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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----X
ADRIAN SCHOOLCRAFT,

Plaintiff,

Case No:

- against -

10 CV 06005

THE CITY OF NEW YORK, ET AL.,

Defendants.
-----X

220 East 42nd Street
New York, New York

July 7, 2014

10:06 a.m.

DEPOSITION OF VINOD DHAR, M.D., pursuant to
Notice, taken at the above place, date and
time, before DENISE ZIVKU, a Notary Public
within and for the State of New York.

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A P P E A R A N C E S:

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(Continued.)

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JAMAICA HOSPITAL MEDICAL CENTER

220 East 42nd Street

New York, New York 10017

BY: GREGORY RADOMISLI, ESQ.

Also Present:

Roy Lubit, M.D.

Magdalena Bauza

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S T I P U L A T I O N S :

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto, that this examination may be sworn to before any Notary Public.

IT IS FURTHER STIPULATED AND AGREED that the filing and certification of the said examination shall be waived.

IT IS FURTHER STIPULATED AND AGREED that all objections to questions, except as to the form of the question, shall be reserved for the time of trial.

1
2 MR. SMITH: Going on the record,
3 it's 10:06 on July 7, 2014. We are at
4 the offices of Martin Clearwater and
5 Bell, 220 East 42nd Street. Here for
6 the deposition of Jamaica Hospital on
7 the policy issues identified by the
8 court.

9 MR. RADOMISLI: Yes. Just a
10 couple of things. One, pursuant to the
11 federal rules, we reserve the right to
12 review and make corrections to the
13 transcript.

14 Secondly, plaintiff's counsel
15 has brought Dr. Roy Lubit, L-u-b-i-t,
16 with him today. He has represented him
17 as his expert. So there are two
18 things. One, we will object to any
19 other expert being identified insofar
20 as the psychiatric issues, given that
21 Dr. Lubit is here today.

22 Secondly, in light of Judge
23 Sweet's prior ruling that all
24 objections will be reserved for trial,
25 I am not going to bust this deposition

1
2 on the grounds that I believe that Dr.
3 Lubit does not have a right to be here.

4 However, we reserve our right to
5 take the position at trial that this
6 entire deposition transcript is annuled
7 as a result of Dr. Lubit's presence and
8 that it should not be and cannot be
9 used for any purpose, whether it be
10 impeachment or any other reason at the
11 time of trial.

12 MR. SMITH: Okay, and of course,
13 the plaintiff disagrees with the
14 assertions by defense counsel that the
15 doctor is not entitled to be here. I
16 also disagree with the assertion that
17 somehow him being here as an agent of a
18 party somehow precludes some other
19 agent for appearing on some other
20 occasion. I know of no law or basis
21 and reason for such a position.

22 Finally, there is no basis that
23 I can see for reserving some right at
24 an unknown date for some unknown reason
25 to maintain an objection to this

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deposition, which is now going forward.

Would you mind swearing in the witness.

V I N O D D H A R, a Witness herein, having been first duly sworn by a Notary Public within and for the State of New York, was examined and testified as follows:

EXAMINATION BY

MR. SMITH:

Q. Will you state your name and address for the record, please.

A. My first name is V-i-n-o-d, V as "Victor" last name is Dhar, D as "David" h-a-r, address is Jamaica Hospital, 8900 Van Wyck Expressway, Jamaica.

MR. SMITH: Counsel, as we've done in the past with some of the other witnesses, I understand the witness has provided his business address. That's fine with me. I don't want to pry into any kind of personal residence issues, but I would only need the residence

1 VINOD DHAR, M.D.

2 information if at the time of trial or
3 some other hearing, I would need to
4 serve process on the doctor.

5 Given that, would you agree to
6 accept service of any papers that I
7 need to serve on the doctor for him to
8 appear as the 30(b)(6) witness in any
9 future proceedings.

10 MR. RADOMISLI: If he's still an
11 employee of Jamaica Hospital at the
12 time, we would accept service, but
13 otherwise we would not. If you just
14 want to ask him his address, you might
15 be better off.

16 Q. All right, would you mind
17 providing us with your address, Doctor?

18 A. My home address is 60, 6-0
19 Juniper Lane, Syosset, New York.

20 Q. Where are you currently working?

21 A. I work at Jamaica Medical
22 Hospital.

23 Q. What's your title?

24 A. I am currently the associate
25 chairman of the department of psychiatry.

1 VINOD DHAR, M.D.

2 Q. How long have you had that
3 position?

4 A. I have had that position for
5 five -- almost nine years. Actually at
6 Jamaica Hospital it would be seven years.

7 Q. Have you had any other positions
8 while working at Jamaica Hospital?

9 A. Yes. I started as an attending.
10 Then the unit chief, and I went to Flushing
11 Hospital. That's where I got my promotion
12 to associate chairman.

