHANGES

Contract changes, if any, over the life of the contract shall be implemented by contract amendments agreed to in Writing by the State and the Vendor.

Attachments to this RFQ begin on the next page.

Quote Number: 30-21439 *Vendor:* Wake Forest University Health Sciences

ATTACHMENT A: PRICING FORM

The quantity of services is undetermined, and no quantities are guaranteed. The quantities listed below are only an "estimate" to obtain pricing.

Pricing for services described herein shall be in the amount and method as set forth and statutorily defined in N.C.G.S. 130A-389(a).

FURNISH AND DELIVER:

Item #	QTY.	UOM	DESCRIPTION	UNIT PRICE	EXTENDED PRICE
1	1,399	Each	STATE'S PORTION OF A MEDICO-LEGAL AUTOPSY SERVICES AND APPLICABLE DELIVERABLES WHEN THE SUBJECT OF THE AUTOPSY BECOMES DECEASED IN THEIR COUNTY OF RESIDENCE	$ 1,050	$ 1,468,950

TOTAL NOT TO EXTENDED PRICE: $ 1,468,950

Quote Number: 30-21439 *Vendor:* Wake Forest University Health Sciences

ATTACHMENT B: LOCATION OF WORKERS UTILIZED BY VENDOR

In accordance with NC General Statute 143-59.4, the Vendor shall detail the location(s) at which performance will occur, as well as the manner in which it intends to utilize resources or workers outside of the United States in the performance of this Contract. The State will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Please complete items a, b, and c below.

a) Will any work under this Contract be performed outside the United States? ☐ YES ☒ NO

If the Vendor answered "YES" above, Vendor shall complete items 1 and 2 below:

1. List the location(s) outside the United States where work under this Contract will be performed by the Vendor, any sub-Contractors, employees, or other persons performing work under the Contract:

2. Describe the corporate structure and location of corporate employees and activities of the Vendor, its affiliates or any other sub-Contractors that will perform work outside the U.S.:

b) The Vendor agrees to provide notice, in writing to the State, of the relocation of the Vendor, employees of the Vendor, sub-Contractors of the Vendor, or other persons performing services under the Contract outside of the United States ☒ YES ☐ NO

NOTE: All Vendor or sub-Contractor personnel providing call or contact center services to the State of North Carolina under the Contract shall disclose to inbound callers the location from which the call or contact center services are being provided.

c) Identify all U.S. locations at which performance will occur:
Medical Center Boulevard
Winston-Salem, NC 27157-3972
NC-006

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ATTACHMENT C: INSTRUCTIONS TO VENDORS

1. **READ, REVIEW AND COMPLY:** It shall be the Vendor's responsibility to read this entire document, review all enclosures and attachments, and any addenda thereto, and comply with all requirements specified herein, regardless of whether appearing in these Instructions to Vendors or elsewhere in this RFQ document.

2. **EXECUTION:** Failure to sign the Execution page (page 3 of the RFQ) in the indicated space will render quote non-responsive and it shall be rejected.

3. **CERTIFICATE TO TRANSACT BUSINESS IN NORTH CAROLINA:** As a condition of contract award, each out-of-State Vendor that is a corporation, limited-liability company or limited-liability partnership shall have received, and shall maintain throughout the term of The Contract, a Certificate of Authority to Transact Business in North Carolina from the North Carolina Secretary of State, as required by North Carolina law. A State contract requiring only an isolated transaction completed within a period of six months, and not in the course of a number of repeated transactions of like nature, shall not be considered as transacting business in North Carolina and shall not require a Certificate of Authority to Transact Business.

4. **ORDER OF PRECEDENCE:** In cases of conflict between specific provisions in this solicitation or in any resulting contract, the order of precedence shall be (high to low) (1) any special terms and conditions specific to this RFQ, including any negotiated terms; (2) specifications in Sections 2, 4, and 5 of this RFQ; (3) North Carolina General Contract Terms and Conditions in ATTACHMENT D: NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS; (4) Instructions in ATTACHMENT C: INSTRUCTIONS TO VENDORS; and (5) Vendor's quote.

5. **INELIGIBLE VENDORS:** As provided in G.S. 147-86.60 and G.S. 147-86.82, the following companies are ineligible to contract with the State of North Carolina or any political subdivision of the State: a) any company identified as engaging in investment activities in Iran, as determined by appearing on the Final Divestment List created by the State Treasurer pursuant to G.S. 147-86.58, and b) any company identified as engaged in a boycott of Israel as determined by appearing on the List of restricted companies created by the State Treasurer pursuant to G.S. 147-86.81. A contract with the State or any of its political subdivisions by any company identified in a) or b) above shall be void *ab initio*.

6. **INFORMATION AND DESCRIPTIVE LITERATURE:** Vendor shall furnish all information requested and in the spaces provided in this document. Further, if required elsewhere in this quote, each Vendor shall submit with their quote sketches, descriptive literature and/or complete specifications covering the products offered.

7. **RECYCLING AND SOURCE REDUCTION:** It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable and less toxic to the extent that the purchase or use is practicable and cost-effective. We also encourage and promote using minimal packaging and the use of recycled/recyclable products in the packaging of commodities purchased. However, no sacrifice in quality of packaging will be acceptable. The company remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Companies are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.

8. **SUSTAINABILITY:** To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all responses meet the following:

   - All copies of the quote are printed double sided.
   - All submittals and copies are printed on recycled paper with a minimum post-consumer content of 30%.
   - Unless absolutely necessary, all quotes and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable.
   - Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.

9. **HISTORICALLY UNDERUTILIZED BUSINESSES:** Pursuant to General Statute 143-48 and Executive Order 150 (1999), the State invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled.

10. **CONFIDENTIAL INFORMATION:** To the extent permitted by applicable statutes and rules, the State will maintain confidential trade secrets that the Vendor does not wish disclosed. As a condition to confidential treatment, each page containing trade secret information shall be identified in boldface at the top and bottom as "CONFIDENTIAL" by the Vendor, with specific trade secret information enclosed in boxes or similar indication. Cost information shall not be deemed confidential under any circumstances. Regardless of what a Vendor may label as a trade secret, the determination whether it is or is not entitled to protection will be determined in accordance with G.S. 132-1.2. Any material labeled as confidential constitutes a representation by the Vendor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under G.S. 132-1.2. Vendors are urged and cautioned to limit the marking of information as a trade secret or as confidential so far as is possible.

11. **PROTEST PROCEDURES:** When a Vendor wishes to protest a Contract resulting from this RFQ that is awarded by the Division of Purchase and Contract, or awarded by an agency in an awarded amount of at least $25,000, a Vendor shall submit a written request addressed to the State Purchasing Officer at Purchase and Contract, 1305 Mail Service Center, Raleigh, NC 27699-1305. A protest request related to an award amount of less than $25,000 shall be sent to the purchasing officer of the agency that issued the award. The protest request shall be received in the proper office within thirty (30) consecutive calendar days from the date of the Contract award. Protest letters shall contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party's claims. **Note:** Contract award notices are sent only to the Vendor actually awarded the Contract, and not to every person or firm responding to a solicitation. Bid status and Award notices are posted on the Internet at https://www.ips.state.nc.us/ips/. All protests will be handled pursuant to the North Carolina Administrative Code, 01 NCAC 05B .1519.

12. **MISCELLANEOUS:** Masculine pronouns shall be read to include feminine pronouns, and the singular of any word or phrase shall be read to include the plural and vice versa.

13. **INFORMAL COMMENTS:** The State shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the State during the competitive process or after award. The State is bound only by information provided in this RFQ and in formal Addenda issued.

14. **COST FOR QUOTE PREPARATION:** Any costs incurred by Vendor in preparing or submitting quotes are the Vendor's sole responsibility; the State of North Carolina will not reimburse any Vendor for any costs incurred prior to award.

15. **VENDOR'S REPRESENTATIVE:** Each Vendor shall submit with its quote the name, address, and telephone number of the person(s) with authority to bind the firm and answer questions or provide clarification concerning the firm's quote.

16. **INSPECTION AT VENDOR'S SITE:** The State reserves the right to inspect, at a reasonable time, the equipment/item, plant or other facilities of a prospective Vendor prior to Contract award, and during the Contract term as necessary for the State determination that such equipment/item, plant or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.

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ATTACHMENT D: NORTH CAROLINA GENERAL CONTRACT TERMS & CONDITIONS

1. **DEFAULT AND PERFORMANCE BOND:** If, through any cause, Vendor shall fail to fulfill in timely and proper manner the obligations under this agreement, the State shall have the right to terminate this contract by giving written notice to the Vendor and specifying the effective date thereof. In case of default by the Vendor for any reason, the State may procure substitute goods from other sources and hold the Vendor responsible for any excess cost occasioned thereby. The State reserves the right to require at any time a performance bond or other acceptable alternative guarantees from a successful Vendor without expense to the State.

   In addition, in the event of default by the Vendor under this Contract or upon the Vendor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against the Vendor, the State may immediately cease doing business with the Vendor, immediately terminate this Contract for cause, and take action to debar the Vendor from doing future business with the State.

2. **GOVERNMENTAL RESTRICTIONS:** In the event any Governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship or performance of the items offered prior to their delivery, it shall be the responsibility of the Vendor to notify, in writing, the issuing purchasing office at once, indicating the specific regulation which required such alterations. The State reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.

3. **AVAILABILITY OF FUNDS:** Any and all payments to the Vendor are dependent upon and subject to the availability of funds to the agency for the purpose set forth in this Contract.

4. **TAXES:** Any applicable taxes shall be invoiced as a separate item.

   a) G.S. 143-59.1 bars the Secretary of Administration from entering into Contracts with Vendors if the Vendor or its affiliates meet one of the conditions of G.S. 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under G.S. 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the Vendor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the quote document the Vendor certifies that it and all of its affiliates, (if it has affiliates), collect(s) the appropriate taxes.

   b) All agencies participating in this Contract are exempt from Federal Taxes, such as excise and transportation. Exemption forms submitted by the Vendor will be executed and returned by the using agency.

   c) Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.

5. **SITUS:** The place of this Contract, its situs and forum, shall be North Carolina, where all matters, whether sounding in Contract or tort, relating to its validity, construction, interpretation and enforcement shall be determined.

6. **GOVERNING LAWS:** This Contract is made under and shall be governed, construed and enforced in accordance with the laws of the State of North Carolina, without regard to its conflict of laws rules.

7. **PAYMENT TERMS:** Payment terms are Net not later than 30 days after receipt of correct invoice or acceptance of goods, whichever is later. The using agency is responsible for all payments to the Vendor under the Contract. Payment by some agencies may be made by procurement card, if the Vendor accepts that card (Visa, MasterCard, etc.) from other customers, and it shall be accepted by the Vendor for payment under the same terms and conditions as any other method of payment accepted by the Vendor. If payment is made by procurement card, then payment may be processed immediately by the Vendor.

8. **NON-DISCRIMINATION:**

   a. The Vendor will take necessary action to comply with all Federal and State requirements concerning fair employment and employment of people with disabilities and concerning the treatment of all employees without regard to discrimination on the basis of any prohibited grounds as defined by Federal and State law.

b. The vendor will take necessary action to ensure its internal employee policies and procedures are consistent with Executive Order #82 (Roy Cooper, December 6, 2018), which extends workplace protections and accommodations to pregnant employees.

9. **CONDITION AND PACKAGING:** Unless otherwise provided by special terms and conditions or specifications, it is understood and agreed that any item offered or shipped has not been sold or used for any purpose and shall be in first class condition. All containers/packaging shall be suitable for handling, storage or shipment.

10. **STANDARDS:** All manufactured items and/or fabricated assemblies subject to operation under pressure, operation by connection to an electric source, or operation involving a connection to a manufactured, natural, or LP gas source shall be constructed and approved in a manner acceptable to the appropriate state inspector which customarily requires the label or re-examination listing or identification marking of the appropriate safety standard organization; such as the American Society of Mechanical Engineers for pressure vessels; the Underwriters Laboratories and /or National Electrical Manufacturers' Association for electrically operated assemblies; or the American Gas Association for gas operated assemblies, where such approvals of listings have been established for the type of device offered and furnished. Further, all items furnished shall meet all requirements of the Occupational Safety and Health Act (OSHA), and state and federal requirements relating to clean air and water pollution.

    The complete product(s) offered herein, and NOT merely its component parts or subsystems, shall comply with the above requirement for safety listing. Having the appropriate certification or safety label affixed to any device delivered pursuant to this solicitation, under the conditions described above, is a material condition of any contract awarded as a result of this solicitation. All costs for product and industry certifications and listings, and any other actions required to supply conforming products to the State as described in this RFQ, are the sole responsibility of the Vendor. The certification or safety label shall be affixed and be visible on the OUTSIDE of the all products that require a certification or safety label in order to pass the State Quality Acceptance Inspection. The requirements of this paragraph 10 shall not be waived by contract award or otherwise by the purchasing agency.

11. **INTELLECTUAL PROPERTY INDEMNITY:** Vendor shall hold and save the State, its officers, agents and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or unpatented invention, articles, device or appliance delivered in connection with this contract.

12. **ADVERTISING:** Vendor agrees not to use the existence of this Contract or the name of the State of North Carolina as part of any commercial advertising or marketing of products or services. A Vendor may inquire whether the State is willing to act as a reference by providing factual information directly to other prospective customers.

13. **ACCESS TO PERSONS AND RECORDS:** During and after the term hereof, the State Auditor and any using agency's internal auditors shall have access to persons and records related to this Contract to verify accounts and data affecting fees or performance under the Contract, as provided in G.S. 143-49(9).

14. **ASSIGNMENT:** No assignment of the Vendor's obligations nor the Vendor's right to receive payment hereunder shall be permitted.

    However, upon written request approved by the issuing purchasing authority and solely as a convenience to the Vendor, the State may:

    a) Forward the Vendor's payment check directly to any person or entity designated by the Vendor, and

    b) Include any person or entity designated by Vendor as a joint payee on the Vendor's payment check.

    In no event shall such approval and action obligate the State to anyone other than the Vendor and the Vendor shall remain responsible for fulfillment of all Contract obligations. Upon advance written request, the State may, in its unfettered discretion, approve an assignment to the surviving entity of a merger, acquisition or corporate reorganization, if made as part of the transfer of all or substantially all of the Vendor's assets. Any purported assignment made in violation of this provision shall be void and a material breach of this Contract.

15. **INSURANCE:**

    COVERAGE - During the term of the Contract, the Vendor at its sole cost and expense shall provide commercial insurance of such type and with such terms and limits as may be reasonably associated with the Contract. As a minimum, the Vendor

shall provide and maintain the following coverage and limits:

a) **Worker's Compensation** - The Vendor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of $500,000.00, covering all of Vendor's employees who are engaged in any work under the Contract. If any work is sublet, the Vendor shall require the sub-Contractor to provide the same coverage for any of his employees engaged in any work under the Contract.

b) **Commercial General Liability** - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of $1,000,000.00 Combined Single Limit. (Defense cost shall be in excess of the limit of liability.)

c) **Automobile** - Automobile Liability Insurance, to include liability coverage, covering all owned, hired and non-owned vehicles, used in connection with the Contract. The minimum combined single limit shall be $250,000.00 bodily injury and property damage; $250,000.00 uninsured/under insured motorist; and $2,500.00 medical payment.

REQUIREMENTS - Providing and maintaining adequate insurance coverage is a material obligation of the Vendor and is of the essence of this Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Vendor shall at all times comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this Contract. The limits of coverage under each insurance policy maintained by the Vendor shall not be interpreted as limiting the Vendor's liability and obligations under the Contract.

16. **GENERAL INDEMNITY:** The Vendor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Vendor in the performance of this Contract and that are attributable to the negligence or intentionally tortious acts of the Vendor provided that the Vendor is notified in writing within 30 days that the State has knowledge of such claims. The Vendor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Vendor goods to the State. The representation and warranty in the preceding sentence shall survive the termination or expiration of this Contract.

17. **ELECTRONIC PROCUREMENT:**

a) Purchasing shall be conducted through the Statewide E-Procurement Service. The State's third party agent shall serve as the Supplier Manager for this E-Procurement Service. The Vendor shall register for the Statewide E-Procurement Service within two (2) business days of notification of award in order to receive an electronic purchase order resulting from award of this contract.

b) **THE SUCCESSFUL BIDDER(S) SHALL PAY A TRANSACTION FEE OF 1.75% (.0175) ON THE TOTAL DOLLAR AMOUNT (EXCLUDING SALES TAXES) OF GOODS INCLUDED ON EACH PURCHASE ORDER ISSUED THROUGH THE STATEWIDE E-PROCUREMENT SERVICE.** This applies to all purchase orders, regardless of the quantity or dollar amount of the purchase order. The transaction fee shall not be stated or included as a separate item on the invoice. There are no additional fees or charges to the Vendor for the services rendered by the Supplier Manager under this contract. Vendor will receive a credit for transaction fees they paid for the purchase of any item(s) if an item(s) is returned through no fault of the Vendor. Transaction fees are non-refundable when an item is rejected and returned, or declined, due to the Vendor's failure to perform or comply with specifications or requirements of the contract.

c) Vendor or its Authorized Reseller, as applicable, will be invoiced monthly for the State's transaction fee by the Supplier Manager. The transaction fee shall be based on a) purchase activity for the prior month, or b) purchases for which the supplier invoice has been paid. Unless Supplier Manager receives written notice from the Vendor identifying with specificity any errors in an invoice for the transaction fee within thirty (30) days of the receipt of

invoice, such invoice shall be deemed to be correct and Vendor shall have waived its right to later dispute the accuracy and completeness of the invoice. Payment of the transaction fee by the Vendor is due to the account designated by the State within thirty (30) days after receipt of the invoice for the transaction fee. If payment of the transaction fee is not received by the State within this payment period, it shall be considered a material breach of contract. Pursuant to G.S. 147-86.23, the Service will charge interest and late payment penalties on past due balances. Interest shall be charged at the rate set by the Secretary of Revenue pursuant to G.S. 105-241.21 as of the date the balances are past due. The late-

payment penalty will be ten percent (10%) of the account receivable. Within thirty (30) days of the receipt of invoice, Vendor may dispute in writing the accuracy of an invoice. No interest shall be charged on disputed and overdue amounts to the extent the State agrees to reduce or adjust the amount in dispute. The Supplier Manager shall provide, whenever reasonably requested by the Vendor in writing (including electronic documents), supporting documentation from the E-Procurement Service that accounts for the amount of the invoice.

d) The Supplier Manager will capture the order from the State approved user, including the shipping and payment information, and submit the order in accordance with the E-Procurement Service. Subsequently, the Supplier Manager will send those orders to the appropriate Vendor on State Contract. The State or State-approved user, not the Supplier Manager, shall be responsible for the solicitation, quotes received, evaluation of quotes received, award of contract, and the payment for goods delivered.

e) Vendor agrees at all times to maintain the confidentiality of its user name and password for the Statewide E-Procurement Services. If Vendor is a corporation, partnership or other legal entity, then the Vendor may authorize its employees to use its password. Vendor shall be responsible for all activity and all charges by such employees. Vendor agrees not to permit a third party to use the Statewide E-Procurement Services through its account. If there is a breach of security through the Vendor's account, Vendor shall immediately change its password and notify the Supplier Manager of the security breach by email. Vendor shall cooperate with the State and the Supplier Manager to mitigate and correct any security breach.

VENDOR IS AND SHALL REMAIN RESPONSIBLE FOR PAYING THE TRANSACTION FEE ON BEHALF OF ANY SUB-CONTRACTOR OR DEALER INVOLVED IN PERFORMANCE UNDER THIS CONTRACT IN THE EVENT THAT SUCH SUB-CONTRACTOR OR DEALER DEFAULTS ON PAYMENT.

18. **COMPLIANCE WITH LAWS:** Vendor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business and performance in accordance with this contract, including those of federal, state, and local agencies having jurisdiction and/or authority.

19. **ENTIRE AGREEMENT:** This RFQ and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements. This RFQ, any Addenda hereto, and the Vendor's quotes are incorporated herein by reference as though set forth verbatim.

    All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

20. **AMENDMENTS:** This contract may be amended only by written amendments duly executed by the State and the Vendor. The NC Division of Purchase and Contract shall give prior approval to any amendment to a contract awarded through that office.

21. **WAIVER:** The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.

22. **FORCE MAJEURE:** Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations as a result of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

23. **SOVEREIGN IMMUNITY:** Notwithstanding any other term or provision in this contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the State under applicable law.

Quote Number: 30-21439 *Vendor:* Wake Forest University Health Sciences

ATTACHMENT E: ADDITIONAL CONTRACT TERMS & CONDITIONS

1. **SERVICES:**
   a) **Service Standards:** The Vendor shall provide high quality services consistent with the standard of practice in the geographic area and with all applicable federal, state, and local laws, rules and regulations, all applicable ethical standards, and standards established by applicable accrediting agencies. The Vendor shall exercise independent professional judgment in the treatment and care of patients.
   b) **Records:** The Vendor shall maintain complete and professionally adequate medical records consistent with the standards of practice and the profession. The Vendor shall prepare all reports, notes, forms, claims and correspondence that are necessary and appropriate to the Vendor's provision of professional services.
   c) **Licenses:** During the term of this Agreement, the Vendor shall hold, a current license at the level required to practice the Vendor's profession and provide the contracted services in the State of North Carolina.

2. **PATENTS AND INVENTIONS:** Any invention or discovery made or conceived in the performance of this contract (hereinafter called "INVENTION"), and any patent granted on such INVENTION shall be jointly or individually owned by Vendor and/or Division in accordance with the following criteria:
   a) Title to any INVENTION made or conceived jointly by employees of both Vendor and Division in the performance of this contract (hereinafter called "JOINT INVENTION") vests jointly in Division and Vendor.
   b) Title to any INVENTION made or conceived solely by employees or students of either Vendor or Division in the performance of this Contract vests in the party whose employees or students made or conceived the INVENTION or discovery.

3. **PUBLICATION:** Vendor and its investigators are free to publish papers dealing with the results of the research project, if any, sponsored under this Contract. However, Division must be given thirty (30 days) to review such papers prior to any publication thereof. The Vendor shall acknowledge the Division's funding role in all publications.

4. **SIMILAR RESEARCH:** Nothing in this Contract may be construed to limit the freedom of the Vendor or of its researchers who are participants under the Contract from engaging in similar research made under grants, contracts, or agreements with parties other than the Division.

5. **FEDERAL INTELLECTUAL PROPERTY BANKRUPTCY PROTECTION ACT:** The Parties agree that the Division shall be entitled to all rights and benefits of the Federal Intellectual Property Bankruptcy Protection Act, Public Law 100-506, codified at 11 U.S.C. 365(n), and any amendments thereto.

Quote Number: 30-21439 *Vendor:* Wake Forest University Health Sciences

ATTACHMENT F: SUPPLEMENTAL VENDOR INFORMATION

HISTORICALLY UNDRUTILIZED BUSINESSES

Historically Underutilized Businesses (HUBs) consist of minority, women and disabled business firms that are at least fifty-one percent owned and operated by an individual(s) of the categories. Also included in this category are disabled business enterprises and non-profit work centers for the blind and severely disabled.

Pursuant to G.S. 143B-1361(a), 143-48 and 143-128.4, the State invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled. This includes utilizing subcontractors to perform the required functions in this RFQ. Any questions concerning NC HUB certification, contact the North Carolina Office of Historically Underutilized Businesses at (919) 807-2330. The Vendor shall respond to question #1 and #2 below.

a) Is Vendor a Historically Underutilized Business? ☐ Yes ☒ No

b) Is Vendor Certified with North Carolina as a Historically Underutilized Business? ☐ Yes ☒ No

If so, state HUB classification: _____

SUSTAINABILITY

According to G.S. 143-58.2, it is the policy of this State to encourage and promote the purchase of products with recycled content and to purchase items that are reusable, refillable, repairable, more durable and less toxic to the extent that the purchase or use is practicable and cost effective.

Do the items offered have any recycled content? ☐ Yes ☒ No

If yes, what is the post-consumer recycled content? _____% What is the total recycled content? _____%

Other sustainable properties:

_____

_____

ATTACHMENT G: DATA PROTECTION

DATA PROTECTION

The requirements of this section apply to all data that the Vendor may create, receive, maintain, or transmit on DHHS's behalf under the terms of this contract. The requirements apply regardless of the Vendor's status as a HIPAA covered entity.

General Provisions

Vendor agrees to maintain DHHS data separately from other data sources in order to ensure data integrity and maintain data security. DHHS information is confidential "protected health information" that may be used and disclosed only in accordance with DHHS, State, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended ("HIPAA"), and its implementing regulations, 45 CFR Parts 160, 162, and 164, including the Omnibus Rule. Data should be maintained in keeping with the requirements of the HIPAA and 256-bit encryption must be used for data in transit.

Furthermore, all information listed in N.C.G.S § 14-113.20(b) as "identifying information" such as social security numbers, employer taxpayer identification numbers, drivers license numbers, and any other numbers or information that can be used to access a person's financial resources, may be used and disclosed only in accordance with the NC Identity Theft Protection Act, N.C.G.S. § 75-60 through 65 and N.C.G.S. § 132-1.10. The Vendor, its employees, agents, and subcontractors must protect all such information against theft and misuse at all times: in storage, while in use, and in transit.

The parties agree that for data that is created, received, maintained, or transmitted for the purposes of fulfilling the terms of this contract, DHHS has the role of the covered entity under HIPAA and the data owner under NC ID Theft law N.C.G.S. § 75-65(a). The Vendor does not own the data, but "maintains" or "possesses" the data under the provisions of N.C.G.S. § 75-65(b). The Vendor shall not take any independent action to notify oversight agencies such as the US Secretary of Health and Human Services or the NC Attorney General's office, or the individuals involved. Any recipient notification or notification of oversight agencies shall be performed directly by DHHS or with the approval of DHHS. Though the Vendor may generate a suggested draft, the language of the recipient letter shall be determined and approved by DHHS.

Notification of DHHS

The Vendor agrees to notify the DHHS when a security or privacy incident takes place. A security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, see 45 CFR 164.304. A privacy incident means an event in which there is reason to suspect a breach under HIPAA, that is, the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164 subpart E (Privacy of Individually Identifiable Health Information) which compromises the security or privacy of the protected health information.

1) **Data Security:** The Vendor shall adopt and apply data security standards and procedures that comply with all applicable federal, state, and local laws, regulations, and rules.
2) **Duty to Report:** The Vendor shall report to DHHS a suspected security incident or confirmed security breach to the DHHS Privacy and Security Office Incident Website at http://www.ncdhhs.gov/pso/ within twenty-four (24) hours after the incident or breach is first discovered, provided that the Vendor shall report a breach involved Social Security Administration data or Internal Revenue Service data within one (1) hour after the breach is first discovered. During the performance of this contract, the Vendor is to notify the Division Contract Administrator of any contact by the federal Office for Civil Rights (OCR) received by the Vendor.
3) **Cost Borne by Contractor:** If any applicable federal, state, or local law, regulation, or rule requires the Division or the Contractor to give affected persons written notice of a security breach arising out of the Vendor's performance under this contract, the Vendor shall bear the cost of the notice.

Risk Assessment and Recipient Notification

When a privacy or security incident has occurred, the Vendor shall:

- notify DHHS immediately, but no later than 24 hours;
- provide detailed information, providing complete and accurate answers to questions from DHHS within 1 business day unless otherwise agreed upon by both DHHS and the Vendor;
- investigate the incident to determine what, if any, information was disclosed and provide this to DHHS within 5 days

- complete a risk assessment within 5 business days of the event and make a preliminary assessment regarding the presence of significant risk of compromise to the data;
- provide a list of all recipients affected within 5 business days of the event;
- update DHHS as more information becomes available;
- provide all additional information required by HIPAA (including 45 CFR 164.410) and NC Identity Theft statutes within 5 days of the event;
- perform action to mitigate the compromise of the data and harm to the individuals involved and report this to DHHS within 10 days;
- determine the cause of the incident and perform remediation such as training, and policy/process changes to prevent these events in the future and report this to DHHS within 10 days;
- pay all costs of notification or provide the notification, at the discretion of the DHHS;
- promptly provide any information requested related to privacy/security issues to DHHS and remediate problems raised by DHHS staff.

Accounting of Disclosures

When it is concluded that the acquisition, access, use, or disclosure of protected health information in a manner not permitted under 45 CFR 164 subpart E (Privacy of Individually Identifiable Health Information) which compromises the security or privacy of the protected health information has taken place, the Vendor shall send the following information via secure email (portal here: https://web1.zixmail.net/s/login?b=ncdhhs) to the DHHS Privacy and Security Office.

- Date of event
- Names and MIDs of the individuals involved
- Description of information disclosed
- Name, address, and phone number of the individual or entity to whom the data was disclosed

Designated Record Set

The Vendor shall evaluate their records to identify the records that qualify as a Designated Record Set as defined in 45 CFR 164.501 and required in 45 CFR 164.524 and shall give this information to DHHS upon request. The Vendor shall provide copies of records and allow amendments when required by the HIPAA Privacy Rule (45 CFR 164.526). Copies of records shall be given to DHHS within 5-10 business days of the request. There shall be no supplemental charge for these processes.

Policies

The Vendor shall maintain compliance with the following:

- NC DHHS Privacy Manual and Security Manual, https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/
- NC Statewide Information Security Manual, https://it.nc.gov/statewide-information-security-policies
- NC DHHS Privacy and Security Policies, http://info.dhhs.state.nc.us/olm/manuals/dhs/pol-80/man/, including the HIPAA Breach Notification for Unsecured PHI policy.

Record Retention

Records shall not be destroyed, purged, or disposed of without express written consent of the Division. State basic records retention policy requires all grant records to be retained for a minimum of five years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years. Records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years followings the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involved this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five-year period described above, whichever is later. Records involved in Temporary Assistance for Needy Families (TANF) and MEDICAID and Human Resources grants and programs must be retained for a minimum of ten years.

Quote Number: 30-21439 *Vendor:* Wake Forest University Health Sciences

ATTACHMENT H: CERTIFICATION OF FINANCIAL CONDITION

Name of Vendor: **Wake Forest University Health Sciences**

The undersigned hereby certifies that: [check all applicable boxes]

[X] The Vendor is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.

Date of latest audit: _____ (If no audit within past 18 months, explain reason below)

[X] The Vendor has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.

[X] The Vendor is current on all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.

[X] The Vendor is not the subject of any current litigation or findings of noncompliance under federal or state law.

[X] The Vendor has not been the subject of any past or current litigation, findings in any past litigation, or findings of noncompliance under federal or state law that may impact in any way its ability to fulfill the requirements of The Contract.

[X] He or she is authorized to make the foregoing statements on behalf of the Vendor.

Note: This shall constitute a continuing certification and Vendor shall notify the Contract Lead within 15 days of any material change to any of the representations made herein.

— **If any one or more of the foregoing boxes is NOT checked, Vendor shall explain the reason(s) in the space below:**

Angela Horton acting for — **06/24/2021**

Signature — Date

Sara Stanley — **Director, Office of Sponsored Programs**

Printed Name — Title

[This Certification must be signed by an individual authorized to bind the Vendor]

Handout 49

Secondary Employment Policy

Secondary Employment Policy

Secondary Employment

Contents:

Policy

It is the policy of the State of North Carolina that any employee who holds a full time position with the state shall consider the state employment responsibilities as primary. Any employment outside of the primary state position is considered secondary employment.

The secondary employment cannot have an adverse effect on or create a conflict of interest with the primary employment. An employee shall obtain approval from the agency head or designee before engaging in any secondary employment.

These provisions for secondary employment apply to all employment not covered by the policy on Dual Employment.

Definitions

Secondary Employment: any activity involving the production or sale of goods, the provision of services, the performance of intellectual or creative work for pay in either an employer/employee relationship or in a self-employment capacity such as an independent contractor

Full Time: an employee who works 40 hours or more

Agency Responsibility

1. Secondary employment shall not be permitted when it would:
    - create either directly or indirectly a conflict of interest with the primary employment.
    - impair in any way the employee's ability to perform all expected duties, to make decisions and carry out in an objective fashion the responsibilities of the employee's position.

Secondary Employment Policy (cont.)

2. If the secondary employment has any impact or may create any possibility of conflict with State operations, the form must be approved by the State Human Resources Director in conjunction with the State Board of Ethics.
3. The employee shall have approval of the agency head, or designee, before beginning any secondary employment. Approval of secondary employment may be withdrawn at any time if it is determined that secondary employment has an adverse impact on primary employment.
4. Each agency shall establish its own specific criteria, not inconsistent with this policy, for approval and tracking of secondary employment based on work situation needs.
5. Each agency shall use a Secondary Employment Form that will be kept in the employee's personnel file that is consistent with the model provided by the Office of State Human Resources.
6. The agency shall notify all new employees of the provisions of the Secondary Employment Policy at the time of job offer.
7. The agency shall send out a notification to all employees annually of the provisions and requirements of Secondary Employment Policy.

Employee Responsibility

It is the responsibility of the employee prior to starting secondary employment:

- to complete a Secondary Employment Form for all employment that is not covered by Dual Employment, and

It also is the responsibility of the employee:

- to update the form annually
- to notify their supervisor and submit a new form when any changes occur to their secondary employment.

Handout 50

District Attorney's Statement

STATE OF NORTH CAROLINA YANCEY COUNTY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 11 CRS 304-05
STATE OF NORTH CAROLINA)) v.)) JOHN PRITCHARD,) Defendant)	STATE'S RESPONSE TO DEFENDANT'S CLAIM OF FACTUAL INNOCENCE

NOW COMES THE STATE OF NORTH CAROLINA, by and through the Office of the District Attorney, R. Seth Banks, and makes the following response to Defendant John Pritchard's ("Defendant" or "Mr. Pritchard") claim of factual innocence. For the reasons stated herein, the State respectfully requests that the Commission find that there is insufficient evidence of factual innocence to merit judicial review and deny Defendant's claim.

PROCEDURAL HISTORY

I. MR. PRITCHARD WAS CONVICTED OF SECOND DEGREE MURDER AND IS PROJECTED TO BE RELEASED ON JANUARY 3, 2027.

On April 17, 2014, John Pritchard was convicted by a jury of his peers of: (i) Second Degree Murder (the "Second Degree Murder Conviction") of Jonathan Russell Whitson ("Mr. Whitson") (ii) Delivery of a Schedule II Controlled Substance; (iii) Possession with Intent to Sell or Deliver a Schedule II Controlled Substance; and (iv) Maintaining a Vehicle, Dwelling, or Place for Keeping Controlled Substances. To be convicted of Second Degree Murder, Caused by Controlled Substance,[1] the jury must have found, beyond a reasonable doubt, that (i) Mr. Whitson's death was caused by ingesting morphine; (ii) Defendant intentionally and unlawfully distributed that morphine; (iii)

[1] The Court instructed the jury pursuant to N.C.P.I. – Crim 206.316, which is entitled "Second Degree Murder, Caused by Controlled Substance."

Defendant's unlawful distribution of that morphine was a proximate cause of Mr. Whitson's death; and (iv) Defendant unlawfully and with malice killed Mr. Whitson.

Following his conviction, the Court sentenced Mr. Pritchard to a minimum of 14 years and 2 months (170 months) and a maximum of 17 years and 9 months (213 months) for the Second Degree Murder conviction (the "Second Degree Murder Sentence"). At the time of his offense, Mr. Pritchard was on probation for Selling a Schedule II Controlled Substance. As a result of the Second Degree Murder Conviction, the Court revoked Mr. Pritchard's probation; activated his suspended sentence of 1 year (12 months) to 1 year and 3 months (15 months) (the "Activated Sentence"); and ordered that the Second Degree Murder Sentence and the Activated Sentence run consecutively. The North Carolina Department of Public Safety calculated Mr. Pritchard's projected release date as January 3, 2027.

After his conviction, the North Carolina Court of Appeals reviewed Defendant's case; the panel of three judges unanimously upheld Defendant's conviction. See State v. Pritchard, No. COA16-8 Aug. 2, 2016 (unpub.) In finding no error, the North Carolina Court of Appeals rejected Defendant's argument that the State failed as a matter of law to prove proximate cause including, inter alia, that the State failed to prove that Mr. Whitson died due to using the morphine provided to him by Defendant. See id. at 7.

II. THE FACTS PRESENTED DO NOT MEET THE REQUIREMENT FOR FACTUAL INNOCENCE.

NCGS § 15A-1460(1) defines a claim of factual innocence as

> a claim on behalf of a living person convicted of a felony in the General Court of Justice of the State of North Carolina, asserting the complete innocence of any criminal responsibility for the felony for which the person was convicted and for any other reduced level of criminal responsibility relating to the crime, and for which there is some credible, verifiable evidence of innocence that has not previously been presented at trial or considered at a hearing granted through post conviction relief.

The evidence presented to the District Attorney's Office as of this filing is neither new, nor evidence asserting complete innocence. While the investigation by the Commission's staff appears to be ongoing, no witnesses have recanted; no new evidence suggests that Defendant did not provide the victim with morphine; and any causation issues were fully litigated at the trial which resulted in Defendant's conviction.

EVIDENCE PRESENTED POST-CONVICTION

I. SIX EXPERTS HAVE BEEN RETAINED ON DEFENDANT'S BEHALF REGARDING THE CAUSE OF MR. WHITSON'S DEATH.

For presentation to this Commission, at least 6 experts have been retained on behalf of Defendant: (i) **Dr. Jerri McLemore**; (ii) **Dr. Barbara Wolf**; (iii) **Dr. Christopher Holstege**; (iv) **Dr. Christina Roberts**; (v) **Dr. George Behonick**; and (vi) **Dr. Andrew Ewens**. Each retained expert opined as to the role the morphine supplied by Defendant played in Mr. Whitson's death.

A. Two of the Experts Conclude That Mr. Whitson's Death Was Caused by Morphine Toxicity.

Dr. Jerri McLemore and Dr. Barbara Wolf, both experts contracted on Defendant's behalf, agree that morphine toxicity was not only the proximate cause of Mr. Whitson's death, but the actual cause. Dr. Jerri McLemore of Wake Forest University and a contract pathologist with the Chief Medical Examiner's Office, agreed with the cause of death presented to the jury, and Dr. McLemore specifically stated that she would find Mr. Whitson's cause of death to be "Aspiration pneumonia Due to Obtundation Due to Drug (morphine) intoxication." Dr. Barbara Wolf, a forensic pathologist based in Florida, "agree[s] with Dr. McLemore's opinion that morphine toxicity contributed to Mr. Whitson's death." Dr. Wolf "would certify the cause of death as morphine toxicity on Part I of the death certificate and list acute pneumonia as a contributory cause of death (Part II of the Death certificate)." Far from suggesting factual innocence, Dr. McLemore and Dr. Wolf agree with the State's expert at trial regarding Mr. Whitson's cause of death.

B. The Remaining Experts' Opinions Are Either Inconclusive or Speculative.

Dr. Christopher Holstege's, Dr. Christena Roberts', and Dr. George Behonick's findings are seemingly inconclusive. Dr. George Behonick states

> that detection of alcohol and morphine in blood indicate the presence of two central nervous (CNS) drugs in the decedent which may have implications as to the overall pharmacologic effects and toxicities experienced by the decedent.

Dr. Behonick further questions the entire field of toxicology by stating: "It is beyond the scope of expertise for a toxicologist to opine as to the absolute cause of death of an individual…" Dr. Holstege states that "Based on the limited data that we have in this case, I simply cannot state that morphine is the direct cause of his death, especially with a blood level that is 'trace.'" Dr. Roberts states that

> I do not agree that the clinical presentation or findings at autopsy with toxicology is consistent with acute toxicity of morphine.[2] Bronchopneumonia was present and pre-existing and therefore could be the cause of death with emphysema as a contributing factor. In my opinion, multiple cultures should have been performed at the time of autopsy that may have provided additional information. Without this information one could opine that Cause of Death is undetermined.

Notably, neither Dr. Christopher Holstege, Dr. Christena Roberts, nor Dr. George Behonick's rule out morphine as a factor in Mr. Whitson's death.

The only expert employed for Defendant who comes close to opining that Mr. Whitson did not die from morphine toxicity is Dr. Andrew Ewens: "It is my opinion that Mr. Whitson most likely did not die from the effects of morphine and alcohol." But remarkably, Dr. Andrew Ewens bases this statement in part from a comparison with Mrs. Whitson:

> Mr. Whitson had shared the same morphine with Mrs. Whitson and Mrs. Whitson did not die. After the third session of morphine injections, Mrs. Whitson was able to leave Mrs. Angel's house and drive home. In fact, Mrs. Whitson stated that she had no physical problems the next day. This suggests that the morphine was not the cause of Mr. Whitson's death.

[2] At least in part, Dr. Roberts bases this statement on the following conjecture: "It should be noted that Jonathan and Stephanie were injecting the same drug and the same amount. Stephanie testified she only did drugs when she was around Whitson. So the two (2) months that he was in jail they would have both reduced their tolerances to opiates [sic]."

The fact that another potential victim fortunately survived the drugs supplied by Defendant does not render Defendant factually innocent.[3]

Finally, at trial, the State's expert was subjected to—and thus the jury heard—thorough cross-examination regarding the issues now raised by the Commission's inquiry. Even in light of this cross-examination, the jury found that Mr. Whitson's use of the morphine delivered by Defendant was a proximate cause of Mr. Whitson's death. Furthermore, as stated in Section I of the State's Procedural History supra, the North Carolina Court of Appeals upheld the jury's determination and rejected Defendant's express contention that the State failed as a matter of law to prove proximate cause. Defendant's post-conviction experts, therefore, are insufficient to establish his factual innocence.

II. DEFENDANT'S SECOND DEGREE MURDER CONVICTION DOES NOT REQUIRE THAT THE STATE PROVE THAT MR. WHITSON'S DEATH RESULTED SOLELY FROM THE USE OF MORPHINE DELIVERED TO HIM BY DEFENDANT.

Defendant's Second Degree Murder Conviction did not require the State to prove that Defendant's delivery of morphine to Mr. Whiston was the sole cause of Mr. Whitson's subsequent death; on the contrary, to be convicted of Second Degree Murder, Defendant's delivery of the morphine must be only a proximate cause of Mr. Whitson's death. The necessary proximate cause exists if Defendant's act was a contributing cause of Mr. Whiston's death; it need not be the only or immediate cause of death. State v. Cummings, 301 N.C. 374, 377 (1980). Additionally, "[t]here may be more than one proximate cause and criminal responsibility arises when the act complained of caused or directly contributed to" Mr. Whitson's death. Id.; State v. Minton, 234 N.C. 716 (1952). Even if Mr. Whitson was more vulnerable due to a pre-existing condition, Defendant was criminally

[3] This is particularly true in light of evidence presented at trial indicating that some amount of the morphine remained accessible to Defendant after Mrs. Whitson's departure.

responsible, and thus not factually innocent, so long as Mr. Whitson's use of the morphine delivered to him by Defendant "caused or directly contributed" to his death.

III. TO DATE, THE STATE HAS RECEIVED NO FURTHER EVIDENCE SUGGESTING DEFENDANT'S FACTUAL INNOCENCE.

As of this filing, no information has been provided to The District Attorney's Office that any witness has recanted or provided any new information suggesting that Defendant did not provide Mr. Whitson with morphine. In fact, as recent as December 8, 2021 Stephanie Whitson Randolph, an eyewitness who testified at trial, testified in a deposition that Defendant provided Mr. Whitson with morphine. Far from suggesting factual innocence, all evidence points to Defendant delivering morphine in violation of NCGS § 90. The possibility that Mr. Whitson was more vulnerable because of preexisting conditions is not evidence of Defendant's innocence. Protecting the vulnerable is precisely why the Second Degree Murder, Caused by Controlled Substance law exists.