13 Q. What's the relationship between
14 Flushing Hospital and Jamaica Hospital?

15 MR. RADOMISLI: Objection to
16 form. You can answer.

17 A. In 1999 Jamaica Hospital took
18 over Flushing Hospital and came under the
19 umbrella Medisys Network. So it was part of
20 the consortium in the same department.

21 Q. When did you start working at
22 Jamaica as an attending?

23 A. That was 1996.

24 Q. And?

25 A. To 1999 and then from 1999 to

1 VINOD DHAR, M.D.

2 2007, I was at Flushing.

3 Q. When you were attending, were
4 you an attending in the psychiatric ward?

5 A. I was inpatient psychiatric
6 unit.

7 Q. Is that the same thing as being
8 in a ward?

9 A. Yeah.

10 Q. You also mentioned that you were
11 unit chief, what was that?

12 A. Well, unit chief is responsible
13 for the both administrative and clinical
14 aspects of the inpatient unit, one unit.

15 Q. What was your title at Flushing
16 Hospital?

17 A. It started with the unit chief
18 and as we progressed in Flushing, then I
19 became the assistant director of inpatient
20 services and then the associate chairman of
21 the entire department.

22 Q. Prior to joining Jamaica
23 Hospital in 1999, did you have any other
24 work?

25 A. Yes. I was in Dayton, Dayton

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VINOD DHAR, M.D.

Mental Health Center from 1990 to 1995, '96.

Q. What did you do in Dayton?

A. I was an attending there.

Q. Where is Dayton?

A. Dayton, Ohio.

Q. What did you do from 1996 -- so '96 you went to Jamaica?

A. Jamaica.

Q. Before Dayton what did you do?

A. I did my training at New York Medical College, Valhalla.

Q. What do you mean by saying you did your training there?

A. I did residency training in psychiatry, general psychiatry.

Q. How long was that?

A. That was three years. Then I did two years of a fellowship in child psychiatry.

Q. Where?

A. Same place, New York -- Westchester Medical Center.

Q. Prior to being at New York Medical College as a resident, what did you

1 VINOD DHAR, M.D.

2 do?

3 A. I was in India. I came here
4 after I did medical schooling in India.

5 Q. So you went to medical school in
6 India?

7 A. Yes.

8 Q. Which one?

9 A. It's called Medical College,
10 Government Medical in Kashmir. State of
11 Kashmir.

12 Q. What were the years of your
13 training at New York Medical College?

14 A. That would be from 1981 to '86.

15 Q. And from '86 to 90, what did you
16 do?

17 A. I worked as an attending at
18 State Hospital, Harlem Valley Psychiatric
19 Center.

20 Q. Where is that?

21 A. It's Wingdale, Upstate,
22 New York.

23 Q. Have you had any other forms of
24 employment, other than at State Hospital,
25 Dayton and Jamaica Hospital?

1 VINOD DHAR, M.D.

2 A. No.

3 MR. RADOMISLI: And Flushing.

4 Q. Right and Flushing. I meant to
5 include Flushing in that since they merged
6 with Jamaica, right?

7 A. Yes.

8 Q. So I will just restate that
9 question just to make it clear.

10 Other than being at State
11 Hospital, Dayton, Flushing and Jamaica
12 Hospital, you had no other employment as a
13 psychiatrist?

14 A. No.

15 Q. Have you had any private
16 practice as a psychiatrist?

17 A. I have -- I am currently in
18 private. It is a part-time small practice,
19 been there since '92 or '93, not sure.

20 Q. Where is that practice?

21 A. That's in Forest Hills, Forest
22 Hills.

23 Q. How much of your working time do
24 you spend at private practice, as opposed to
25 working at Jamaica?

1 VINOD DHAR, M.D.

2 A. I spend -- I have 40 hours of
3 work at Jamaica and I spend 15 to 20 hours
4 at the most private practice.

5 Q. So it's about a third of your
6 working time is the private practice; is
7 that fair to say?

8 A. Yes.

9 Q. Is it fair to say you have
10 experience making decisions about
11 involuntarily committing patients based on
12 your work experience with State, Dayton,
13 Flushing and Jamaica?

14 A. Yes. But mainly at Jamaica.

15 Q. Can you give me an approximation
16 of the number of patients that you've made a
17 decision to involuntarily commit to a
18 psychiatric institution?

19 MR. RADOMISLI: Objection. This
20 witness is a 30(b)(6) witness and so he
21 could talk about the policy of the
22 hospital. Anything he does personally
23 I am going to object.