CONCLUSION

The evidence presented to the District Attorney's Office as of this filing is neither new, nor evidence asserting complete innocence. While the investigation appears to be incomplete, no witnesses have recanted, no new evidence suggests that Defendant did not provide the victim with morphine, and causation issues were litigated at trial. Therefore, the State respectfully requests the Commission find that there is insufficient evidence of factual innocence to merit judicial review and deny Defendant's claim.

This, the 10th day of December, 2021.

Office of the District Attorney
35th Judicial District

By: *Milton Fletcher* – signed electronically
Milton Fletcher
Assistant District Attorney
NC Bar #41234
PO Box 24
Bakersville, NC 28705

CERTIFICATE OF SERVICE

This is to certify that I have this date served a copy of the foregoing State's Response to Defendant's Claim of Factual Innocence by email, as instructed by the Commission and as set forth below:

Lindsey Guice Smith
Executive Director
Innocence Commission
Lindsey.G.Smith@nccourts.org

This the 10th day of December, 2021.

Milton Fletcher – signed electronically
Milton Fletcher
Assistant District Attorney
35th Prosecutorial District

Handout 51

Jonathan Whitson Medical Records Chart

Sealed by Order of the Court.

Handout 52

Jonathan Whitson Mission Hospital Medical Records - January 2010 until death

Sealed by Order of the Court.

Handout 53

Mission Hospital Medical Records from 1-1-05 to 1-1-10

Sealed by Order of the Court.

Handout 54

Email from Dr. Roberts with BaseIt Morphine Chapters

Ziegler, Brian T.

From: CJ Consulting <cj-consulting@live.com>
Sent: Wednesday, December 15, 2021 3:43 PM
To: Ziegler, Brian T.
Subject: RE: Baselt Morphine
Attachments: Baselt Morphine chapter.pdf

Here is a copy of the chapter on morphine from Baselt. This book title "disposition of Toxic Drugs and Chemicals in Man is a refernce that pulls together literature for each drug and discusses therapuetic, supratherapeutic and toxic levels of a drug.

The concept that the urine only shows usage over several days and varies from day to day and throughout the day is a very basic concept in Forensic Toxicology. It won't be reiterated here in every chapter for every drug but comes from Forensic Tox texts

Dr. Roberts

Sent from Mail for Windows

From: Ziegler, Brian T.
Sent: Wednesday, December 15, 2021 3:22 PM
To: cj-consulting@live.com
Cc: Tanner, Beth
Subject: Baselt Morphine

Dr. Roberts, you can just reply to this email to send the material. Thanks so much.

Brian Ziegler
Staff Attorney
919- 890-1580 Office
919-890-1937 Fax
www.InnocenceCommission-NC.gov

THE NORTH CAROLINA
INNOCENCE
INQUIRY COMMISSION

Analysis. Moricizine has been determined in biological fluids by liquid chromatography (Whitney et al., 1981; Piotrovski and Metelitsa, 1982; Martin-Light et al., 1984; Poirier, 1985; Yang et al., 1989; Yang and Chan, 1995).

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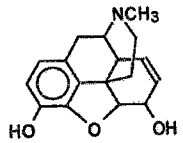
Morphine



T½: 1.3–6.7 hr
Vd: 2–5 L/kg
Fb: 0.35
pKa: 8.1
b/p: 1.0 (morphine)
0.6 (morphine glucuronides)

Occurrence and Usage. Morphine (Astramorph, Avinza, DepoDur, Duramorph, Kadian, Kapanol, MS Contin, MSIR, Oramorph, Roxanol) is prototypical of the narcotic analgesics, having been available for thousands of years as the primary constituent of crude opium and finally isolated as a pure alkaloid in 1803. It remains a popular drug for treatment of moderate to severe pain, often by subcutaneous, intramuscular, intravenous, epidural or intrathecal injection of the sulfate salt at an initial dose of 1–10 mg/70 kg; solutions of 0.5–25 mg/mL are available in 1–60 mL containers for this purpose. Oral preparations are available in normal-release solutions of 2–4 mg/mL, a 20 mg/mL concentrate, or 15–30 mg tablets or capsules to be taken in doses of 5–30 mg every 4 hours; sustained-release tablets or capsules contain 15–200 mg and are taken at 8–24 hour intervals. Poppy seed, a common food ingredient, may contain morphine at concentrations of 4–200 mg/kg, leading to oral morphine doses as high as 5–10 mg per helping of poppy seed food. Morphine is also a metabolite of codeine, ethylmorphine, heroin and pholcodine.

Blood Concentrations. A single oral dose of a 30 mg immediate-release morphine tablet given to healthy adults resulted in peak plasma concentrations averaging 24 µg/L for morphine at 0.8 hours, 94 µg/L for morphine-6-glucuronide (an active metabolite) at 1.6 hours and 481 µg/L for morphine-3-glucuronide at 1.4 hours. The same volunteers given a single oral 60 mg dose of a modified-release capsule exhibited peak plasma levels for these 3 species averaging 16, 81 and 456 µg/L, respectively, at 7.9, 9.3 and 9.7 hours (Bochner et al., 1999). The apparent morphine elimination half-life for the modified-release preparation used in the above study (Kapanol) was estimated at 15–16 hours (Broomhead et al., 1997), but other sustained-release oral preparations such as Oramorph were found to exhibit half-lives as short as 3.2 hours (Drake et al., 1996). The oral bioavailability of morphine ranges from 15–64% and averages 38%; a 20–30 mg oral dose in adult terminal cancer patients was sufficient to maintain serum morphine levels above 20 µg/L (considered to be analgesic) for 4–6 hours in most patients (Sawe et al., 1981). In adult cancer patients receiving 15 mg immediate-release oral doses every 6 hours (60 mg/day) for 5 days, steady-state plasma concentrations averaged 14 µg/L morphine, 77 µg/L morphine-6-glucuronide and 515 µg/L morphine-3-glucuronide (Hasselstrom et al., 1991). Adult cancer patients titrated to achieve pain relief with 60–180 mg daily of sustained-release morphine had trough serum concentrations averaging 19, 118 and 896 µg/L for morphine, morphine-6-glucuronide and morphine-3-glucuronide, respectively (Klepstad et al., 2000). Adult cancer patients receiving an average daily oral sustained-release morphine dose of 170 mg (range, 10–1400) had average plasma levels at 1–2 hours post-dose of 36 µg/L (range, 2.9–320) for morphine, 349 µg/L (range, 14–3644) for morphine-6-glucuronide and 1712 µg/L (range 86–15,360) for morphine-3-glucuronide (Holthe et al., 2002).

Intramuscular injection of 10 mg/70 kg in 11 adult surgical patients resulted in an average peak serum level of 70 µg/L at 10–20 minutes after administration, with a decline to 20 µg/L by 4 hours; in this study it was noted that morphine-3-glucuronide, a metabolite devoid of pharmacologic activity, appeared in serum within 20 minutes after administration and exceeded the free morphine concentration after 2 hours (Berkowitz et al., 1975). The epidural administration of 0.1 mg/kg (7 mg/70 kg) of the drug to 9 adult surgical patients produced an average maximal serum concentration of 79 µg/L at 10 minutes, declining to less than 10 µg/L by 4 hours; the morphine-3-glucuronide level reached an average peak of 99 µg/L at 2 hours (Drost et al., 1986).

Using an assay specific for unconjugated morphine, it was found that a single 0.125 mg/kg (8.75 mg/70 kg) intravenous dose of morphine in 11 healthy adults produced an average serum morphine concentration of 437 µg/L at 0.5 minutes, with a rapid early decline to 23 µg/L by 2 hours (Aitkenhead et al., 1984). Plasma morphine concentrations of 46–83 µg/L (average, 65) were found necessary to produce surgical analgesia in pediatric patients (Dahlstrom et al., 1979). Large doses (55–65 mg) of morphine given by intravenous infusion to adult surgical patients produced peak plasma concentrations of 800–2600 µg/L with concentrations of 300–500 µg/L still detected after 1.5 hours; this amount of drug produced profound respiratory depression in all patients and assisted ventilation was required (Stanski et al., 1976).

The plasma half-life of morphine in adult surgical patients averages 1.8 hours for women and 2.9 hours for men (Rigg et al., 1978). The half-life is not significantly increased in renal failure patients (Aitkenhead et al., 1984), but is approximately doubled in cirrhotic subjects (Mazoit et al., 1987). In neonates, it averages 6.8 hours (Lynn and Slattery, 1987). The elimination half-life of morphine-6-glucuronide is similar to that of morphine in patients with normal renal function, but may be prolonged in renal disease (Peterson et al., 1990).

Metabolism and Excretion. Approximately 5% of a morphine dose is N-demethylated to normorphine, which is less active than morphine as an analgesic and which probably does not contribute significantly to overall pharmacologic effects; normorphine is found as a urinary metabolite in both the free (1%) and conjugated (4%) forms. The majority of administered morphine is inactivated by conversion to morphine-3-glucuronide, most of which is excreted in the bile with a portion eventually eliminated in the feces. However, there is substantial enterohepatic circulation of conjugated and intestinally-deconjugated morphine, with the result that up to 87% of a morphine dose is eliminated in the 72 hour urine, with 75% present as morphine-3-glucuronide. Enterohepatic circulation, as well as hepatocyte secretion into blood, of the glucuronide may account for its presence in plasma. Free morphine in the urine accounts for about 10% of the dose, while very small amounts of morphine-6-glucuronide,

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morphine-3-ethereal sulfate and morphine-3,6-diglucuronide are also present (Boerner et al., 1975; [illegible], 1975; Hahn et al., 1977; Yeh et al., 1977). There is evidence that morphine-6-glucuronide is an active metabolite and speculation that it is a significant contributor to analgesia during chronic morphine treatment (Hanks et al., 1987; Osborne et al., 1990; van Dorp et al., 2006).

Certain investigators have suggested that codeine is a minor metabolite of morphine in man, but others have shown that codeine arises as an impurity in commercial morphine to the extent of 0.04%, and that this is the source of urinary codeine following morphine administration (Boerner and Abbott, [illegible]; Boerner et al., 1974; Yeh, 1974). Hydromorphone has been identified as a minor metabolite in chronic pain patients receiving large doses of morphine (Cone et al., 2006).

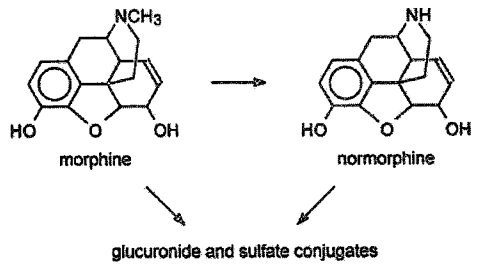
The following morphine concentrations were found in a subject who received multiple administrations of intravenous morphine during a 48 hour period of hospitalization and who died of traumatic injuries (Cravey and Reed, 1977):

Morphine Concentrations in a Trauma Patient (mg/L or mg/kg)

Blood	Brain	Lung	Liver	Bile
0.67	0.04	0.21	0.11	0.44

As expected from animal studies on the blood-brain barrier penetration by morphine (Oldendorf et al., 1972), the brain concentration is very low. Since the radioimmunoassay procedure used in the above body distribution study is 80% cross-reactive with morphine-3-glucuronide, it is likely that this metabolite accounts for a portion of the above concentrations. This contribution may be especially important in the case of the blood concentration, since the data of Spiehler and Brown (1987) show that unconjugated morphine averages just 42% (range, 0–100%) of the total blood morphine level in forensic cases.

Eating of poppy seed foods has resulted in total morphine and codeine concentrations as high as 0.100 and 0.007 mg/L, respectively, in serum and 4.5 and 0.2 mg/L, respectively, in urine (Bjerver et al., 1982; Fritschi et al., 1985; Hayes et al., 1987; Pettitt et al., 1987; Streumpler, 1987; Zebelman et al., 1987; Thevis et al., 2003). The drinking of 240 mL of *Papaveris fructus* herbal teas containing 10–32 mg/L morphine produced peak urinary total morphine concentrations of 1–7 mg/L at 2–6 hours in 5 healthy men (Van Thuyne et al., 2003). The analysis of urine for thebaine, present in poppy seeds but not in pharmaceutical or illicit opiate dosage forms, has been suggested as a means of differentiating dietary sources from intentional drug use (Cassella et al., 1997).



Toxicity. Adverse or toxic effects of morphine usage include pupillary constriction, constipation, urinary retention, nausea, vomiting, hypothermia, drowsiness, dizziness, apathy, confusion, respiratory depression, hypotension, cold and clammy skin, coma and pulmonary edema. Impairment of cognition and motor control is demonstrable in healthy volunteers at plasma morphine concentrations equal to or greater than 0.040 mg/L (Kerr et al., 1991). Doses greater than 30 mg parenterally and 100 mg orally are toxic to the nontolerant adult, and death may occur following doses of 120 mg or more. Three adult renal failure patients exhibited prolonged respiratory failure after morphine administration, at a time when plasma morphine concentrations were less than 0.004 mg/L but morphine-6-glucuronide levels were 0.130–1.171 mg/L (Osborne et al., 1986). Two neonates receiving intravenous morphine infusions experienced seizures at serum morphine concentrations of 0.061 and 0.090 mg/L

(Koren et al., 1985). A 46 year old woman developed coma after ingesting at least 5 g of prolonged-release morphine tablets, but survived with treatment; her plasma concentrations, first measured 60 hours post-ingestion, were 0.62, 6.2 and 11 mg/L for morphine, morphine-3-glucuronide and morphine-6-glucuronide, respectively (Westerling et al., 1998).

Morphine *per se* is rarely used by addicts in the United States and there is little information on tissue concentrations to be expected following fatal overdosage. However, the drug is apparently used more commonly in Europe, and one report of 10 adult fatalities involving the intravenous administration of morphine, with no other drugs found, presented the following information (Felby et al., 1974):

Total Morphine Concentrations in Fatalities (mg/L or mg/kg)

	Blood	Muscle	Liver	Urine
Average	0.7	0.8	3.0	52
(Range)	(0.2–2.3)	(0.1–2.0)	(0.4–18)	(14–81)

* By gas chromatography after acid hydrolysis and silylation

Chan et al. (1986) reported the deaths of two men involving oral or intravenous morphine administration, with findings of 0.07–0.35 mg/L unconjugated morphine in blood and 2.9–7.0 mg/kg total drug in liver. A man who had been receiving a continuous intrathecal morphine infusion was found dead after apparently having removed morphine from his infusion pump and injecting himself intravenously; his postmortem unconjugated morphine levels were 0.46 mg/L in peripheral blood and 0.10 mg/L in spinal fluid (Gock et al., 1999).

Morphine may exhibit postmortem redistribution; heart/femoral blood concentration ratios averaged 2.2 (range, 1.0–5.8) in a series of 10 cases (Dalpe-Scott et al., 1995) and 1.2 (range 0.05–2.8) in another series of 24 deaths (Hepler et al., 2004).

Analysis. The assay of morphine is discussed in the section on heroin.

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Handout 55

Criminal Poisoning Clinical and Forensic Perspectives Excerpts

Christopher P. Holstege, MD
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Gregory B. Saathoff, MD
R. Brent Furbee, MD

CRIMINAL POISONING

Clinical and Forensic Perspectives

Foreword by The Lord Alderdice, FRCPsych, House of Lords
and Honorable Edwin Meese, III, Former United States Attorney General

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Christopher P. Holstege, MD, is an associate professor of emergency medicine and pediatrics at the University of Virginia's School of Medicine and chief of the University of Virginia's Division of Medical Toxicology. His clinical practice is associated with the University of Virginia's Center of Clinical Toxicology. He has published extensively in the medical literature with over 100 publications in medical journals, periodicals, and books. Dr. Holstege speaks extensively on various topics in the field of medical toxicology, with a focus on areas such as criminal poisoners and chemical weapons of mass destruction. He has been integrally involved in the diagnosis and management of a number of high profile criminal poisonings, including the dioxin poisoning of the Ukrainian President Viktor Yushchenko.

In appreciation of his work in both education and clinical service, Dr. Holstege received the Dean's Award for Clinical Excellence from the University of Virginia, the National Faculty Teaching Award from the American College of Emergency Physicians, and the Attending Teacher of the Year Award from the University of Virginia's Department of Emergency Medicine. He currently serves on the Board of Trustees of the American Academy of Clinical Toxicology and on the Steering Committee of the University of Virginia's Critical Incident Analysis Group (CIAG). He is a consultant to the Federal Bureau of Investigation (FBI).

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He wrote *The Negotiator's Guide to Psychotropic Drugs* for the FBI's Crisis Negotiation Unit, and he was a co-author of the FBI's threat assessment monograph: The School Shooter. In addition to this, he has published in the areas of personality disorders, police psychiatry, posttraumatic stress disorders, public response to weapons of mass destruction, and biologic psychiatry. He assembled and led a University of Virginia medical team that served as the U.S. component of the international medical group charged with diagnosis and treatment of President Viktor Yuschenko who was poisoned in 2004. He has served as an expert witness on espionage- and terrorist-related cases in federal court. Since 1996 he has served as a conflict resolution specialist, and in 2006, he was appointed to the Research Advisory Board of the FBI's National Center for the Analysis of Violent Crime.

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Dr. Furbee has served as a consultant in several criminal and civil cases in the United States. He was a member of the investigative team for the Indiana State Police in the *State of Indiana v. Orville Lynn Majors* case, the largest criminal investigation in that state's history. He has authored publications regarding homicidal poisoning and the toxicity of heavy metals, manganese, plants, drugs of abuse, pharmaceuticals, and venomous animals. Dr. Furbee is an associate clinical professor of emergency medicine at the Indiana University School of Medicine and a fellow of the American College of Medical Toxicology.

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Foreword

Criminal Poisoning: Clinical and Forensic Perspectives, edited by Dr. Holstege, Agent Neer, Dr. Saathoff, and Dr. Furbee, is to our knowledge the most comprehensive book written to date specifically addressing the subject of criminal poisoning. This text will provide a valuable resource for any medical or law enforcement personnel evaluating a potential criminal poisoning.

Historically, criminal poisoning cases have often proved difficult to diagnose, investigate, and prosecute. The delivery methods employed can be markedly sophisticated and subtle. The deviousness associated with criminal poisonings is manifest in such notorious cases as the 1982 Chicago Tylenol Cyanide Murders and the 2006 Alexander Litvinenko Polonium-210 Poisoning. The criminals behind such acts may be able to avoid detection for decades and until caught may even be viewed as model citizens, as exemplified by the medical serial killer Dr. Harold Shipman, who is estimated to have murdered some 250 of his patients in the 1980s and 1990s in Britain. This book is timely not only because of the increased range of poisons now available for the more "common criminal" contexts and in family and domestic crimes, but also because the use of poisons has even extended in recent times to attempts to change high-level political leadership, exemplified by the 2004 dioxin poisoning of the current Ukrainian president Viktor Yushchenko.

This book combines the expertise found within the fields of law enforcement, toxicology, and psychiatry to give a unique perspective on criminal poisoning. All of the four editors have not only recognized expertise in their respective fields, but also extensive personal experience investigating criminal poisoning cases, and each has worked closely with both medical and law enforcement systems to bring criminal poisoners to justice.

The time and resources necessary to medically detect, formally investigate, and legally prosecute a criminal poisoning can be substantial. We commend the editors, authors, and publisher on the extensive work needed to produce this important book. There is no doubt that *Criminal Poisoning: Clinical and Forensic Perspectives* is a major step forward in assisting our medical and law enforcement personnel with criminal poisoning cases.

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Honorable Edwin Meese, III
Former United States Attorney General
1985–1988

Preface

Throughout history, poisons and their effects have been well described. Paracelsus (1493–1541) correctly noted that "All substances are poisons; there is none which is not a poison. The right dose differentiates a poison...." As life in the modern era has become more complex, so has the use of numerous poisons by criminals.

A criminal poisoning occurs when an individual or group of individuals deliberately attempts to inflict harm on others through the use of a toxin. Such acts can be performed by an individual working alone (e.g., medical murderer Michael J. Swango), by a specific group (e.g., Aum Shinrikyo attacks on the Tokyo subway system), or through government sponsorship (e.g., the Soviet-Bulgarian poisoning of Georgi Markov). Innumerable potential toxins can inflict harm on humans. Such toxins can include pharmaceuticals, herbals, household products, environmental agents, occupational chemicals, drugs of abuse, and chemical warfare agents.

The detection and prosecution of criminal poisoning cases has become more challenging. The emergence of the Internet has allowed a wealth of information on poisoning to become more accessible. That free flow of information, coupled with the emergence of a host of new chemicals, has made the job of detecting and prosecuting criminal poisonings more difficult.

This book, *Criminal Poisoning: Clinical and Forensic Perspectives,* is intended for use by law enforcement, attorneys, and medical providers when investigating a criminal poisoning. It is divided into three sections: 1) Introduction to Poisoning; 2) Agents Used by Past Poisoners; and 3) Specific Classes of Poisoners. The agents chosen for inclusion were chosen either because they have been frequently encountered in past criminal poisonings (e.g., cyanide) or have been infrequently encountered but have been recently present in actual prominent cases (e.g., dioxin) or highlighted in the media due to the potential concern of use (e.g., sodium monofluoroacetate).

Each chapter that is dedicated to a specific toxin is divided into 6 sections: Case, History, Potential Delivery Methods, Toxicologic Mechanisms, Analytical Detection, and the Conclusion. The intention of providing a case at the beginning of each toxin's chapter is to reinforce the difficulty in medically diagnosing and legally evaluating a criminal poisoning. Much can be learned from past criminal poisonings to both help detect future poisonings and prevent perpetuation of errors that can occur during the investigation. Many different delivery methods have been devised by past poisoners, some quite unique to avoid detection by both the victim and the investigative team. When considering a criminal poisoning, the investigative team must realize that some poisoners have devised sophisticated and unique methods in which to administer toxins. Because the intention of this book is not to fully educate the general law enforcement community and basic medical providers into the biochemical mechanisms and analytical detection techniques, these sections were written with the intent to give a basic overview. This book is not intended to be a comprehensive resource for laboratory analysis of criminal poisoning.

This book is written by skilled clinicians engaged in the diagnosis and treatment of poisoned patients and by law enforcement officials experienced in investigating criminal poisonings. This diverse group of professionals brings unique clinical expertise to each area, many with past research and publications within their respective areas. It is the intent of the editors to provide the reader with unique insight into the realm of criminal poisoning.

10 Drugs of Abuse

Rachel Haroz and Susan Ney

CASE STUDY

On November 28, 1953, Frank Olson fell 170 feet to his death from a 10th floor room in the Statler Hotel in Manhattan, New York. He was a biochemist, an expert in aerobiology with the United States Army, and an employee of the Central Intelligence Agency (CIA). At the time, the death was deemed a suicide.[1] Twenty-two years later the Rockefeller commission and congressional hearings revealed that Olson's death had been preceded 9 days prior by the surreptitious administration of 70 μg of lysergic acid diethylamide (LSD) in a glass of Cointreau during a military retreat at Deep Creek Lodge in Maryland.[2] Olson developed hallucinations shortly after ingesting the LSD. Those hallucinations were followed by depression, paranoia, and ultimately his death.[3]

Despite congressional hearings, a repeat autopsy 40 years later, and a subsequent intriguing homicide investigation, the actual course of Frank Olson's death is still controversial.[1,3] This administration of LSD was part of an extensive program, Project MK ULTRA, that was launched on April 13, 1953, by the CIA and was headed by Dr. Sidney Gottlieb.[1] The aim was "research and development

of chemical, biological, and radiological materials capable of employment in clandestine operations to control human behavior."[2] Although the project focused largely on LSD, other drugs such as barbiturates, amphetamines (including 3,4-methylenedioxymethampheamine), sodium pentothal, alcohol, scopolamine, marijuana, psilocybin, heroin, and mescaline were included. These drugs were administered to civilian and military personnel as well as thousands of other unwitting participants, generally without any informed consent or medical prescreening. For instance, in Operation Midnight Climax, prostitutes would lure subjects, generally businessmen, to safe houses disguised as bordellos. The men were then administered LSD and observed behind two-way mirrors.[2, 4]

HISTORY

The term "drugs of abuse" is broad and encompasses numerous categories of pharmacologic agents. Several drugs of abuse are discussed in other chapters within this book. This chapter will focus on four drugs: benzoylmethylecgonine (cocaine), methamphetamine, LSD, and 3,4-methylenedioxymethamphetamine (MDMA or ecstasy).

Cocaine, derived from leaves of the *Erythroxylum coca* plant, has been used by humans as a stimulant for over 5000 years.[5] Until the late 19th century, cocaine was generally consumed in small amounts by chewing leaves and drinking cocaine-laced wines such as Vin Mariani; thus harmful side effects were rare. In 1884, Sigmund Freud declared that cocaine was a miracle drug. At the same time, Merck increased production from less than a pound in 1883 to 158,352 pounds in 1886. Concurrently, chemical advances allowed for more purified cocaine to be available, and abuse increased exponentially.[6] Despite government efforts, cocaine use continued to increase and peaked dramatically in the United States in the 1980s with the spread of crack, a freebase and cheaper form than the powder.[7] Currently, cocaine is a Schedule II drug under the Controlled Substances Act (CSA) of 1970.

Although cocaine is often associated with violent crime, intentional criminal poisoning is not frequently reported. There are, however, cases of prenatal, infant, and child deaths determined to be homicides. In *State* v. *McKnight*, the South Carolina Supreme Court upheld a ruling that intrauterine fetal demise was caused by the known ingestion of cocaine by the pregnant McKnight. Cocaine metabolites were found in the fetus's system. The verdict was homicide by child abuse, with a subsequent 20-year prison term.[8] In September of 2000, rescue personnel found a 10-month-old female infant experiencing ventricular fibrillation and apnea. Despite initial resuscitation, the infant died. The parents initially claimed the child had eaten rat poison, but later admitted that 2 hours before calling for assistance, the infant's 2-year-old brother was found eating crack cocaine and also feeding it to the infant. Investigators found crack cocaine throughout the house and in the infant's crib. At autopsy, the infant was found to have two "crack rocks," 0.3 cm in diameter, in her duodenum. The cause of death was determined to be cocaine poisoning by homicide.[9] In another case in West Branch, Michigan, a woman pled guilty to attempted manslaughter after her infant died from cocaine intoxication caused by ingestion of the mother's breast milk.[10] In a different case, syringes with cocaine were found in a supermarket. One syringe was found piercing a pear. The pear flesh tested positive for cocaine, indicating injection. Product tampering was suspected, but it did not appear that there were any casualties.[11]

Methamphetamine (MA) is a derivative of amphetamine. First synthesized by the Germans and Japanese in the late 19th century, it became popular during World War II. At that time, Japan, Germany, and the United States supplied their military personnel with MA to increase performance and reduce flight fatigue. Postwar spread of MA from surplus army supplies led to the "first epidemic" in Japan, and subsequently MA popularity grew in the western United States in the 1960s. Production and distribution at that time were largely controlled by San Francisco Bay-area motorcycle gangs but were eventually taken over by Mexican traffickers and spread east.[12] MA abuse today is rampant both in the United States and globally. With 25 million users, amphetamine ranks second after cannabis in prevalence of abuse. Currently, MA is a Schedule II drug under the CSA. Deaths related to MA intoxication and violence are common, but like cocaine, criminal poisoning is rare and intentional poisonings have not been reported. The Supreme Court of Hawaii recently overturned a manslaughter conviction

for a woman who smoked MA during the late stages of pregnancy, causing the death of her newborn child.[13]

LSD was first synthesized in 1938 by the Swiss biochemist Albert Hofmann. He accidentally exposed himself to the drug in 1943, leading to the first LSD "trip."[14] A potent hallucinogen and psychedelic, LSD quickly became popular. Within medical communities, LSD was believed to induce a model for psychosis and was used to further investigate schizophrenia and potential medications for its treatment.[4] Other research focused on LSD as a possible adjunct in psychotherapy. At the same time, Timothy Leary, a Harvard psychology professor, advocated LSD use and encouraged people to "Tune in. Turn on. Drop out."[7] Despite being outlawed in 1965 and a subsequent decrease in use, LSD is still widely available. Naturally occurring lysergic acid can be found in the fungus *Claviceps purpurea,* and in the morning glory plants *Rivea corymbosa* and *Ipomoea violacea.*[15] LSD is currently a Schedule I drug under the CSA.

MDMA was first synthesized in 1912 by Anton Köllisch for Merck as an intermediate precursor for another chemical. It remained relatively obscure for several decades. In the 1970s, it gained popularity in psychotherapy, and its use among youth continued to grow into the 1980s and 1990s with the rise of the rave culture.[16,17] MDMA is currently a Schedule I drug under the CSA. Criminal poisoning with MDMA is rare. Recently two teenagers were charged with homicide after providing a 16-year-old girl with MDMA and then failing to call emergency services when she had an adverse reaction.[18]

POTENTIAL DELIVERY METHODS

Cocaine comes in several forms. Coca leaves are generally chewed but can be steeped into teas and beverages. Cocaine hydrochloride is a water-soluble powder and can be injected intravenously (Figure 10.1), injected subcutaneously ("skin popping"; Figure 10.2), as well as absorbed through mucous membranes by nasal insufflation and vaginal or rectal administration.[19] Two alkaloid forms, crack and freebase, have lower melting points and can therefore be smoked and thus inhaled. In addition, coca paste, or "bazooka," a form of coca leaves, water, sulfuric acid, and kerosene, is smoked in South America.[20] Cocaine hydrochloride is available medically in the form of a powder and topical solution in various concentrations as an anesthetic for medical procedures. It is also mixed into a topical anesthetic solution with tetracaine and adrenaline (TAC). Toxicity from mucosal exposure to the solution has been reported, and toxicity from dermal exposure is certainly possible.[21]

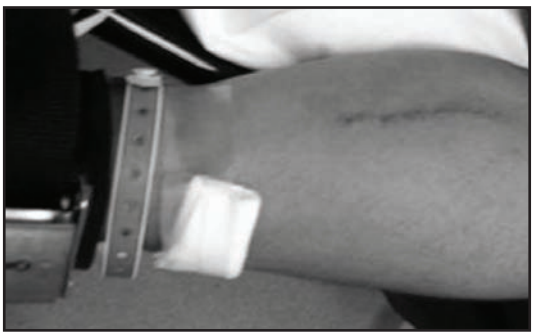

FIGURE 10-1 **Track marks in an intravenous drug abuser** (See Color Plate 7.)

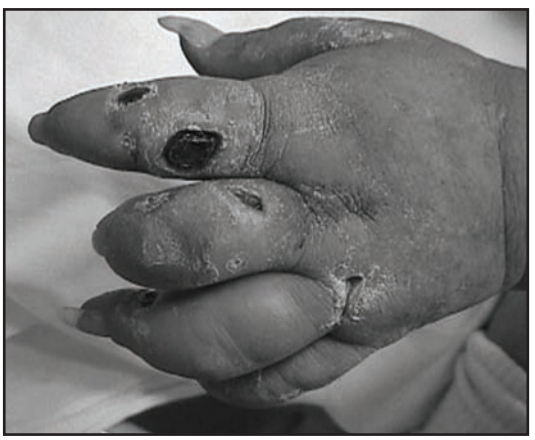

FIGURE 10-2 **Skin popping on a hand of a subcutaneous injecting drug abuser** (See Color Plate 8.)

Methamphetamine hydrochloride is usually a powder that can be injected intravenously, smoked, nasally insufflated, or ingested. It may also come in capsule or tablet form. The crystal form, or "ice," is generally smoked. Other, more novel methods of administration include transrectal administration and "parachuting." Parachuting involves placing the MA in a wrapper prior to ingestion, thus allowing it to unravel in the gastrointestinal tract in an attempt to prolong the duration of action.[22,23]

LSD can be found in liquid, powder, gelatin sheet, or tablet form. It is usually ingested, although reports exist of nasal insufflation, subcutaneous and intravenous injection, smoking, and conjunctival instillation. The liquid form is often ingested on sugar cubes or blotter paper that has been soaked in LSD.[15]

MDMA is generally found in tablet form (Figure 10.3), but it may appear as a powder or in capsules. It is usually ingested, but it can be injected, smoked, or nasally insufflated.[24]

FIGURE 10-3 **MDMA tablets** (See Color Plate 9.)

TOXICOLOGIC MECHANISMS

Cocaine exhibits its effects through several different mechanisms. Peripherally, it blocks reuptake of catecholamines such as norepinephrine, causing stimulation of α and β adrenergic and dopamine receptors, which then leads to an increase in sympathomimetic symptoms. In the central nervous system (CNS), cocaine mainly acts by blocking dopamine reuptake, leading to euphoria and CNS stimulation. Cocaine also blocks sodium channels. In low doses, it acts as an anesthetic at sensory neurons, and at higher doses, it may block cardiac conduction, leading to dysrhythmias.[19,25,26]

Methamphetamine exhibits similar action to cocaine centrally and peripherally, albeit by a slightly different mechanism. Methamphetamine increases production and release of dopamine, blocks reuptake of catecholamines, inhibits catecholamine breakdown by monoamine oxidase, and leads to depletion of dopamine and serotonin.[27,28]

The exact mechanism of action of LSD has not been elucidated. It appears that LSD may act as a partial agonist and antagonist of serotonin (5-hydroxytryptamine, or 5-HT).[29] LSD may also act as an agonist and antagonist on postsynaptic dopamine receptors.[15]

MDMA is structurally and pharmacologically similar to methamphetamine. In addition, it acts as a hallucinogen. It increases release of dopamine and serotonin, blocks serotonin reuptake, and inhibits monoamine oxidase. It also has activity at α_2-adrenergic, M_1-muscarinic, and H_1 receptors and may exhibit less activity at M_2-, α_1-, and β-adrenergic receptors.[17,30,31]

CLINICAL EFFECTS

Cocaine and methamphetamine are potent stimulants, and exposure to them leads to a wide variety of mostly sympathomimetic symptoms. Patients may present complaining of agitation, confusion, chest pain, dyspnea, palpitations, headache, abdominal pain, weakness, hallucinations, and seizures.[32] Clinical findings may reveal hyperthermia, tachycardia, tachypnea, hypertension, change in behavior, focal neurologic findings, seizures, mydriasis, diaphoresis, hyperthermia, and hyperactive bowel sounds.[33] Patients may also present with choreiform movements and, after methamphetamine use, bruxism.[33]

Chest pain and dyspnea are common complaints after cocaine exposure but may also be seen with methamphetamine use.[32,34] These symptoms may be due to cardiac ischemia or infarction, aortic dissection, pneumothorax, asthma exacerbation, "crack lung," and pulmonary edema (cardiac and noncardiac).[32-35] Dysrhythmias are more common with cocaine use due to cocaine's sodium-channel-blocking properties; dysrhythmias may manifest as atrial fibrillation, ventricular fibrillation, ventricular tachycardia, and torsade de pointes.[35]

While the cardiovascular effects of cocaine and methamphetamine are similar, the duration is different. Symptoms from cocaine use subside more rapidly, with heart rate and blood pressure returning to baseline within 30 minutes. Symptoms from methamphetamine use may continue for several hours.[26] Abdominal pain secondary to gastrointestinal ischemia may result in ulceration, bowel perforation, or ischemic colitis.[26,36] Other findings may include rhabdomyolysis, renal failure, and multi-organ failure.[33]

Neurologically, patients may have intracranial hemorrhages, strokes, and seizures as well as psychosis.[26,32] These conditions are largely due to significant hypertension and vasospasm,[26,32] but in both methamphetamine and cocaine use, some cases may be the result of a vasculitis.[37] With methamphetamine, the vasculitis has a typical beaded pattern on angiography.[37] In addition, patients with repeated cocaine and methamphetamine use over several days may present with hypotension, bradycardia, and a depressed mental status secondary to catecholamine depletion.[38] Cocaethylene is an active metabolite of coingestion of alcohol and cocaine, and while less potent than cocaine, it has a longer duration of action, which may account for some cocaine-related symptoms (e.g., coronary vasospasm, hepatotoxicity) seen long after the last use of cocaine.

A unique presentation of methamphetamine is "meth mouth" (Figure 10.4). Vasoconstriction decreases saliva production and flow. In combination with the overall poor hygiene and bruxism, the teeth become decayed on the buccal and anterior surfaces, and periodontal disease ensues.[39]

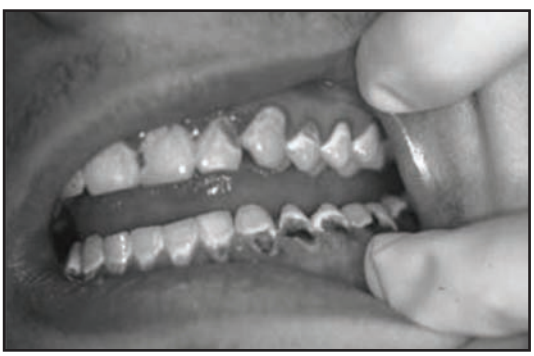

FIGURE 10-4 **Meth mouth of a chronic methamphetamine abuser**
(See Color Plate 10.)
Used with permission from Dr. John A. Svirksy

Laboratory values may vary based on the presentation. Basic chemistry panels may demonstrate acidosis, hyperglycemia, hypokalemia (early in toxicity) or hyperkalemia (late in toxicity), and elevation of renal function tests (i.e., creatinine). Creatine phosphokinase and cardiac enzymes may be elevated, indicating rhabdomyolysis and myocardial infarction.[26] Electrocardiograms may show a dysrhythmia, prolonged intervals, or ST-elevation myocardial infarctions.[35] Chest x-rays may demonstrate widening of the mediastinum in aortic dissection, pneumothorax, vasocongestion, or free air below the diaphragm. Abdominal x-rays may show body-stuffed packets (of drugs). Cerebral CT scans may demonstrate a stroke, either ischemic or hemorrhagic.[26] Lumbar puncture may show red blood cells or xanthochromia consistent with intracranial bleeding.[26] Cardiac catheterization may result in normal coronaries or may show diseased vessels.

Signs and symptoms of LSD exposure are initially sympathomimetic: nausea, flushing, chills, tachycardia, hypertension, tremors, mydriasis, hyperthermia, hyperreflexia, and piloerection.[15] Some will also experience dizziness, weakness, sleepiness, paresthesias, and blurry vision. The hallmark hallucinations usually start within 20 to 60 minutes and last 6 to 12 hours.[40] These hallucinations are described as largely visual but can be auditory. Rarely synesthesia, the mixing of senses, occurs. Time may become distorted and mood labile. People on LSD may discuss "oneness with the universe," but they may also experience feelings of extreme anxiety, paranoia, or fear. Trauma may be self-inflicted or unintentional.[15] "Flashbacks" may occur and are generally similar to prior LSD experiences but usually less intense. Rarely, people will have prolonged or permanent pyschosis; this is more common in patients with underlying mental illness.[15]

Although largely seen as a benign exposure, LSD use has led to significant morbidity and mortality. In 1972, eight individuals mistakenly snorted LSD. They presented to the emergency department with varying degrees of respiratory failure, tachycardia, hyperthermia, hypertension, and a universal coagulopathy. With supportive care, including mechanical ventilation, all eight survived.[41] In another case, an 18-year-old man presented with confusion, agitation, hypertension, and hyperthermia with an axillary temperature of 106.4°F (41.3°C). He recovered within 18 hours with supportive care that included aggressive cooling.[42] LSD exposure, however, can also prove fatal. In 1975, a 34-year-old man died of unknown causes; autopsy revealed unusually high tissue levels of LSD. Death was determined to be secondary to LSD toxicity.[43] In another case in 1985, a 25-year-old man died after hospital admission; based

on medical and toxicologic analysis, the cause of death was determined to be LSD toxicity. An antemortem serum LSD level of 14.4 ng/mL was significantly higher than the previously highest recorded level of 9.5 ng/mL in patients who survived.[44]

The clinical presentation of LSD is such that routine tests are not necessary and generally normal if performed. However, as in the previous example, lab abnormalities may exist in extreme cases including leukocytosis, neutrophilia, elevations in LDH, liver transaminases, uric acid, and blood glucose as well as a coagulopathy.[45]

MDMA users may present with both sympathomimetic and hallucinogenic symptoms. They may initially experience palpitations, blurry vision, dry mouth, sweating, and bruxism. They may feel extra energy, euphoria, extroversion, increased empathy, increased sociability, mild perceptual disturbances, and changed perception of colors and sounds.[17] Some patients also experience ataxia and confusion.[24] Initial exam findings may reveal a change in mental status, agitation, tachycardia, hypertension, hyperthermia, and mydriasis. The hyperthermia, in combination with sweating and increased physical activity, may lead to dehydration, compensated by consumption of water.[46] Cases of subsequent rhabdomyolysis, liver failure, and multi-organ failure have been reported.[46] Profound hyponatremia has been reported with sodium levels ranging from 107 to 128 mmol/L.[47] The cause may be multifactorial. MDMA appears to cause an inappropriate secretion of the antidiuretic hormone (SIADH).[47] In addition to the dehydration and water consumption, SIADH leads to hyponatremia, which subsequently contributes to a change in mental status, seizures, cerebral edema, brain herniation, and death.[47] Case reports have also illustrated that fatalities may occur with ingestion of only one tablet, usually in young females.[48]

Routine laboratory testing in cases of MDMA abuse may reveal hyponatremia. In the setting of liver failure, raised serum transaminases, hypoglycemia, and elevated prothrombin time may be observed. Creatinine phosphokinase and creatinine may be elevated, indicative of rhabdomyolysis and renal failure. Head CT scans may show cerebral edema or brain herniation.

In addition, MDMA tablets may contain various other substances such as 3,4-methylenedioxyethylamphetamine (MDEA), 3,4-methylenedioxyamphetamine (MDA), as well as nonamphetamines, including but not limited to caffeine, dextromethorphan, paramethoxyamphetamine (PMA), ketamine, ephedrine, or acetaminophen.[49]

ANALYTIC DETECTION

The initial screening for cocaine is usually an immunoassay of the urine, which usually detects a metabolite of cocaine, benzoylecgonine. It may remain positive for up to 72 hours after cocaine use.[50] Gas chromatography-mass spectrometry (GC-MS) can detect cocaine in the urine up to 14 days.[51] Postmortem redistribution may not be significant for cocaine, evidenced by a strong correlation between femoral and heart blood concentrations. Cocaine and its metabolites (benzoylecgonine, ecgonine methyl ester, and ecgonine) can also be found in vitreous humor and correlate with heart and peripheral blood concentrations.[52] Actual cocaine and metabolite levels, however, have a wide distribution and do not correlate with the clinical picture or severity of findings.[51] There is no known toxic level of cocaethylene. GC-MS is the most specific test for cocaethylene.[53]

Although methamphetamine has been reported to have a "toxic level" of 5 μg/mL, a retrospective review of deaths in Japan revealed that half of the methamphetamine poisoning cases had a serum less than this level.[54] Testing specifically for methamphetamine and its metabolites, including amphetamine, can be done on blood, urine, saliva, or hair. Urine and saliva can be tested using GC-MS, with urine resulting in positive tests 3 days after drug use and saliva for only 24 hours.[55] Hair can be tested using cation-selective exhaustive injection and sweeping micellar electrokinetic chromatography; these methods have been reported to give positive results months after exposure.[56] Elevated magnesium, calcium, and creatinine postmortem may point to methamphetamine overdose.