24 MR. SMITH: Are you instructing
25 him not to answer that question?

1 VINOD DHAR, M.D.

2 MR. RADOMISLI: Yes.

3 MR. SMITH: It's sort of just
4 getting his background about the issues
5 that he's going to be providing
6 information about. You wouldn't object
7 if I asked if he was a doctor. So I'm
8 not so sure getting some more pedigree
9 information about experience and
10 background is really inappropriate
11 instruction.

12 MR. RADOMISLI: I think it is.

13 Q. Well, is it fair to say that you
14 have extensive experience in involuntarily
15 committing patients?

16 A. Yes. I have experience because
17 I oversee the department.

18 Q. Did State Hospital have an
19 involuntary policy?

20 A. Yes, but State Hospital is
21 different and I am not familiar -- I wasn't
22 involved. I was just treating the patients.
23 I don't know how the patients came there or
24 what status.

25 Q. Well, as an attending at State

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VINOD DHAR, M.D.

Hospital, did you make decisions to involuntarily commit patients to the psychiatric ward?

MR. RADOMISLI: Same objection.

A. No.

Q. I'm sorry?

MR. RADOMISLI: I said same objection, but he already answered the question.

Q. The answer was no?

A. Objection.

MR. SMITH: Was there an answer?
(Record read.)

MR. CALLAN: Could you read back the question and answer, please.

(Record read.)

Q. As the assistant chair in the department of psychiatric -- the department of psychiatry at Jamaica Hospital, what are your duties?

A. My duties include to see -- to oversee of the day-to-day running of the department, both clinical and administrative.

1 VINOD DHAR, M.D.

2 Q. What are the day-to-day clinical
3 duties?

4 A. That means finding out the
5 patients that are in the ER inpatient, any
6 problematic patients, any second opinions on
7 any difficult patients and to attend the
8 administrative meetings.

9 Q. So is it fair to say that in the
10 clinical part of your responsibilities at
11 Jamaica are to act as a supervisor for the
12 other psychiatrists that are working in the
13 emergency room and in the inpatient ward at
14 Jamaica Hospital?

15 MR. RADOMISLI: Objection to
16 form and on the grounds that it's a
17 legal conclusion.

18 A. Yes.

19 Q. Is the answer yes?

20 A. Yes.

21 Q. What did you do to prepare for
22 today's deposition?

23 A. I don't think I did anything
24 about preparing for the deposition.

25 Q. Did you review any documents?

1 VINOD DHAR, M.D.

2 A. I reviewed the regular policies.

3 Q. Can you describe for me what
4 you're referring to?

5 A. The hospital policy.

6 Q. Which one?

7 A. The CPEP policy, actually.

8 Q. What's the CPEP policy?

9 A. CPEP is Comprehensive
10 Psychiatric Emergency Program and the
11 emergency room is part of the CPEP.

12 Q. Did you review anything else?

13 A. No.

14 MR. RADOMISLI: You reviewed
15 other policies, correct?

16 THE WITNESS: Other policies,
17 yes.

18 Q. Tell me what policies you
19 reviewed?

20 A. I reviewed the policy about our
21 emergency admissions and voluntary
22 admissions.

23 Q. Anything else?

24 A. Not that I can recall.

25 Q. Did you speak to anybody, other

1 VINOD DHAR, M.D.

2 than your attorney, about your appearance
3 here today?

4 A. My department chair knows about
5 that I'm here today.

6 Q. Who is that?

7 A. That's Dr. Vivek.

8 Q. Other than informing your
9 chairman that you were going, did you
10 discuss anything about your testimony with
11 Dr. Vivek?

12 A. I just informed him that I am
13 going there and he just told me to stay calm
14 and answer what you know.

15 Q. And did you speak with anybody
16 else about your deposition?

17 A. No.

18 Q. Have you ever spoken with a Dr.
19 Isakov about this case?

20 A. No.

21 Q. Have you ever spoken with Dr.
22 Bernier about this case?

23 A. No.

24 Q. Have you ever spoken with
25 anybody, to your recollection, about Adrian

1 VINOD DHAR, M.D.

2 Schoolcraft?

3 A. Actually, no, I haven't spoken
4 about this case anytime. No, I wasn't
5 involved with this case, no.

6 Q. So I take it that you've never
7 looked at the patient's chart in this case?

8 A. That's correct. I never looked.

9 Q. And you never had any
10 discussions with anybody about the contents
11 of the chart?

12 A. No.

13 Q. That's correct, you never had
14 any discussions with anybody about --

15 A. I never had any discussion, no.

16 Q. One of the ground rules of the
17 depositions, I will just cover it now, is
18 it's important that you let me ask my whole
19 long meandering question, so that the court
20 reporter can take it down, give your lawyer
21 a chance to interject and then you get to
22 answer.