LSD use can be detected by immunoassay of the urine but has many false positives. Therefore, confirmation testing by high-performance liquid chromatography or gas chromatography is often necessary and can be done on the blood or urine.[57] At autopsy, edema throughout the abdominal organs, brain, and lungs may be found.[43] The postmortem levels of LSD in the

blood may be lower than the antemortem levels, likely due to redistribution.[44]

MDMA is often not detected on routine drug-of-abuse tests. While GC-MS has the widest application, there are many alternative methods (e.g., immunoassay, electrophoresis, and high-performance liquid chromatography) for determining if MDMA is present in blood or urine.[58-60] However, MDMA has nonlinear kinetics, which make blood concentrations difficult to interpret and correlation of concentrations with clinical effects even more difficult.[61] Extremely divergent MDMA levels have produced fatalities.[62]

It should be noted that urine drug tests are an indication of exposure but cannot be used to determine impairment. Any test that is to be used for legal purposes should be obtained and processes observing a strict chain of custody. Results of positive tests should be confirmed by a second, more specific method, such as GC-MS.

CONCLUSION

Although actual cases of criminal poisoning by cocaine, methamphetamine, LSD, and MDMA are rare, some have been reported. Positive tests for cocaine and methamphetamine on routine drug testing are usually deemed secondary to recreational use, not intentional poisoning. Meanwhile, LSD and MDMA are usually not detected on any routine tests. In addition, no specific "toxic levels" exist for any of these drugs. Therefore a suspicious history and clinical symptoms in the right setting should lead investigators to further testing.

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14 Opioids

Ziad N. Kazzi and Kevin S. Barlotta

CASE STUDY

On October 23, 2002, over 40 Chechen terrorists took 914 people hostage in the Dubrovka Theater Center in Moscow, Russia, during the musical *Nord-Ost*. The terrorists repeatedly threatened to detonate explosive and destroy the theater if their political demands were not met by the Russians. After several days of captivity, Russian special forces, known as spetsnaz, stormed the theater 15 minutes after introducing a mysterious aerosolized gas into its ventilation system. This gas, believed to be a mixture of carfentanyl (a fentanyl derivative) and halothane (an anesthetic), resulted in a massive inhalation exposure, leaving 127 hostages and the Chechen terrorists dead. Victims initially treated by the healthcare teams were reported to exhibit classic signs of opioid toxicity consisting of miosis and depressed consciousness and respiratory function. This incident captured the world's attention and generated controversy over the use of aerosolized opiates.[1-3]

HISTORY

Opiates are the naturally derived narcotics, such as morphine and codeine, found in opium. Opium is isolated from the poppy plant *Papaver somniferum*. Opioids include opiates and other substances that bind to opioid receptors. Opioids include semisynthetic compounds such as hydrocodone, hydromorphone, oxycodone, and fentanyl. Heroin is the only opioid currently listed as a Schedule I drug by the U.S. Drug Enforcement Administration, primarily due to its rapid onset, clinical effects (euphoria and sedation), and high abuse potential. These drugs all have potent analgesic and sedative properties but different pharmacokinetic properties.

Long before its categorization by Linnaeus as *Papaver somniferum,* opium was recognized for its medicinal uses as a remedy to a variety of ailments. As early as the third century BCE, Egyptian and Sumerian civilizations began extracting the sap from the immature seeds of the opium poppy for use as an analgesic. Morphine, named after the Greek god of dreams Morpheus, was isolated from opium in 1804 by German chemist Friedrich Sertürner. The isolation of codeine followed in 1832. With the invention of the hypodermic needle in 1853, morphine's use became widespread. Decades later, heroin was synthesized by Dresser by diacetylating morphine. Opioids are frequently associated with addiction. Their abuse remains a worldwide threat to public health and a continued, potentially lethal, vehicle for misuse and criminal poisoning.[4]

Opioids are often utilized in palliative care and can be administered in excess, thereby leading to an accusation of euthanasia.[5] Even for medical experts, it is difficult to distinguish between relieving suffering and intentionally hastening death.[6] Because of this, it is often difficult to prosecute such cases for murder. For example, in one small study, five U.S. physicians were indicted for murder related to opioid overdose deaths, with none found guilty.[7] In 2003, a 53-year-old German physician was investigated for possible murder after her use of morphine to treat multiple hospital patients led to several deaths at the private Paracelsus Hospital Silbersee in Langenhagen, Germany. Suspicions were raised when health insurance companies monitoring patients' files for the preceding 2 years found extremely high costs and dosages of morphine without evidence of severe pain and suffering among the patients.[8] Controversy even encompassed the death of Sigmund Freud, which is thought by some to have been hastened by the administration of morphine.[9]

There are notorious cases in which opioids were utilized in criminal poisoning. One of the most notable involved Dr. Harold Frederick Shipman of Great Britain who was convicted of murdering 15 of his patients. He is actually thought to have killed hundreds of his patients using morphine and diamorphine (heroin) in a murderous career that spanned more than two decades, earning him the notoriety of the most prolific British serial killer (see Chapter 26).[10,11]

POTENTIAL DELIVERY METHODS

Opioids can be administered through a variety of routes including oral consumption, intravenous injection, topical application, rectal deposition, and intranasal as well as pulmonary inhalation (smoking). Historically, opioids have been abused through intravenous administration, but subcutaneous administration ("skin popping") has become another common avenue of abuse (Figure 14.1). Currently, oral administration has regained popularity due to the availability of oral opioid preparations and the risks associated with intravenous abuse, including viral hepatitis and HIV infections.[12,13]

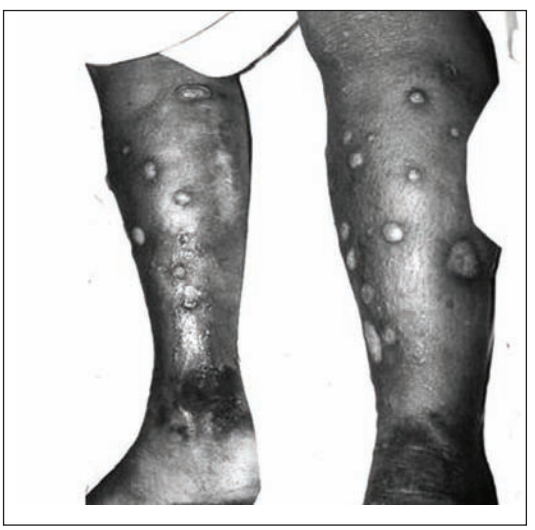

FIGURE 14-1 **Subcutaneous injection of opioids (skin popping) resulting in multiple ulcers of the legs.** (See Color Plate 11.)

Transdermal delivery is a route used by patients who are chronically dependent on opioid analgesia. These patches usually contain a large amount of the drug and can lead to significant central nervous system (CNS) depression or death if they are ingested, licked, chewed, or smoked, or if they are inadvertently or intentionally placed on the skin in a manner inconsistent with the instructions given with the prescription.[14]

Occasionally, "body packers" (i.e., individuals who ingest opioid-laden packets to smuggle them through border inspections) are poisoned when the packet contents spill into their gastrointestinal tract, leading to significant morbidity and mortality (Figure 14.2).[15]

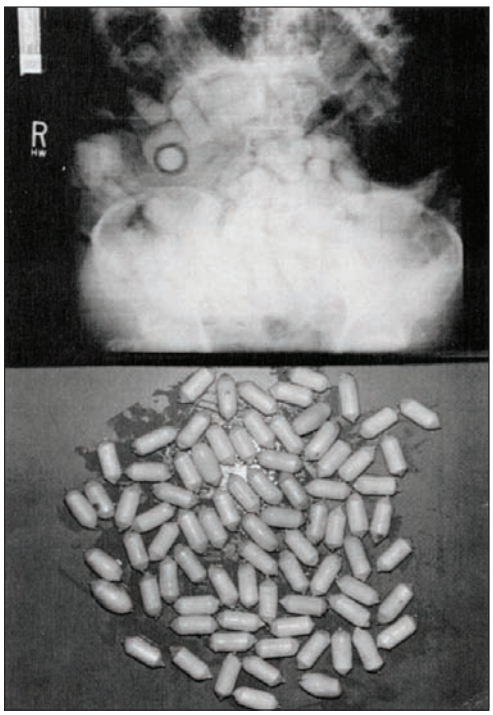

FIGURE 14-2 **Body packer carrying multiple condoms filled heroin.** ***Reprinted with permission from Dr. CV Wetli.***

As noted previously, a novel method of delivery was used in Moscow when Chechen terrorists were subdued with a potent aerosolized fentanyl derivative (carfentanyl).[1]

TOXICOLOGIC MECHANISMS

Opioids exert their clinical effects by binding to specific CNS receptors. These receptors consist of three major classes (mu, kappa, and delta; or OP3, OP2, and OP1). Various opioids have different affinity profiles with respect to the opioid receptors; hence the differences in the clinical effects. For example, mu receptors are primarily responsible for the sensation of euphoria, and specific opioids are preferred for abuse due to their potent mu receptor agonism.[16]

CLINICAL EFFECTS

Opioid poisoning can have widespread clinical manifestations depending on the agent used, dose, method of delivery, and the presence of a coingestant(s). The classic toxidrome consists of miosis (pupillary constriction) and respiratory and CNS depression. Although pinpoint pupils are often associated with opioid poisoning, one should not rely on them exclusively in making the diagnosis. Gastrointestinal motility is decreased. CNS and respiratory depression can lead to a number of potentially serious secondary effects including anoxic brain injury, aspiration pneumonia, and muscle breakdown (rhabdomyolysis). The onset of clinical effects for oral ingestion of opioids varies, but most are within 30 to 60 minutes; the effects of inhalation or injection are more rapid (within 5 minutes). Duration of clinical effects depends upon the specific opioid drug and a person's preexisting health and physical status.

Acute lung injury has been associated with opioid poisoning. It manifests as bilateral, noncardiogenic pulmonary edema leading to shortness of breath and cough after toxic patients resume breathing. Such individuals often produce pink-frothy sputum and develop hypoxemia. Rales are often heard on clinical examination.[17] The cause and mechanism of this injury is not well understood.[18]

Several opioids cause additional nonclassic signs and symptoms that confound clinical diagnosis. For example, tramadol, propoxyphene, and meperidine may cause seizures.[19-21] Propoxyphene and methadone can directly cause cardiac conduction abnormalities (prolonged QRS and QTc intervals) and dysrhythmias.[22,23] Movement disorders may also be seen with drugs such as fentanyl, including life-threatening chest wall rigidity.[24]

Certain opioids, like meperidine, fentanyl, propoxyphene, dextromethorphan, and tramadol, have serotonergic properties and may lead

to a serotonin syndrome when combined with other serotonin agonists.[25-27] Serotonin syndrome manifests as a triad of neuro-excitatory features including neuromuscular hyperactivity (tremor, clonus, myoclonus), autonomic hyperactivity (diaphoresis, fever, tachycardia), and altered mental status.[27]

Adulterants or contaminants may confound the clinical presentation of a patient presenting with opioid toxicity. For example, clenbuterol-contaminated heroin produced an outbreak of an atypical clinical illness consisting of tachycardia, palpitations, hypokalemia, and hyperglycemia.[28] Heroin adulterated with quinine has been reported to produce cardiotoxicity due to the quinine-induced sodium channel blockade and QRS interval prolongation.[29,30]

The opioid toxidrome may be mimicked by nonopioid agents such as clonidine, barbiturates, valproic acid, oxymetazoline, and antipsychotics. Pontine strokes may occasionally manifest with miosis and CNS and respiratory depression.[31,32]

Diagnostic chest radiographs may reveal findings of noncardiogenic pulmonary edema while arterial blood gases may reveal low arterial oxygen pressure. Other laboratory abnormalities such as leukocytosis are neither consistent nor clinically useful.[17]

In summary, patients who are poisoned with opioids typically present with a triad of miosis along with CNS and respiratory depression. Although these signs should lead healthcare and law enforcement personnel to suspect exposure to opioids, other substances and diseases can mimic opioid toxicity (e.g., clonidine toxicity and tetrahydrozoline toxicity). The possibility of atypical presentations stemming from coingestants, drug-to-drug interactions, and drug-specific effects must also be considered.

ANALYTIC DETECTION

Commercial immunoassays (e.g., EMIT, by Dade-Behring; TDx, by Abbott) are designed to detect naturally occurring opiates (morphine and codeine). Specific gas chromatography-mass spectrometry (GC-MS) analysis protocols are available for confirming natural, synthetic, and semisynthetic opioid compounds from urine specimens. In addition, specific immunoassays and GC-MS protocols are available for detection of methadone and propoxyphene.

Poppy seeds that are used in culinary settings, such as in poppy seed bagels, contain codeine and morphine and can produce a positive result in morphine and codeine assays. These levels rise in urine rapidly and may be detectable up to 3 days in urine and 1 day in serum.[33] Detection of 6-monoacetylmorphine in urine differentiates poppy seed ingestion from heroin (diacetylmorphine) abuse.[34]

CONCLUSION

Criminal opioid poisoning poses several diagnostic and forensic challenges. Criminal investigators and medical personnel need to pay special attention to the clinical findings, keeping in mind the specific characteristics of each opioid. Diagnostic testing is available for all substances, but immunoassays have specific limitations. The habits, lifestyle, and associations of opioid victims may reveal information that may guide the police in their investigation of suspicious deaths.

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26 Medical Serial Killers

Thomas M. Neer, James McCarthy, Bernard Postles, and R. Brent Furbee

INTRODUCTION

The true incidence of homicides committed by medical professionals is impossible to determine. There are, however, numerous examples of healthcare providers preying on helpless patients, such as the notorious cases of Donald Harvey, Kristen Gilbert, Genene Jones, Efren Saldivar, and Charles Cullen. For several reasons, the healthcare system is historically slow to investigate such allegations. Ironically, the failure of healthcare workers to consider a coworker as a murderer has caused delays in the recognition of those deaths as homicides and subsequently delayed the prevention of further murders. When patient homicide is discovered, individuals and institutions are reticent to document it for fear of damage to their reputations and increased exposure to litigation. This chapter will focus on three cases in which the authors were directly involved with the criminal investigation: Michael Swango (Neer and McCarthy), Harold Shipman (Postles), and Orville Lynn Majors (Furbee).

MICHAEL SWANGO, MD

When Michael Swango graduated valedictorian of his Quincy, Illinois, high school class in 1972, no one suspected he would become a notorious doctor and murderer. Although he pled guilty to the poisoning deaths of four hospital patients in New York and Ohio, authorities believe he was responsible for many more, especially when he worked in hospitals in Africa. What makes Dr. Swango's activities particularly disturbing is that despite his history of aberrant behavior, warnings from coworkers, and dismissals from hospitals, he was able to get hired repeatedly by other medical facilities and to continue poisoning. In many cases, the substances he used left no obvious signs of poisoning. In most cases, physical evidence was lacking, due in part to the passage of time from the deaths to the subsequent police investigation and because of the refusal of some families to have autopsies performed.

The first signs of trouble appeared after Swango entered the Southern Illinois University School of Medicine in 1979. Despite the school's rigorous curriculum and demanding schedule, Swango continued to drive great distances to work as a part-time emergency medical technician (EMT). Classmates could not understand why Swango would work while attending medical school, considering that time was precious and he was not exceptionally talented. Because he crammed for examinations, classmates coined the word "swangoing" to describe his study habits. During a class in radiology, Swango asked the professor what a particular mass was on an x-ray. The professor replied, "That's the heart, Mike." In an anatomy lab, Swango drew the attention of his classmates by mangling the section he was required to dissect.

On clinical rotations, several of Swango's patients died mysteriously. Although none was considered homicide, classmates jokingly referred to him as Double-O-Swango, a reference to the James Bond (agent 007) character and his "license to kill." While working on his OB/GYN rotation, faculty caught him falsifying records. To avoid expulsion from school, Swango hired a lawyer and was able to negotiate a compromise, agreeing to repeat his clinical rotation. Still, two classmates felt so strongly about Swango's incompetence that they sent a formal letter to the dean outlining their misgivings about him.

Swango graduated from medical school in 1983. In July, he began a general surgery internship and neurosurgery residency at Ohio State University (OSU). Within months, the staff noticed oddities such as a fascination with Nazis and the Holocaust. Supervisors noted that his medical histories were cursory at best and that he had difficulty performing basic surgical procedures. When criticized, he immediately did push-ups.

In January 1984, supervisors placed him on probation and warned him that his residency in neurosurgery was in jeopardy. Within weeks, several suspicious deaths occurred on the floor where he worked; some were under his care, but others were not. Almost all deaths were preceded by respiratory arrests, and Swango had visited many patients immediately prior to their codes. On several occasions, Swango had been seen next to the patient's intravenous (IV) line. One patient reported that Swango injected an unknown substance into her IV line, which caused intense burning and paralysis. Swango told her that when the substance reached her elbow, she would be dead.

Wary hospital administrators elected to conduct an internal inquiry rather than contact the police. Despite inconsistencies in Swango's accounts to other doctors about the suspicious deaths, he was never formally interviewed about them. When the OSU Police Department was finally called to investigate these deaths 9 months later, Swango had been dismissed from the hospital, and physical evidence was no longer available. Nevertheless, the police conducted a comprehensive investigation for 13 months and interviewed more than 400 people, including 45 doctors and more than 100 nurses. A subsequent review of their investigation by the Franklin County Prosecutor's Office determined that due to a lack of physical evidence, Swango would not be charged.[1]

After Swango left OSU, coworkers recalled an incident during his rotation at the Children's Hospital from April to June of 1984. Swango brought in a box of chicken for doctors. One by one, those eating became violently ill with severe stomach cramps, headaches, and vomiting. At the time, no one suspected Swango might have been poisoning them.[1]

After leaving OSU, Swango worked as a paramedic for the EMS company that had employed

him during medical school. Coworkers, apparently unaware of his recent dismissal from OSU, observed a change in his behavior. In addition to volunteering for extra shifts, he seemed obsessed with death, pasting into a scrapbook a number of news articles on traffic accidents and plane crashes. The more gruesome a tragedy, the more excited Swango became. When a gunman entered a McDonald's in San Ysidro, California, and killed several people, Swango complained that someone else always stole his ideas.

In October 1984, concerns intensified when several of Swango's coworkers became ill after consuming doughnuts that he brought them. Their symptoms included severe headaches, gastrointestinal distress, and vomiting. Suspecting that Swango may have poisoned the doughnuts, coworkers searched his locker and found a box of arsenic-laden ant poison. A week later, before leaving to answer a call, a coworker brewed unsweetened tea. Swango was seen in the area. When the coworker and his colleagues returned and found overly sweet tea, they took samples of it. The lab results confirmed suspicions: the tea contained arsenic consistent with Swango's ant poison. A coworker recalled that Swango's ambition was to be a doctor who invented an untraceable poison.

A criminal investigation ensued, and Swango was arrested. A search of his apartment revealed mouse poison, bottles of ant poison, leaf and garden spray, numerous sacks of castor beans, roach powder, needles and syringes, a jug of sulfuric acid, numerous jars of assorted chemicals, a book on satanism, a book on how to extract ricin, and several index cards containing recipes for ricin, cyanide, and botulism.[1] Although Swango maintained his innocence, in August 1985 he was convicted of assault and sentenced to 5 years in prison but was released after serving only half this time.

When news about Swango's interest in ricin was made public, a doctor at OSU recalled the unexpected death of one of his patients. The patient had died of respiratory arrest. What puzzled him was that the autopsy revealed clots in the arteries of the patient's heart and in the vessels of her kidneys, liver, intestines, and lungs. When the doctor learned that Swango had been on duty at the time, he suspected that Swango may have killed his patient with ricin because he believed that blood clots were a telltale sign.[1]

In 1988, after Swango was released from prison, he concealed his conviction and medical degree and moved to Virginia, working at a placement center counseling students applying to medical school. Shortly after his arrival, two workers became ill after they drank coffee; staff contacted the Board of Health to check if the coffee had spoiled but no problems were found. Before suspicion could fall on Swango, he quit and began working as a lab technician at a coal company, marrying a nurse he had dated in Ohio.

Coworkers considered Swango odd because he often talked of serial murder. When several of his coworkers fell ill with headaches and severe abdominal distress, Swango expressed interest in their symptoms, calling some at home to question them. Eventually, coworkers discovered Swango's identity after opening his briefcase and finding news articles about suspicious deaths at OSU Medical School. This led them to suspect Swango of poisoning, and they notified the police. Unfortunately, important physical evidence had disappeared. A search of Swango's residence revealed a variety of books on poisons but no evidence linking him directly to any criminal activity.

Before quitting his job and leaving Virginia, Swango divorced his wife and began dating a local nurse, Kristen Kinney. He applied to work as a physician at a residency program in Sioux Falls, South Dakota, one of the few states that allowed felons to work in hospitals. Using what was described as unusual charm and persuasion, Swango disarmed his interviewers by disclosing his previous criminal conviction, minimizing culpability and concealing incriminating details. His perceived honesty impressed the administrator, allowing Swango to begin work before a thorough background check was performed.

In 1992 problems started. A Sioux Falls hospital across town from where Swango worked complained that he was sexually harassing a nurse. When Swango's employer confronted him about these accusations, Swango apologized, and the matter was dropped.

Coincidently, 2 months later, an ABC news documentary by John Stossel on the previous suspicious deaths at OSU Medical School aired nationally. Officials at the South Dakota hospital promptly contacted OSU for additional

details, then fired Swango, who contested his dismissal. Although his fiancée, Kinney, outwardly defended him, privately she had doubts about his innocence after discovering incriminating information in their apartment, including a hidden poison recipe card. Because Kinney complained about stomach problems and migraines, officials later wondered whether Swango may have been poisoning her. The stress of her association with Swango reached a peak when she was found at night wandering naked and confused on the freezing streets of Sioux Falls. Her worried parents eventually persuaded her to return to Virginia.

As Kinney regained control of her life, Swango returned to Virginia and started leaning on her financially and emotionally. In 1993, he was accepted into a psychiatric residency at the State University of New York (SUNY) Hospital at Stony Brook. Although he readily disclosed his assault conviction during his interview, he claimed it was due to a bar room brawl. His new assignment began with a required surgical internship at the nearby Veterans Affairs (VA) hospital in Northport, New York.

VA hospitals often have a large number of elderly and terminally ill patients. It is not uncommon for such patients to request do not resuscitate (DNR) orders. As a rule, after staff members discuss DNR with patients, they seldom raise the issue again unless the patient asks. Swango, however, aggressively tried to persuade patients who had not requested DNR orders to change their minds. He was no doubt aware that hospital personnel who know a patient has requested a DNR are less inclined to question a patient's death.

In at least one instance, Swango entered a DNR order on behalf of a patient without consent. Swango had been pressuring the patient to request a DNR, but the patient refused. Investigation determined that Swango, listed as a first-year resident (R-1), told his supervisor (an R-2) that he had contacted the chief resident via telephone after the patient became unconscious and that they had discussed the need for a DNR order. Swango convinced the R-2 that this conversation with the family constituted a DNR order. During a subsequent interview, the chief resident asserted that he had received no such phone call and would have recalled it. R-1's do not commonly telephone the chief resident about a routine DNR order. During a subsequent interview, the R-2 conceded that he had probably been tricked by Swango. Incidentally, the R-2 recalled a previous occasion when he dined with Swango at a restaurant and became violently nauseated on the drive home. In several other suspicious deaths at Northport, Swango was observed in patients' rooms immediately prior to their demise.

During Swango's time at Northport, Kinney committed suicide. In her suicide note, she sounded exhausted and depressed but claimed she still loved Swango. Kinney's parents believe their daughter's suicide was caused by the stress of her relationship with him and the chronic headaches and stomach problems she had been experiencing. Before Kinney was buried, her mother clipped off a section of her hair for sentimental reasons. Later, the Federal Bureau of Investigation (FBI) Laboratory determined the hair contained large amounts of arsenic. Swango's longstanding interest in arsenic, coupled with Kinney's chronic headaches and abdominal distress, strongly suggest he was poisoning her, but this suspicion cannot be confirmed. As will be discussed later in this chapter, there is strong evidence that Swango poisoned other acquaintances, although not necessarily to kill them.

When hospital officials in South Dakota learned that Swango was working as a doctor, they contacted VA officials who promptly suspended Swango and initiated an inquiry into suspicious deaths. Without notifying the FBI, the Suffolk County Police Department, or the Suffolk County Medical Examiner's Office, the VA's Office of Inspector General (VA-OIG) conducted a cursory investigation and advised the U.S. Attorney's Office that they could find no evidence of wrongdoing.

During their investigation, the VA rejected requests by Suffolk County homicide detectives to interview Swango, claiming the county had no jurisdiction on federal property.[2,3] The detectives promptly contacted the FBI. When the two agencies arrived, they were shocked to learn that Swango had already been fired and allowed to return to remove his belongings. It seemed that the VA-OIG lacked an understanding of the value of immediate physical evidence. Years later, an FBI agent was shown photographs the VA-OIG had taken of Swango's quarters and was shocked to see bottles, pill

containers, notebooks, and binders that might have contained possible evidence of a murder.

Swango relocated to Georgia, legally changed his name to Jackson Kirk, moved in with one of Kinney's friends, and secured a job at a water treatment facility. At that time, neither the FBI nor any other law enforcement agency had sufficient evidence to arrest him for murder. Without eyewitnesses or specific knowledge of the type of substance he used to kill people in hospitals, the FBI continued their investigation.

The FBI obtained an arrest warrant for Swango for falsifying his application for employment at the Northport VA hospital. They exhumed the bodies of five patients who had died under suspicious circumstances. However, before process could be served, he disappeared. Thinking he may have fled the country, the FBI placed a border stop on him. Almost 2 years later, as Swango was returning from overseas, U.S. immigration officials detained him based on the outstanding warrant.

A subsequent investigation revealed that while Swango was living in Georgia, he had quietly applied through the Evangelical Lutheran Church to work as a physician in Africa. To avoid having to explain the suspension of his medical license, he submitted forged documents indicating that he was properly licensed and in good standing.

When Swango subsequently arrived at Mneme Hospital in rural Zimbabwe, he was greeted warmly because qualified doctors were in high demand. Nonetheless, it soon became apparent that Swango's medical skills were lacking, particularly in the area of obstetrics and general surgery. Hospital officials reassigned Swango to Mpilo Hospital in Bulawayo for several months for remedial education and closer supervision.

Swango returned to Mneme Hospital, but nurses and patients complained about his suspicious behavior and abruptness with patients. A pregnant patient awaiting dispatch to the delivery room recalled seeing Swango surreptitiously remove a syringe from his jacket pocket and inject her IV with an unknown substance, practically in front of nurses. She instantly felt an intense burning sensation and paralysis but was able to attract the attention of a nurse who confronted Swango. He adamantly denied injecting anything. A patient, who had undergone a successful leg amputation and was soon to be discharged, reported that Swango entered the ward late at night and injected him in the buttocks with a substance that immediately caused intense burning and paralysis. After administering the injection, Swango waved "bye-bye" to the patient and left the room. It was noted that Swango was not assigned to this ward, and the patient was not under his direct care.

The symptoms described by these survivors suggest Swango may have injected them with succinylcholine, a muscle relaxant. However, this could not be proven because blood samples were never drawn from these patients.

Thereafter, nurses began noticing an inordinate number of deaths when Swango was around. Hospital officials notified the police who initiated a criminal investigation and found five suspicious deaths and two attempted murders. Their investigation determined that Swango neglected to record treatment or drugs given and failed to swab areas before giving injections. They noted that patients died within minutes of injection and that with the exception of one, Swango certified the deaths himself, avoiding postmortem. All of the patients who died had fully recovered or had undergone successful surgeries. A search of Swango's quarters revealed syringes, medication, and other substances, but before they could be forensically tested, the police lost them. Nevertheless, the hospital suspended Swango, and he promptly hired a lawyer to contest this action. Amazingly, in the interim, he was allowed to work as a volunteer at Mpilo Hospital.[4]

As the criminal probe expanded, Swango fled to Zambia and quietly obtained a position at the University Teaching Hospital (UTH) in Lusaka. It was not long before nurses noticed his indifference to patients. As an adjunct to his regular duties, he earned extra money certifying the deaths of patients brought in dead. When Swango pronounced a man dead without entering the examination room, the family complained to administrators who ordered Swango to show greater sensitivity. Swango then propped up the corpse in full view of the bereaved family, inserted a tongue depressor in his mouth, tapped the deceased's knee for reflexes, and laid him back down, saying, "He's dead."

UTH doctors found Swango's surgical skills lacking. Besides Swango's marginal medical

skills, the nursing staff found his hygiene to be so poor that they refused to eat food he brought them. Informed that Swango was suspected of killing patients in Zimbabwe, UTH suspended him. Swango promptly contested the suspension. Although UTH officials were ultimately unable to attribute specific deaths to him, they were wary. In early 1994, when Zambian immigration officials arrived at UTH to question him, Swango climbed out a window and fled to Namibia. In the capital, Windhoek, Swango tried unsuccessfully to obtain a job at a forensic laboratory. Zimbabwean authorities had already disseminated a warning about him.

The police and Interpol turned over to the FBI dozens of Swango's books (many on serial murders), a partial diary, and an address book that, because of weight restrictions, he was forced to leave behind. Contact with the individuals listed in this address book enabled the FBI to piece together Swango's activities in Namibia.

Unable to find employment in Africa, Swango made arrangements to work at a hospital in Saudi Arabia. This required him to return to the United States and obtain a visa. When he reentered the United States, the FBI arrested him based on the sealed fraud indictment. In Swango's possession was a notebook with a reminder to himself to research all available information on serial killers by examining public documents and going to libraries and bookstores. Organized into dozens of short, numbered paragraphs with repeated references to death, murder, and emptiness in life, the writings resembled the beginning of a screenplay whose overall tone was, not surprisingly, somber. The following are some selected excerpts:

> *He could look at himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world. . . . He could feel he was God in disguise.*[5]

> *There is, of course, one major disadvantage that dawns on every master criminal sooner or later. He can never achieve public recognition, or at least only at the cost of being caught. He must be content with the admiration of a very small circle. This explains why so many "master criminals" seem to take a certain pleasure in being caught. They are at last losing their anonymity. This is the irony of the career of the master criminal; unless he is caught, he feels at the end the same frustration, the same intolerable sense of non-recognition that drove him to crime in the first place.*[6]

> *Spin bacteria out of blood samples and mix it with anything, ie cyclosponne [sic] at hospital pharmacy. . . . You think pharmacies don't know anything beyond counting pills . . . but we're scientists; we're chemists. Any fool can use a centrifuge. Pharmacies create compounds; we create things. Pharmacies intent on killing their patients gave them placebos instead of anti-ejection drugs. How simple. Look for a drug that wasn't there…*[7]

Swango pled guilty to the single fraud charge (Title 18, USC 1001) and was sentenced to 5 years in a federal prison. This conviction afforded the FBI time to further investigate in Africa and the United States. As part of the investigation, three bodies were exhumed in New York and four in Zimbabwe in hopes of discovering what killed these individuals.

While Swango was serving his sentence in a federal prison, the FBI went to interview him. They learned that he was enjoying high status among inmates, teaching Graduate Educational Development (GED) classes, working in the prison library where he had access to reading materials, living in a dorm with access to cooking facilities, cooking for the other inmates, and receiving regular visits from his half-brother. When the staff discovered him serving refreshments during an awards ceremony, they stopped him because this was a violation of the judge's sentencing order prohibiting Swango from accepting work in prison food service, the infirmary, or pharmacy. FBI agents explained the history of Swango's obsession with poisoning people and the continuing danger he posed. Coincidentally, there was a rebroadcast of an ABC documentary about suspicious deaths attributed to Swango. Prison officials promptly transferred him to a more secure facility. Less than a month after his arrival, an inmate attempted to cut his throat. Swango ducked, and the near fatal wound missed his carotid artery, leaving a scar across his face.

FBI agents visited Swango and outlined their investigative work in New York and Africa. They told him he would stand trial in New York

on five capital murder charges and that he if he were acquitted, he would be sent to Africa to stand trial for murders there. The agents made clear they would accompany him to ensure that Zimbabwean investigators and prosecutors had all the information they needed. Swango countered that this was impossible in the absence of an extradition treaty. When the agents produced a recently ratified treaty between the United States and Zimbabwe, Swango indicated he was willing to make a deal. He was flown to New York and in a matter of weeks agreed to plead guilty to three federal murder charges in New York and one state charge in Columbus, Ohio. Swango would be sentenced to life without parole, and charges in Zimbabwe would be dropped.

Considering Swango's lifelong interest in poisons and access to a variety of medicines, it is difficult to determine all the substances he may have used. In New York, Swango used epinephrine and succinylcholine to kill patients. In Ohio, on at least one occasion, he used potassium. Proving potassium poisoning can be difficult because as the body dies, cells release potassium, producing high levels in the decedent. In this case, the patient Swango injected was being monitored with an electrocardiogram (ECG). Physicians were able to review the ECG and identify when the victim's heart reacted to the injection and when she died; the times coincided with Swango's visit.

There appear to be no common characteristics in the poisons Swango is suspected of using except their availability. He has denied singling out victims and described his selection as random. He has claimed that he killed with no emotion. Because he was a doctor, gaining access to patients in hospitals, particularly in Africa, was easy, and he was supremely confident he could talk his way out of any suspicions.

His victims were diverse in race, age, gender, religion, education, and health. Risks that might have dissuaded others from committing a murder, such as the presence of medical personnel, did little to deter Swango, as he often injected poisons with other staff nearby. In fact, those who survived his poisonous injections reported that he would carry a legitimate syringe in one hand while concealing another in his jacket pocket.

FBI agents who investigated Swango for several years believe he enjoyed killing people at whim. He seemed to derive particular pleasure witnessing the surprised reactions of victims as well as the shock and grief expressed by families and hospital staff. Many victims were not patients under Swango's care. For a doctor whose own competence was often called into question and who must have felt increasingly self-conscious because of his inadequacies, he may have been particularly gratified to see the patients of other physicians die, especially if their deaths were unexpected.

Apart from patients and coworkers, there is evidence that Swango routinely poisoned acquaintances, including his girlfriends and landlords. Remarkably, almost no one suspected Swango of poisoning them until they were questioned by FBI agents. Then many recalled experiencing periods of severe and unexplained headaches, abdominal cramps, and vomiting in his company—symptoms that disappeared after Swango left.

Anger appears to be Swango's motivation for poisoning a number of acquaintances, although revenge was sometimes a clear motive. In New York, after arguing with his landlord, he sought to reconcile by giving her a large drink from a local convenience store. Immediately after drinking it, she became violently ill with severe stomach distress, headaches, and double vision—symptoms consistent with arsenic poisoning. He had a landlord in Africa who experienced identical symptoms shortly after Swango rented a room; later, a sample of her hair contained traces of arsenic. At least two girlfriends reported similar illness when they were with Swango. According to many sources in the United States and Africa, Swango frequently carried with him a bag that he guarded carefully. When one girlfriend inquired what it contained, Swango answered "vitamins" and would not allow her to look inside.

In addition to anger and revenge, it seems clear there was a strong sadistic element to Swango's actions. This sadistic quality was evident in a Toastmaster's speech that Swango helped a female acquaintance write in Africa. Describing her own negative experiences with doctors, she asked Swango for help in editing the speech. She was shocked when he wrote an eerie piece about how words can cause miscommunication. In his example, Swango described how a child's accidental death was made all the

more tragic because his parents did not understand the medical procedures performed on him. What struck the woman was that Swango's example was not only unrelated to her topic, but that Swango presented it with remarkable coldness. Swango's reference to a child involved in an accident resonated with FBI agents who had met a Zimbabwean doctor who suspected Swango of murdering a child who was recovering from surgery following an accident.

In choosing a career as a doctor, Swango guaranteed himself easy access to the most trusting and unsuspecting of victims and unlimited opportunities to kill them. This access, coupled with his obsession with violence, made him a dangerous individual. The healthcare system in which Swango operated could not have been more conducive to fulfilling his murderous fantasies. It was a system characterized by poor information sharing, incomplete background investigations, reluctance to acknowledge mistakes, fear of lawsuits, aversion to negative publicity, and a need to fill positions.[8] Within this system, Swango found that he could take advantage of people's trust and use his skills of persuasion to overcome people's doubts. His confidence in talking his way out of trouble served him well. Far from feeling worried about allegations against him, he often appeared to relish the attention and the challenge of talking his way out of trouble.

By working long hours in hospitals (and sometimes living in them), Swango was able to monitor the presence of staff and take calculated risks to enter rooms of patients (often ones not under his supervision) and quickly kill them. His nefarious activities were so completely unexpected that it is understandable that staff failed to recognize the demonic swath he was silently cutting through wards to which he was not even assigned. Securing evidence for possible prosecution was not only a matter far from their job description, it was something far from their imaginations. Although exhumations ultimately proved helpful in identifying causes of death, they alone could not prove Swango's guilt. Exhumations require the permission of victims' families, and they are not always willing to provide it. In such cases, or in the case of cremations, potential toxicologic evidence is lost.

Swango was one of those rare individuals whose capacity for evil was nearly unimaginable. Operating on a higher intellectual plane than most serial murderers, he was smart enough, at least for a while, to avoid detection. He used his intellect, medical training, and charm to con nearly all he knew. With a sense of entitlement and complete indifference to the feelings of others, he exploited people and organizations to satisfy his obsessions and perverse desires. He knew the difference between right and wrong, as evidenced by his efforts to avoid detection, but he chose to pursue a path of violence.

The FBI's persistence paid off by pulling together the work of state, local, and foreign police, medical examiners, toxicologists, pathologists, emergency medicine personnel, laboratory and forensic examiners, behavioral specialists, journalists, television producers, diplomats, prosecutors, and hundreds of witnesses. Swango pled guilty to three murders in New York and one in Ohio. He was sentenced to four consecutive life sentences without the possibility of parole.

HAROLD FREDERICK SHIPMAN

On January 31, 2000, at Preston Crown Court in Northern England, Dr. Harold Frederick Shipman was convicted of the murder of 15 of his patients and of forging the will of one of them. The number of murder counts in the indictment earned Shipman the notoriety of the most prolific British serial killer. But, as investigators knew before his trial, and as a subsequent official inquiry would establish, the 15 murders with which he was convicted were only the tip of the iceberg; it became apparent that Shipman had killed hundreds of his patients in a murderous career that spanned more than two decades.

Shipman was a general practitioner (GP). General practice in the United Kingdom involves a doctor contracting his skills to the National Health Service, maintaining a list of patients in the area, and catering to their medical needs—usually when patients come to his office or clinic with an ailment. Home visits are undertaken but are less popular with doctors given the amount of time they consume. The offices do not have facilities for admitting patients overnight, and appointments typically last for only 10 or 15 minutes.

Unlike other medical personnel who have murdered patients in the enclosed medical

setting of a hospital, Shipman primarily murdered his patients in their homes, although there were a few occasions when he murdered them during an appointment. This meant that only rarely did he run the risk of other medical professionals either interrupting him in the act of killing or raising concerns about the number of deaths among patients. A combination of deceit and arrogance were usually sufficient to allay suspicion.

Shipman trained as a doctor at Pontefract General Hospital in the North of England from 1970 until he qualified in 1973. He remained at the hospital practicing as a "junior doctor" until he left in 1974, having obtained employment as a GP at the Abraham Ormerod Medical Practice in Todmorden in the North of England.

While he was at this practice, his fellow doctors discovered that Shipman had forged documentation to obtain the drug pethidine (known as meperidine in the United States) from a nearby community pharmacy for his own illicit use. He admitted to an addiction to pethidine, which he was taking intravenously. Shipman was prosecuted for the offences and heavily fined; his employment was terminated, and he obtained treatment for his addiction. In interviews with detectives, Shipman claimed to have started abusing drugs to escape from the pressure of his work, which he claimed had left him with depression.

In 1975, he moved to Hyde in Greater Manchester and joined the Donneybrook medical practice. He told his fellow doctors of his previous addiction and his criminal convictions. They obviously decided that his addiction and his previous dishonesty were not in conflict with his medical ethics, as they employed him at the practice.

In 1992, following a dispute over funding and the computerization of the practice, Shipman left Donneybrook and set up a solo practice. He took most of his patient list with him. He first came to the notice of the police in March 1998 after another GP expressed concerns to the local coroner.

U.K. doctors are authorized to issue a Medical Certificate of Cause of Death (MCCD) following the death of a patient when there are no suspicious circumstances, when they have treated the individual during the course of the final illness (within 14 days of death), and when the doctor is confident they know what has caused the death. Once an MCCD has been issued, the death is registered and burial is authorized. When a body is to be cremated, a second doctor from a different medical practice is needed to countersign documentation. Providing the second doctor is content that there are no suspicious circumstances, there is no need to report the matter to the coroner and no need for a postmortem examination or any further investigation of the death.

This procedure allowed Shipman to issue an MCCD for patients whom he had murdered and, if they were to be cremated, the opportunity to persuade a fellow doctor to countersign cremation documentation. In most cases, Shipman went to the Brooke practice that operated from a building opposite his own. At the Brooke practice, there were several doctors, and they took it in rotation to countersign cremation certificates referred to them by Shipman. One of these doctors became concerned by the number of certificates that she and her fellow doctors were asked to countersign. She compared the number of deaths being referred by Shipman with the number generated within the larger community of Brooke, and she found Shipman's numbers alarmingly high. She suspected that Shipman might be killing his patients and contacted the coroner.

The coroner took the doctor's concerns to the police who began an investigation based on an examination of cremation certificates completed by Shipman over the preceding 6 months. Nineteen deaths became the focus of the investigation. The investigation was not thorough, probably because there was a fear that the doctor, the coroner, and the investigators would be proved wrong, and the good name of Dr. Shipman would be besmirched. But perhaps more significantly was the inability of investigators to identify a credible motive for Shipman. The reluctance to believe that a doctor could murder his patients became known as the "credibility gap." The investigation was closed and Shipman continued to practice. No interview of Shipman took place. Nor were postmortem examinations conducted on the bodies of two of Shipman's patients who died during the investigation.

Shipman was eventually stopped in July 1998 when the police were contacted by the daughter of one of his patients. She alleged that Shipman

might have been involved in the forgery of a will purportedly made by her mother. The 81-year-old female patient had died suddenly on June 24, 1998, within a few hours of a home visit by Shipman, who was supposedly obtaining a blood sample. She was discovered in the late morning by two friends after she had failed to keep an appointment with them. The door to her house was unlocked, and she was lying fully clothed on a sofa in the living room.

Shipman attended at the house, issuing an MCCD and certifying the cause of death as old age. Although this is an acceptable cause of death in individuals over 70 years, there should be documentation of a prolonged general deterioration in health affecting the major organs. This was not the situation, but the patient's daughter accepted Shipman's explanation of death and believed in his concern for her general well-being.

During the subsequent investigation, it was apparent that Shipman had lied. The patient had been living an active life. She did volunteer work, drove a car, and enjoyed an active social life, having been walking in the nearby countryside earlier in the week and visiting friends the evening before her death. She was not suffering from any life-threatening conditions and was being treated for only minor ailments.

Following burial, a poorly typed will leaving the patient's property to Shipman came to the attention of her daughter. The will had arrived by post at a local solicitor's office on the day of her mother's death and was dated some 3 weeks before the death. The solicitors did not know the patient and had never acted for her. The daughter, after making some initial enquiries, contacted the police.

Realizing that this was the same doctor investigated earlier in the year, the police opened investigations, exhuming the body to perform a postmortem exam. The pathologist did not agree with Shipman's cause of death on the MCCD; thus, muscle tissue was obtained and sent for analysis. Forensic toxicologists soon detected opiates in the tissue that were consistent with the administration of a significant quantity of morphine or diamorphine. The patient had not been suffering from any condition that warranted prescribing or administering morphine prior to her death.