23 A. I'm sorry.

24 Q. No, it's okay, but if you
25 anticipate which is common, what I am asking

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VINOD DHAR, M.D.

you and you answer it, she has to stop taking down what I'm saying and break the transcript up and say what you're saying, so just take your time.

A. Sure.

Q. We're not in a hurry.

A. One thing that my chairman told me is just relax.

Q. Well, I won't tell him.

A. Okay.

Q. The other really important instruction is that since you're under oath, it's important that you understand the question, so if I ask you a question and you're not sure about what I am asking you, please let me know; okay?

A. Sure.

Q. Let show you what's been marked as Exhibit 30 or Exhibit 130. I have copies for everybody. This is a multipage document containing several Jamaica policy statements that were provided in discovery in this case.

A. Yeah.

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VINOD DHAR, M.D.

Q. Are you -- I'm going to ask you a lot of questions about these documents, but before we get into each individual policy, you mentioned that you had looked at a CPEP policy. Is that in this collection?

A. No. This is exclusively for the emergency room.

Q. Which is exclusively for the emergency room?

A. This policy.

MR. RADOMISLI: Well, in 2009 did they have the CPEP?

THE WITNESS: No.

MR. SMITH: Okay. So I'm not sure, Greg, that the documents that the witness has testified that he looked at has been produced?

MR. RADOMISLI: I'm sure it hasn't and I didn't know he looked at it frankly, because as we just established, there was no CPEP in 2009.

MR. SMITH: Well, you established it. I didn't establish it.

MR. RADOMISLI: You can --

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VINOD DHAR, M.D.

MR. SMITH: In any event, I understand and I'm not disputing that fact with you, but just as a matter of form, I would like to know what the witness has reviewed in preparing for the deposition. I am going to make a request for a copy of the CPEP policy.

MR. RADOMISLI: CPEP.

MR. SMITH: Whatever it is. Have it produced.

MR. RADOMISLI: Taken under advisement. Please follow-up in writing.

Q. You don't have a copy of that policy with you, do you?

A. No, I didn't bring it with me, no.

Q. Did you review, in preparing for your deposition any of the policy statements that are contained within Exhibit 130?

A. Well, actually this is part of the CPEP. This is one of the components of the CPEP. It's not going to be different from the policy of the CPEP. The CPEP has

1 VINOD DHAR, M.D.

2 three components and this is one of the
3 components of the CPEP.

4 MR. RADOMISLI: Did you review
5 anything, other than the documents that
6 are in front of you today?

7 THE WITNESS: Yes. A different
8 policy, but that doesn't -- called
9 from CPEP, Comprehensive thing about
10 the program, CPEP.

11 Q. You see the first page of this
12 document?

13 A. Yeah.

14 Q. It's entitled Department of
15 Psychiatry Emergency Room Services. See
16 that?

17 A. Yeah.

18 Q. This page, did you review this
19 page in preparing for your deposition?

20 A. I mean, I didn't look at it for
21 preparing for the deposition, but I have
22 read it. I know about it.

23 Q. When was the last time you read
24 this page of this exhibit?

25 A. I wouldn't recall the last time

1 VINOD DHAR, M.D.

2 I read it.

3 Q. You see on the bottom there's
4 some notations about review and revise?

5 A. Hmm-mm.

6 Q. And then there's some dates?

7 A. Yes.

8 Q. Do you see that?

9 A. Yes.

10 Q. Do you have any knowledge about
11 what those dates are?

12 A. Well, when our policy is created
13 every year they're supposed to review and
14 update. So this is what it means, it was
15 reviewed and revised.

16 Q. Do you know who did the
17 reviewing and the revising?

18 A. It is generally done by the
19 administrative staff, administrator and the
20 chairman.

21 Q. And in October and
22 November 2009, who was the administrative
23 staff person involved from in the creation
24 of this policy?

25 MR. LEE: Objection to the form.

1 VINOD DHAR, M.D.

2 A. I don't know. He is not there
3 now. I think his name was Mr. Mule.

4 Q. Can you spell that for me?

5 A. M-u-l-e.

6 Q. Who was the chair?

7 A. No, he -- the chair was Vivek,
8 Dr. Vivek.

9 Q. Did you personally have any roll
10 in the review and revising of department of
11 psychiatric, psychiatry admission
12 procedures?

13 A. Yes, review.

14 Q. Were you part of a committee
15 that would regularly review this or was it
16 on an ad hoc basis that you would review the
17 procedure?