Press interest in the investigation resulted in the reexamination of the deaths of the earlier investigation. This in turn created media interest and resulted in the public expressing concerns that they had harbored for many years about the circumstances surrounding the deaths of family members and friends who had been patients of Shipman. All these reported concerns and the circumstances surrounding the deaths were investigated, resulting in a thorough examination of the 136 deaths of Shipman's patients.

What the investigation found was extraordinary. Many of the deaths shared similarities. Shipman used the same lies and stories to explain deaths to multiple families. It became apparent that Shipman was a consummate liar who forged legal documentation and falsified medical records.

In the course of the investigation, the bodies of 12 of Shipman's patients were exhumed and postmortem examinations carried out by a pathologist. Each of them had had an MCCD issued by Shipman giving a cause of death. In none of them could the pathologist agree with the cause of death as stated by Shipman in the MCCD.

Deep muscle tissue was submitted for examination by forensic toxicologists. In nine cases, substantial quantities of morphine were found in the tissue, consistent with morphine levels in deaths caused by that drug. None of the patients had been suffering from any condition that required the administration of morphine. In fact, investigators deliberately avoided exhuming bodies where evidence existed that morphine had been used therapeutically. The significant issue was that morphine was present at all. In each case, the pathologist concluded that the patient had died as a result of morphine toxicity.

The toxicology and pathology in the other three exhumation cases was inconclusive. Because the bodies had been buried nearly 5 years, body tissue degradation was more advanced, making interpretation difficult for pathologists.

Investigators used the many similarities in the circumstances surrounding different deaths to show that Shipman was responsible for killing patients whose bodies had been cremated and were therefore unavailable for pathologic examination. The lack of a cause of death was seen as a difficulty, but prosecutors were convinced that the similarities among the cases were sufficiently compelling. Shipman was thus

charged with six deaths wherein the body had been cremated.

Not all of the murders included in the indictment were exactly alike. In fact, investigators charged Shipman with cases in which some of the similarities were present but new similarities with other cases were identified that could be mapped to other cases. Many of these similarities were present not only in the 15 counts in the indictment but also in the other deaths that were investigated.

These similarities were formed into criteria used to determine whether Shipman was likely to have murdered in any particular case. One salient feature was that the death occurred within a short time of Shipman having visited the patients in their home or administered to them in his office. Usually, death occurred within just a few hours of his consult, but, on occasions, he was discovered in his ministrations by members of the family or friends who had arrived home unexpectedly—after he had administered morphine but before he had had a chance to leave. In such cases, he often told the same lies to family or friends.

In one case, a 77-year-old female patient living alone was in the process of doing her laundry and cooking her lunch when Shipman called at her home to deliver antibiotic tablets. The woman, a ballroom dancer who was fit and active, was suffering from a chest infection, and Shipman had prescribed the antibiotics. While there, he injected her with a massive dose of morphine or diamorphine, causing her to collapse. Before he could leave, the patient's dance partner arrived. Shipman claimed that he had found the patient in a collapsed state and had summoned an ambulance. When the patient failed to respond, Shipman pronounced her dead and went through a charade of canceling the ambulance. Subsequent inquiries with the ambulance service and telephone records failed to validate Shipman's story. Shipman performed this charade on many occasions when he was interrupted while murdering his patients.

Many of Shipman's victims were elderly and living alone, almost always in good health but suffering from minor ailments. These circumstances obviously made it safer for him to carry out murder—he was less likely to be interrupted and had a ready excuse to be in attendance. On occasion, however, he mistakenly believed that patients were alone in their home.

On one such occasion, he attended at the home of an 81-year-old patient who was in discomfort with a hip prosthesis. He murdered her with a lethal injection of diamorphine. The woman's friend was at her home but had gone upstairs just before Shipman arrived. As she was returning through the kitchen, she heard voices in the living room; knowing her friend was expecting the doctor, she waited in the kitchen in silence to afford her friend some privacy. After a few moments, the voices stopped, and a few minutes later, Shipman entered the kitchen. He was somewhat surprised by the friend, but without any difficulty said that the patient had collapsed and died.

Shipman's capacity to lie manifested itself in other ways. He falsified the causes of death on the MCCD, and he lied on cremation documentation in which he said that his victims' relatives had been present at the time of death when they had not been. This deception was obviously to allay the suspicions of the counter-signing doctor.

Shipman forged other documentation to cover his tracks. He kept his patients' medical notes on a computerized system to do so. These were supplemented by paper records containing correspondence and reports from medical experts and specialists to whom patients had been referred as well as written records relating to visits conducted at a patient's home and where Shipman would not have had access to his computer. In many cases, shortly after murdering a patient, he altered the medical record to create a false history of a medical condition that he then used on the MCCD as the cause of death. Most commonly, Shipman falsified symptoms of heart disease or of high blood pressure before then listing the cause of death as a heart attack or stroke.

None of these practices were known to his patients, and many of them regarded him highly. His patient list was extensive, and there was a waitlist to get on it. He was regarded as a good doctor who was plain speaking and had a caring manner. He could be relied upon to spend time with his patients and was willing to attend to the elderly ones in their homes.

He was also prepared to confront those who regulated his practice, especially in relation to curbs on his drugs budget. He regarded them as petty bureaucrats who deprived his patients of

the best drugs and most appropriate care, and he seized every opportunity to let it be known. This made him popular with his patients but brought him into conflict with health authorities. He saw those who opposed him as feeble minded and inferior, and he often adopted an aggressive and demeaning attitude toward them.

At a meeting, he took great delight in ridiculing a drug company's representative who perhaps did not know her product, eventually reducing her to tears. He aggressively challenged speakers at medical conferences, almost shouting them down. He was arrogant and aggressive whenever his authority was challenged, and this manifested itself when relatives and friends asked why their perfectly healthy relatives had died suddenly.

His caring manner seemed to disappear on such occasions, and he seemed unable to empathize with the relatives who had suffered a sudden and devastating loss. On many occasions, he would bring the relatives together and "pontificate" about what had been wrong with the patient. He would chastise relatives because they had failed to appreciate how ill the patient had been, implying they had failed to provide the necessary support and care. But he stopped short of suggesting they were to blame for their relative's death.

He implied that he was the only one who recognized the seriousness of the patient's condition and that he had been doing his utmost to treat the patient. This charade was partly to satisfy his desire to appear omnipotent, to revel in the attention he was given, and to enjoy the esteem of others. However, he also needed to provide as full an explanation as possible to ensure that the family would not press for a postmortem examination that might have led to his crimes being discovered.

There is no doubt that Shipman had a conceited view of himself, and there is no better illustration than in the wording of the will he forged that led to his arrest. In it, Shipman wrote (assuming the part of the deceased patient) that he should be rewarded for all the care he had given her and the people of Hyde and that he was sensible enough to deal with any difficulties that the bequest would present him.

When arrested and interviewed, he took exception to the questioning of detectives and attempted to dominate the interview with a combination of tactics, including accusing the interviewer of asking two questions at once, adopting a sneering attitude toward them because of their lack of general medical practice knowledge, and implying that they were intellectually inferior. His arrogance, however, failed to provide him with plausible answers to the questions, and he was consequently charged with the offenses.

Investigators sought to identify how Shipman had obtained the murder weapon—morphine. Early in the investigation, detectives discovered Shipman's previous convictions for obtaining pethidine. Since then, Shipman reported that he had decided not to carry any controlled drugs—including morphine—unless it was an absolute emergency. This decision meant that Shipman was not required to maintain a drug register.

Diamorphine (diacetylmorphine, heroin) is a stronger version of morphine, having about twice its potency. However, after entering the body, diamorphine metabolizes almost immediately into morphine. Consequently, forensic toxicology findings indicated the presence of morphine, although detectives established that Shipman had been illicitly obtaining diamorphine and then administering it to his patients to kill them. The presence of an intermediate metabolite, 6-monoacetyl morphine, may sometimes help identify diamorphine as the original drug if exposure has been recent.

Shipman had been writing out prescriptions for diamorphine for patients who did not need it and, on some occasions, had been writing prescriptions for fictitious patients. He would go to the pharmacy, collect the drug, and keep it himself. On some occasions, he would write prescriptions for patients who had died several days before. On other occasions, he would write a prescription for a patient who needed the drug, collect it, and then deliver only part of the prescription to the patient, retaining the rest. He also obtained the murder weapon by taking the residue of diamorphine from a patient who had died of natural causes (usually cancer) on the pretext of disposing of it in a safe manner.

Although there was no evidence that Shipman had returned to abusing drugs, his methods of obtaining diamorphine to murder his patients were almost identical to those he used to obtain pethidine for self-administration 20 years earlier.

Shipman's home was searched on two occasions. Despite his role as a health authority, the interior of his home was dirty with unwashed clothes and dishes. The officers conducting searches were both surprised and disgusted by their findings, especially when they discovered a quantity of permitted medicines and ointments in the house. Hidden in one of the innocuous medicine boxes were four 10 mg ampoules of diamorphine together with 50 morphine sulphate tablets, which he had taken from the homes of two separate patients some years earlier, supposedly so he could properly dispose of the drugs. This provided evidence of Shipman's practice of hoarding diamorphine.

The condition of Shipman's home was surprising especially because he was married and had four children, three of whom were young adults living in the house. Shipman's wife and children supported him during his medical career and continued to support him after his conviction, refusing to believe that he was responsible for the murders. There is speculation that Shipman was an autocratic individual who did not allow meals to commence until he was present. Shipman must have used deceit to keep his murderous activities from his family. There is no indication that any of them knew he was murdering his patients. However, for that to be the case, he must have lied to them about his whereabouts at times when he was carrying out a murder. It is likely, given the town's size, that his family members knew many of his victims.

It is difficult to identify what motivated Shipman to kill his patients. Except for his last victim, there is no evidence that he attempted to profit financially from his murders. Likewise, there was no evidence to suggest that any of his victims had been the victims of any form of sexual abuse by Shipman before or after death. The victim's clothing was often still buttoned, in many cases with high necklines as one might expect given the age of the victims. This lack of disturbance was surprising because Shipman usually described how he fought to save their lives. There was no evidence of "arranging of the body" except on a few occasions when he placed a magazine or pair of glasses on the victim's knee to suggest death had occurred suddenly during some mundane activity.

To identify Shipman's motivation, it is perhaps necessary to turn to some of the findings of the Public Inquiry, convened after his conviction. At Shipman's conviction, investigators had already provided evidence of a further 23 patient deaths, demonstrating that Shipman murdered them. However, prosecutors wanted to wait until after the trial before dealing with these additional charges. As evidence unfolded in the trial, the British government—particularly the Secretary of State for Health and the Secretary of State for Home Affairs—realized that a GP murdering his patient posed a threat to public safety. Consequently, they announced that a Public Inquiry would be held.

A Public Inquiry requires the appointment of a senior judge of the English High Court who utilizes a team of government lawyers to hear evidence from witnesses and experts to make recommendations for the future safety of the public. In the case of Shipman, the terms of reference required the Inquiry to establish the extent of Shipman's unlawful activities. The Inquiry investigated every death in which Shipman had been involved back to the start of his general practice; in each case, the Inquiry published a finding as to whether Shipman had murdered the patient.[9-14] This was a much wider remit than that of the criminal investigation and involved an examination of more deaths.

The Inquiry concluded that, together with the 15 convicted murders, sufficient evidence existed to establish that Shipman had killed 215 of his patients and that there was a "real possibility" that he had killed another 45. Destruction of documentation and witnesses' fading memories prohibited the Inquiry from making a decision in a further 38 cases, mainly from when he was in Todmorden. The Inquiry examined 888 deaths.

Although not covered by the terms of reference, toward the end of the Public Inquiry, concern was expressed about Shipman's time as a junior doctor at Pontefract General Hospital. The Inquiry decided—as well as it was able, given the passage of time—to examine the deaths Shipman was involved with at the hospital in the early 1970s. The Inquiry was hampered by the passage of time but concluded that there was suspicion about Shipman's involvement in 24 cases of death during his tenure at the hospital.

The Inquiry also examined Shipman's possible motivation and method of selecting his victims. This was a difficult task. Shipman never

admitted responsibility for his crimes and refused to cooperate with police, prison authorities, or the Inquiry after his conviction. In fact, a forensic psychiatrist advising the police, who still hoped to gain a full account from Shipman, advised that Shipman was unlikely to remember details of everyone he had murdered and that consequently, he might never be able to provide a full account. There is no indication that Shipman kept written records of his murders. In January 2004, during the Inquiry process, Shipman hung himself in his prison cell.

Of those Shipman murdered, 171 were women and 44 were men. The majority of his victims were murdered in their homes and were elderly. Although most were women, if the opportunity arose, he murdered men. The imbalance in female victims over male victims is perhaps explained by the fact that, in general, women live longer than men and were thus more likely to be living alone in the community where Shipman worked.

Although he tended to choose elderly victims, he occasionally killed younger victims if he felt safe in doing so. His youngest victim was a 41-year-old man who was in the advanced stages of terminal cancer and whose death Shipman hastened with an overdose of diamorphine. His oldest victim was a 93-year-old woman.

The earliest death for which Shipman was responsible occurred in March 1975 and the last, which resulted in his arrest, was in June 1998. The majority of the killings (143) were in a 6-year period while he was operating as a solo practitioner. Over an 18-year period, he killed 72 people while practicing as a GP in partnership. The increasing murder rate as the years passed suggests that there was an addictive element to his murders. This may explain why the close proximity of fellow professionals did not deter him.

However, despite his addictive nature and his extreme self-confidence, he seemed to be aware that he could be caught. There are gaps between murders, sometimes of many months; these long gaps seem to have occurred after he had just escaped detection. On one occasion, as Shipman explained to the daughter of a victim why a postmortem examination was unnecessary, the victim groaned. The woman lived another 24 hours. Shipman may have worried that she would recover and disclose what he had done, but she did not survive. Two months later, Shipman killed another patient. In that case, a relative complained about the hospital's failings. Shipman may have been concerned that an investigation of that matter would result in his discovery. It did not, but after these two close calls, Shipman did not kill for more than a year.

On another occasion, in February 1994, Shipman gave a patient, suffering an asthma attack, a large dose of diamorphine—an inappropriate treatment that caused her to collapse. The patient's daughter arrived, intervened, and summoned an ambulance. The patient was taken to hospital where she survived in a vegetative state for more than a year before dying from pneumonia brought on by inactivity. Shipman was forced to admit his administration of morphine to ambulance staff and doctors at the hospital. Shipman must have worried that he would be investigated at least for negligence, and he was careful to curtail his murders for some time. The Public Inquiry later criticized the senior medical personnel for failing to report Shipman at that time because they had been made aware of Shipman's actions that, at best, indicated incompetence. The coroner and pathologist were also criticized for their failure to thoroughly examine the true circumstances of this death. If Shipman had been caught at this time, his murderous career would have ended 6 years earlier, and over 100 lives would have been saved.

Early on, Shipman appeared to have selected victims suffering from terminal illness or those who were extremely ill. He may have thought these murders were less likely to attract attention and lead to his discovery. It may also have been that he was able to rationalize the killing of a terminally ill individual as an act of mercy. However, as time passed, he became bolder, selecting patients who had some ailment but were not at imminent risk of death.

Although he still killed terminally ill people, he often singled out those who had been or were likely to become a burden on his practice and a demand on his time—individuals with chronic conditions or those with mild mental health problems who were otherwise physically well. Shipman may have believed he was saving all of them from an unhappy and pointless existence. Possibly supporting this is the fact that when he was called to care for individuals who had suffered a heart attack, rather than treat them, he would give them a lethal injection, perhaps

out of concern for their future quality of life. He had even been heard to comment that he did not believe in "keeping them going."

There are also examples of Shipman murdering patients who would not take his advice—particularly in relation to going into elderly residential care. He seems to have taken delight in killing the fitter member of a married couple, thereby ensuring that the less mobile surviving member would be taken into residential care.

Despite outlining Shipman's victimology, it was not possible for the Public Inquiry or anyone else to state what Shipman's motivations may have been. At an impressionable age, he witnessed his mother's decline and eventual death from cancer. In the process, he no doubt witnessed the relief from pain she gained from the administration of morphine. It is impossible to say whether this had any influence on his desire to kill.

Insight into Shipman's motivation can perhaps be gained from the circumstances surrounding his capture. His attempt at forging his patient's will was at best amateurish. The document was ill-prepared and was sent to a lawyer who had no dealings with the patient. Shipman knew the patient well and knew her daughter was a solicitor. He must have realized that the validity of the will would be challenged and the circumstances of its creation investigated. There was little likelihood of him getting away with the proceeds of his patient's estate, estimated at 360,000 pounds. Yet, he pressed on with his scheme, which, given the date of the creation of the will, had taken him some time to plan.

Whatever the motivation for his deeds, Shipman managed to evade detection for over 20 years because the safeguards designed to prevent such events were inadequate. For instance, there was no system for monitoring death rates at a particular practice. Had there been such a system, Shipman's high death rate would have been identified. Also, there was no close examination of the MCCDs, and family members did not have the opportunity to challenge that information. Had they had such an opportunity, they would very likely have discovered that Shipman had lied extensively on the documentation.

Furthermore, there were failings in the control of dangerous drugs such as diamorphine. While controls were in place until a doctor prescribed the drugs, no one effectively monitored the amounts being prescribed by an individual doctor. Nor were there any controls once they had been collected or delivered to the patient in respect to disposing excess drugs. Shipman exploited this flaw to access the murder weapon. Shipman managed for two separate lengthy periods to obtain dangerous drugs in huge quantities without detection.

The Public Inquiry made a number of recommendations in order to close the loopholes that Shipman exploited. However, 3 years after the Inquiry, many of these had still not been implemented.

ORVILLE LYNN MAJORS

A licensed practical nurse (LPN), Lynn Majors joined the Vermillion County Hospital (VCH) staff in the fall of 1993. VCH was a small rural but modern hospital with a dedicated staff. As with most small towns, the members of the hospital staff knew each other well. When the four-bed critical care unit had patients, Majors would be assigned there with a registered nurse (RN) as his supervisor. When the unit was empty, he usually was assigned to pass medications on the medical floor. The annual admission rate in that intensive care unit (ICU) had been consistently close to 350 patients, with about 27 deaths. In 1993 the rate increased almost imperceptibly, but by the spring of 1994, a climb in those numbers began to draw attention. Rumors began to circulate that Majors was associated with that increase. By summer of 1994, the increase in ICU cardiac arrests was clearly noted, and in July, the death rate in the ICU accelerated. There are conflicting stories as to when the hospital administration became aware and what steps were taken. In early 1995, the nursing director of the ICU completed a survey comparing the deaths in the ICU for 1993–1994 with employee time cards. What she found was of grave concern. Of the 147 deaths in VCH's ICU between May of 1993 and December of 1994, 130 occurred when Majors was working. In March, VCH officials notified the Indiana State Police of their concerns. Majors was placed on leave and eventually fired. Thus began the largest criminal investigation in Indiana's history. It lasted four years and cost over two million dollars.

The Indiana State Police assembled an independent medical investigative team consisting

of an emergency physician, a registered nurse, two intensivists, two pathologists, a medical toxicologist, a cardiac electrophysiologist, a cardiac pathologist, and an epidemiologist. Over two years, charts were reviewed on all patients who had died during the period in question. The thrust of the investigation was to answer *two* questions for each case:

1. Was the death consistent with the patient's clinical course?
2. If not, was there a person or persons who appeared to be associated with the death?

Within weeks, their review showed that deaths in the ICU followed one of three patterns:

1. Sudden onset of hypertension followed by circulatory collapse and cardiac arrest
2. Sudden loss of consciousness followed by oxygen desaturation, then dysrhythmia
3. Unheralded terminal dysrhythmia with wide-complex tachycardia, then asystole

The investigative team members generally believed that over 100 of the cases appeared suspicious. Majors was in close proximity when death occurred in nearly all of the cases. Seven cases were selected for trial. While many more cases were suspected murders, the prosecution decided that presenting a large number of cases would tend to be confusing to both witnesses and the jury. They chose cases that demonstrated ECG findings consistent with hyperkalemia and that in many cases involved witnesses who saw Majors inject the patient just prior to death.

The investigators determined that Majors had killed the majority of victims with potassium chloride. ECG findings of QRS widening, P-wave changes, and sine-wave patterns were frequently documented. A search of Majors's van revealed eight vials of potassium chloride, two syringes of epinephrine, and three vials of injectable nitroglycerin.

Majors was usually assigned to the ICU, but if the unit was empty, he was assigned to pass medicines on the wards. Investigators believe that when Majors worked on the medicine floor, he injected patients with epinephrine intravenously, causing a hypertensive crisis and eventually ventricular tachycardia. He would then initiate a code, and almost invariably, lidocaine would be ordered as part of the resuscitation effort. It is speculated that Majors would then add potassium to the lidocaine infusion or inject potassium directly into the intravenous line. The patient would be moved from the floor to the ICU, and Majors moved with them to staff the area with a supervising RN. In the ICU, he would inject the patient with more intravenous potassium. On one occasion, there were three simultaneous cardiac resuscitations in progress in the four-bed ICU. Majors had discovered all three. When Majors took a vacation, the deaths stopped. According to police investigators, of the 33 patients moved from the wards to the ICU, Majors moved 23. None of those 23 survived to discharge.

Some of the victims' family members described unusual behavior in Majors. In one case, he was working with the IV fluid bags when a family member entered. Majors ran from the room, almost knocking down the patient's wife. He sat at the nurses' station staring into the room. Moments later, the patient gasped and fell back on the bed, unconscious and cyanotic. Though the patient survived the initial resuscitation, the supervising RN's notes state that he died hours later after suffering a "respiratory arrest" while on the ventilator.

Despite all of the resuscitations, only one set of electrolytes was ever documented. The potassium was 6.8 mEq/L. In that case, the patient had suffered an arrest on the ward and was moved to the ICU. The records of that "code blue" are bizarre. The initial blood pressure entry was 229/158 mm Hg. Pressure then dropped to 94/57 mm Hg only 16 minutes later. It increased to 209/159 mm Hg 46 minutes later before dropping again to 105/100 mm Hg. Two more peaks hit 224/158 mm Hg and 173/105 mm Hg before the patient became asystolic. These events led the medical investigators to speculate that the patient was receiving intravenous infusion that had been laced with potassium chloride. It also appears that during the code, he received doses of epinephrine causing the marked increases in his blood pressure. Epinephrine shifts serum potassium back into the cells, thus decreasing its effects on the heart. Eventually, if epinephrine is not given, potassium shifts back into the serum resulting in asystole. ECG monitor strips show markedly peaked T waves consistent with hyperkalemia (Figure 26.1). In a different case, tracings demonstrated the sine-wave pattern considered virtually

pathognomonic of hyperkalemia (Figure 26.2). Likely because the patients were older and no one suspected anything but natural causes, routine lab work, drug screens, and autopsies were almost never done.

In the state of Indiana, the accused has a right to request that trial proceedings begin within 75 days of arrest. Knowing that this would be a complicated and difficult case to present to a jury, prosecutors delayed Majors's arrest until the case could be presented. As a result of the work of the Indiana State Police investigative team, Majors was arrested on December 29, 1997. Trial began 19 months later.

Because of publicity, the venue was changed to nearby Brazil, Indiana, in Clay County. Jurors were selected from Miami County in north-central Indiana. The prosecution argued that the deaths of the seven patients were not consistent with their clinical course. Furthermore, cardiac rhythms, consistent among the patients, were indicative of either:

1. Massive myocardial infarction
2. Catastrophic saddle embolus (a large blood clot in the root of the pulmonary artery)
3. Injection of potassium chloride

Cardiac pathologist Bruce Waller ruled out a myocardial infarction. Pathologists John Heidingsfelder and Mark LeVaughn showed that saddle emboli were not present in the exhumed bodies. Ruling out the first two, cardiac electrophysiologist Eric Prystowski testified that the only plausible explanation that remained was poisoning with potassium.

In October of 1999, Orville Lynn Majors was sentenced to 180 years in prison for six of the seven murders for which he was tried. Like other serial killers, he had several supporters who saw him as a scapegoat. The prosecution was disallowed the presentation of certain compelling statistics. During the investigation, an intense epidemiologic study of VCH was performed. Time cards, vacation dates, and time and date of deaths were reviewed in a blinded fashion.

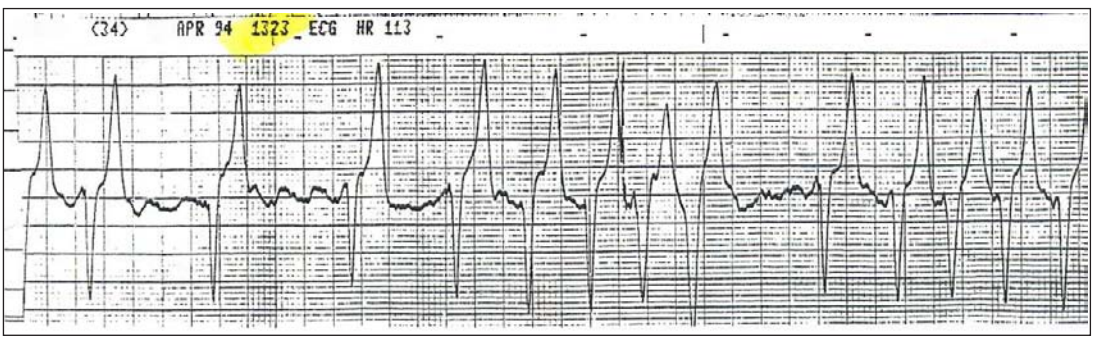

FIGURE 26.1 **This monitor strip shows tall peaked T waves often indicative of marked hyperkalemia.**

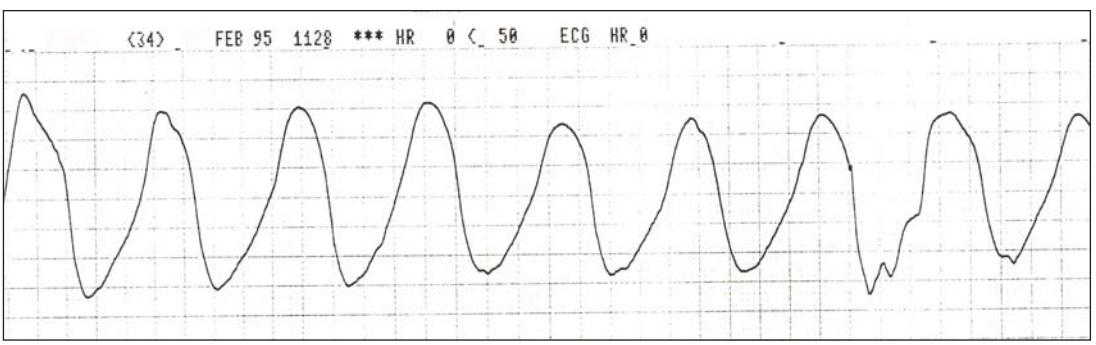

FIGURE 26.2 **Concomitant widening of the QRS and T waves leads to the usually terminal pattern known as "sine wave."**

Stephen Lamm, MD, found that the mortality was of "epidemic proportions" from July to December 1994. He concluded the following:

> *"Increased mortality occurred in the Intensive Care Unit. . . . One intensive care nurse was uniquely and very strongly associated with that mortality. . . . No other service or service provider shows any association that even approximates in magnitude that of the ICU nurse. . . . The likelihood of someone dying in the Intensive Care Unit was 42.96 times greater than it would be if he were not working."*

The statistics also showed that when Majors took a vacation, the deaths essentially stopped[15] (Figure 26.3). Graphs relating time worked to deaths were also ruled inadmissible. One member of the prosecution team remarked that if the jury had been allowed to see those charts, the trial would have been over in half a day. After the trial, they were allowed to review those charts[15] (Figures 26.4 and 26.5). What they saw was chilling. The death rate tripled during Majors's employment. In terms of hours per patient deaths, he had approximately one death per 10 hours worked, while workers who were not part of his team had rates of one death per hundreds of hours. Those graphs were based upon the statistics compiled by Dawn Stirek, the nursing director of the Vermillion County Hospital ICU.[15] In the end, it was her courage in performing the study that sparked the investigation and trial.

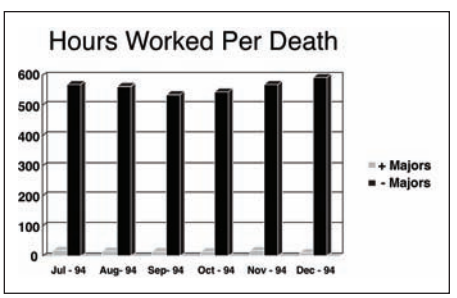

FIGURE 26.3 **The graph above compares the hours worked per patient death when Majors was working compared to when he was absent.**

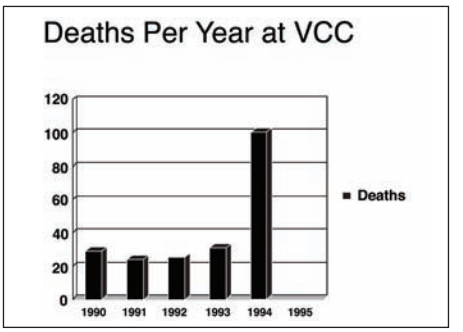

FIGURE 26.4 **The graph above represents the number of deaths per year in the Vermillion County Hospital Intensive care unit. Majors was hired in late 1993 and dismissed in spring of 1995.**

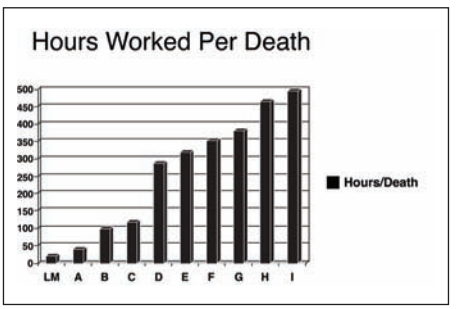

FIGURE 26.5 **The graph above represents the hours worked per patient death for each nurse working in the Vermillion County Hospital intensive care unit. Majors is represented at the far left. The three nurses represented to the right of him frequently worked as part of his team.**

THE COMMON THREADS IN MEDICAL SERIAL KILLERS

The Poisoners

In most reported cases of medical serial killers, the perpetrator is narcissistic. While they occasionally claim to be euthanizing patients, close scrutiny indicates that there is secondary gain in the form of excitement or superiority. Investigators in the Majors case speculated that

he appeared to try to pass himself as a physician, commonly wearing surgical scrubs and no nametag indicating he was an LPN. Donald Harvey characterized his motivation as follows, "I controlled other people's lives, whether they lived or died. I had that power to control. After I didn't get caught for the first 15, I thought it was my right. I appointed myself judge, prosecutor and jury. So I played God."[16]

Another striking characteristic is that the poisoners frequently polarized their coworkers, having a few staunch supporters and an equal number of detractors. Often, they appear to be more knowledgeable than others at their training level and in most cases assume tasks above their capability. They curry favor with their supervisors, providing a shield for their activity and leading to deflection of criticism as jealousy by coworkers. A surprising number are suspected by coworkers. In general, it is the nursing staff that recognizes the problem first. Physicians, nurses, and hospital administrators are often so difficult to convince that more deaths occur after the killer has been identified.

The majority of serial killers in the healthcare system are male. Making up only 7% of all nurses, they account for 33% of the murderers.[17] Surreptitious behavior is often noted by coworkers or family members. Remarkably, killers' bizarre behavior is only noted in retrospect. Equally impressive is how often lethal injections are made with families present yet no one connecting the injection and death.

M. William Phelps, in his account of Kristen Gilbert, *Perfect Poison*, attempts to answer the difficult question of why these people murder: "Adults don't wake up and decide to become serial killers; they are wired at some point—usually during childhood—so that they might later cultivate a malevolence and perpetrate crimes based on what they have been taught."[18]

The Victims

For serial killers to operate in a healthcare setting, selection of victims is important. The very old or very young are often targeted because they are unable to communicate. In some cases, the victims may recognize the perpetrator but are unable to verbalize their fears. Even when they can, their complaints are disregarded as delusions. In the Majors case, a patient told his family that a nurse was trying to kill him and that if the family did not take him from the hospital that evening, he would not survive until morning. The family disregarded his concerns, and the patient was killed during the night.

When deaths are both sudden and unexpected, they should raise concern. This is especially true when multiple deaths have occurred. Several things shelter the serial killer in this setting, but the greatest is the near refusal on the part of healtcare providers to accept that something as heinous as murder could occur. Thus, these deaths are often accepted as natural, particularly in regard to elderly victims. A common defense for healthcare serial killers is that the patients were old and sick so their death was anticipated. Furthermore, the likelihood of an autopsy being ordered on an 80-year-old is low. When faced with an unexpected death, healthcare workers should bear in mind that even elderly patients almost always have a clinical course that declines prior to death. They might consider how many times they have lost patients when death actually was a complete surprise.

The Methods

Potassium chloride has been a relatively popular drug among serial killers because it is readily available and quick acting. Because of postmortem redistribution, the serum concentration rises rapidly after death. Thus, an elevated postmortem potassium concentration is common and of no predictive value in the determination of the premortem level. In recent years, hospitals have made efforts to avoid accidental administration of potassium chloride. Though very seldom reported in medical literature, potassium overdose and death have been a concern in the healthcare setting.[19] When given surreptitiously, it is unlikely to be treated successfully in resuscitation attempts unless electrolytes are measured. Often overlooked is neuromuscular paralysis that occurs as a result of potassium administration.

Neuromuscular paralytic agents are available in the hospital setting and are not controlled substances. They have rapid onset and appear to induce coma. Patients exposed to these agents

can frequently identify their assailants, but they are not always believed. Laboratory detection is possible but not rapidly available in most hospitals. Kerskes et al. described the use of high-performance liquid chromatography-electrospray ionization-mass spectrometry (LC-ESI-MS) for the detection of quaternary nitrogen muscle relaxants such as pancuronium and rocuronium.[20]

Because of its use in homicidal poisoning, the detection of succinylcholine has been the subject of much study. Gao et al. were able to detect succinylcholine to a concentration of 0.25 μg/mL in human plasma, but concentrations may be well below that in postmortem specimens. They applied their method in a patient receiving 1 mg/kg as an IV bolus. The initial plasma concentration of 25.33 μg/mL declined to 0.11 μg/mL in 3 minutes. By 4 minutes, it was undetectable.[21] In postmortem specimens, such attempts at obtaining levels would be of little use.

In 2001, William Sybers, a Florida physician and medical examiner, was found guilty of the first-degree murder of his wife.[22] The conviction was heavily based upon laboratory determination that she had been injected with succinylcholine. A method was described to identify the metabolite, succinylmonocholine, as a marker for the neuromuscular paralytic agent. The metabolite is present for a much longer period and was felt to occur only after exposure to succinylcholine and not as an endogenous compound. In February of 2003, Sybers appealed on the basis that the test for succinylmonocholine was new and not accepted as standard medical practice. His appeal was successful, and a new trial was ordered. He subsequently agreed to a plea bargain and was sentenced to 10 years and a $500,000 fine, though he continued to maintain his innocence. He was released on time served for the original conviction. In November of 2003, LeBeau and Quenzer of the FBI Laboratory in Quantico, Virginia, released results of a small study of succinylmonocholine in patients who had not been injected with succinylcholine prior to death. They were able to identify small concentrations of the compound in autopsy tissue from the six patients they studied. They concluded that, "succinylmonocholine is not an exclusive indicator of exposure to the parent drug, succinylcholine."[23]

While timely supportive care is life saving following lower doses of paralytic agents, little is known about the effects of massive doses. Prolonged paralysis has been reported,[24] but there appears to be other potentially life-threatening effects from paralytic agents such as hyperkalemia, hyperthermia, or cholinergic activity.[25]

Opioids have been widely used to murder. These agents are found throughout hospitals, but they are controlled. Parenteral administration may occur if the drug can be removed and replaced with water or other liquid. Many undocumented reports exist concerning healthcare workers who are discovered diverting opioids when patients complain of pain in the face of repeated or high-dose analgesic administration. Naloxone, if given in adequate doses, will reverse opioid-induced coma. Many healthcare providers are unaware that opiate screens typically only demonstrate the presence of morphine, codeine, or heroin, with 6-acetyl morphine used to distinguish the latter.[26,27] Oxycodone or hydrocodone will occasionally cause positive opiate screens if present in high doses, but synthetic agents such as meperidine, propoxyphene, or fentanyl derivatives will not.

Sedative–hypnotics such as benzodiazepines may be used but seem to be less dependable as lethal agents. Benzodiazepines cause less profound respiratory compromise than opioids or paralytic agents. Veterinary pharmaceuticals may also be used.

Arsenic has long been used in malicious poisonings. Donald Harvey used it to kill patients, and Michael Swango employed it in an attack on coworkers. For serial killers it has the advantage of lacking a recognizable toxidrome. The initial symptoms are similar to gastroenteritis, and the poison can be administered in small doses that have a cumulative and eventually fatal effect. It has the disadvantage of being very detectable, even in exhumations. In living patients, 24-hour urine specimens are the most useful to demonstrate arsenic. Elevated arsenic concentrations may be found in people who have consumed seafood, but speciation of the type of arsenic can help exclude it.[28]

Cyanide was also allegedly used by Donald Harvey and Michael Swango. Many other serial killers have employed it in the past. Humans are capable of metabolizing small amounts of cyanide, but increasing doses cause symptoms such as altered consciousness, tachypnea, tachycardia, and acidosis. Lethal doses rapidly produce

respiratory arrest.[29] There are disadvantages to its use as a lethal agent. It is relatively difficult to obtain. Incorrect usage can injure the perpetrator, and it is thought that some people can detect its odor.[30] Laboratory detection is usually available at reference labs but not in hospitals. A concern about cyanide analysis is that whole blood concentrations, while widely employed, may not be as reliable as red cell or plasma cyanide concentrations. Vesey and Wilson reported significant artifactual cyanide formation because acidification during the test caused cyanide production from thiocyanate.[31] Plasma or red blood cell cyanide analysis is therefore recommended when cyanide poisoning is suspected.[29]

Laboratory Studies

Laboratory studies have a limited but critical role in the detection of healthcare serial killers. They also play an important role in their prosecution. A major deficiency is the inaccuracy of postmortem urine or serum concentrations in predicting premortem concentrations. A number of reports of postmortem redistribution of drugs show that many drugs shift from internal organs into central circulation after death. Postmortem blood collected from large thoracic vessels or the heart may be several times higher in concentration than blood collected from the femoral or other peripheral vessels.[32,33]

Blood chemistries also vary. While some electrolytes such as sodium or chloride decline postmortem, potassium begins to climb within an hour after death.[32-36] This information was derived from comparing postmortem electrolyte concentrations with premortem concentrations obtained a short time before death.

Unfortunately, many of the specimens examined in investigations of suspected serial killings are obtained following exhumation. These materials are generally much less revealing of toxins but have some utility. In a review of their experience and of the previous medical literature, Grellner and Glenewinkel cite 40 pharmacologic agents that have been recovered by postmortem sampling in the interval between death and testing.[37] Neuromuscular paralytic agents are among compounds successfully recovered.[38]

A chillingly consistent finding in hospitals where serial killers have operated is the slow response of administrators and physicians to involve the police. This reluctance appears to be due to both a fear of litigation and potential adverse media coverage; sadly, it costs more lives. Healthcare providers and administrators are neither trained nor appropriate to conduct investigations of suspected homicides. Whistleblowers have been ignored, or worse, punished for raising the question of criminal activity. Anonymous reporting has been a fairly common way of contacting police in these cases.

Hospital mortality committees are required to provide surveillance of deaths that occur. Variations in mortality rates must be explored, not simply excused. The following list describes some of the factors that can indicate a potential problem:

- **Deaths occur around meal times:** As Donald Harvey noted, during meals, half the nursing staff is off the unit. The remaining staff members are busy in other rooms, leaving many patients unattended.
- **Deaths occur in 24-hour cycles (same shift):** This was noted with Kristen Gilbert and Orville Lynn Majors. In addition, vacation times often correspond with a cessation of codes and deaths, as seen with Genene Jones and Majors.[16]
- **Deaths do not follow "glide slope":** Prior to typical natural death, a progressive decline in clinical course often predicts the outcome. This decline can be subtle in the elderly or the critically ill. Patients usually show a clinical decline before terminal events, whereas murdered patients have abrupt arrests.
- **Success rates during codes is poor:** The immediate survival rate of in-hospital codes is 44%, with 17% finally living to leave the hospital. Success rates appear to be lower when a serial killer is at work. In a review of 14,720 cardiac arrests in 207 hospitals, Peberdy et al. found the most common causes were cardiac arrhythmias, acute respiratory insufficiency, and hypotension.[39] Resuscitation teams must assume they are working with the most common causes of cardiac arrest. They seldom have the time to determine and correct the cause of the arrest if an unknown toxin is at work.
- **Evidence exists of uncharted injections:** While this factor is very difficult to find during a routine chart review, it still

deserves notation. In-hospital poisonings are generally administered orally or, more often, intravenously. *Because the perpetrator is usually the person charting, injections of unordered medicines are undocumented.* Discovery of needle marks, witness reports of injections, or questionable discarded medications should be checked against physicians' orders and nursing notes.

- **Medications frequently come from the hospital:** In several cases, the hospital pharmacy or medications on the wards serve as the source for the serial killer's poison. These medications are chosen because they are easily procured and because many of them will not show up on routine drug screens. For example, serum potassium concentration increases shortly after death, making it an unreliable indictor of premortem potassium concentration. Neuromuscular paralytic drugs, another frequent choice of poison, will not be found by a drug screen and require specific testing that is generally beyond the ability of most hospital laboratories.

While state laws prescribe certain circumstances that mandate a coroner's case, an autopsy is not necessarily performed even in those instances. Particularly, deaths of elderly patients are considered "natural" simply because of their age. As in the Majors case, out of 140 deaths, none had a postmortem examination unless they were exhumed as part of the investigation. As Harvey put it, "I could have been apprehended with the first one if they had done the autopsy."[40]

If a patient death is not consistent with the clinical course, an autopsy is imperative. If the autopsy is not consistent with the reported medical condition(s), homicide should be in the differential diagnosis. Physicians have an obligation to report concerns to the coroner or medical examiner.

- **Patient complaints are ignored:** Unfortunately, this is almost always found in retrospect. Remarkably, even the victims are often unaware that they are being abused.
- **Employee suspicions are ignored:** Almost without exception, it is the killer's coworkers who discover the criminal activity. In case after case, physicians and administrators discount reports and denigrate whistle-blowers. More than half of nurses in one study feared there would be repercussions if they reported a medication error.[41]
- **Communication among hospitals is poor:** Probably the most effective approach to this problem is better communication between hospitals and preemployment screening to look for potential problems.

CONCLUSION

Numerous healthcare professionals have been found guilty of murdering their patients. These perpetrators used a variety of poisons to kill their victims. Even though these murderers were unique in how they killed, a number of common characteristics have been noted regarding these cases that should heighten healthcare workers' and administration's concern of potential foul play (Table 26.1).

TABLE 26.1 **Common Factors in Medical Serial Killings**

- Deaths occur around meal times.
- Deaths occur in 24-hour cycles (same shift).
- Deaths do not follow "glide slope."
- Resuscitation rate is low.
- Evidence exists of uncharted injections.
- Medications used in the murder frequently come from the hospital.
- Few autopsies are performed.
- Patient complaints are ignored.
- Employee suspicions are ignored.
- Communication among hospitals is poor.

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