18 A. On ad hoc basis.

19 Q. See the second page of this
20 exhibit?

21 A. Yes.

22 Q. There is another policy
23 statement called involuntary legal status?

24 A. Yeah.

25 Q. Can you tell me what that

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VINOD DHAR, M.D.

statement is about?

A. Can I review it for a second?

Q. Yeah, sure.

A. This is 927. That means any involuntary patient -- a patient who needs to be admitted to the hospital, psychiatric hospital on an involuntary basis can be admitted by what's called a two physician certification.

Q. And that's what this policy provides for?

A. Yes.

Q. How many ways can a patient be involuntary committed to the psychiatric emergency room or the psychiatric ward at Jamaica Hospital?

MR. RADOMISLI: Objection to the form.

A. There are essentially only one way -- two ways. One is 939, and under that article you can admit a patient who is potentially dangerous to self or others to a psychiatric emergency room.

Q. What's the other way?

1 VINOD DHAR, M.D.

2 A. Other way is the patient can be
3 admitted on 2PC.

4 Q. And that's this 927?

5 A. 927, yeah.

6 Q. How is 939 and 927, how are they
7 different?

8 A. 939 is when a patient comes
9 directly into the emergency room and he is
10 brought by -- there is a number of agencies
11 that can bring the patient there. 927 is
12 when a patient is transferred from other
13 hospital on an involuntary basis.

14 Q. Is 939 what's known as an
15 emergency involuntary commitment?

16 A. Yes.

17 MR. RADOMISLI: Objection to
18 form.

19 Q. What are the types of agencies
20 that bring in an individual under 939?

21 A. I think there is a police
22 officer, director of community services,
23 physicians, psychiatrists, and family member
24 can apply or someone who is interested can
25 apply for patient put in application for

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VINOD DHAR, M.D.

patient involuntary admission and through
the court system.

MR. RADOMISLI: He asked you
about 939 only.

THE WITNESS: Yeah.

Q. In order for a patient to be
involuntary committed under 939, what
medical or psychiatric conclusions need to
be made?

MR. RADOMISLI: I've given you a
little bit leeway, but you're going
beyond the scope. If you're just
asking in general, you want to say
pursuant to the Jamaica Hospital
policy.

MR. SMITH: Okay. All right,
that's fine. I will restate the
question.

MR. RADOMISLI: Then he can look
at the policy if you want.

MR. SMITH: Well -- I don't want
him to just read back what the words on
the paper are. I want to know how the
policy is actually applied and

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VINOD DHAR, M.D.

effectuated. If it was just to read the piece of paper we wouldn't need a witness. I could just read it in my office.

MR. RADOMISLI: No. No. I understand that. You can go through the policy and ask him what it all means. That's fine, but it's just the general.

MR. SMITH: All right, okay. So then I will rephrase the question the way your counsel has requested that I do so.

Q. Under Jamaica Hospital's policy, what medical or psychiatric conclusions are required in order to involuntarily commit a patient to the hospital, either in the psychiatric emergency room or in an inpatient service area or a ward?

MR. RADOMISLI: Under 939?

MR. SMITH: Under 939.

A. Patient has to be --

MR. SMITH: The record should reflect that counsel has just shown the

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VINOD DHAR, M.D.

witness the emergency admission policy
of the hospital.

MR. RADOMISLI: Which is part of
Exhibit 130.

MR. SMITH: Right, I know, but
it's slightly suggestive of you to be
showing him documents when I'm asking
him questions.

MR. RADOMISLI: I don't think
it's suggestive.

MR. LEE: Wasn't the question
about the policy?

MR. SMITH: You too now want to
join in on this?

Q. Can you just answer my question,
please?

A. A patient has to be a danger to
self or someone else. That dangerousness or
patient has to be not capable of taking care
of himself for medical or his health or his
living arrangement.

Q. And how do the staff at the
hospital make this determination about
dangerousness?

1 VINOD DHAR, M.D.

2 A. It's based on what the -- when
3 the patient comes to the hospital, the
4 report, accompanying person. And then it is
5 evaluation by the psychiatrist.

6 Q. Is there any methodology or a
7 checklist or some other factors that are
8 regularly looked at in effectuating the
9 Jamaica Hospital policy?

10 A. Yeah. I mean, there is about
11 policy regarding psychiatric evaluation, how
12 that is to be done, what is to be noted in
13 that evaluation, and based on that
14 evaluation you're to come up to a diagnosis
15 and then based on the diagnosis, you then
16 make a decision.

17 Q. Are some of the factors that you
18 just identified -- let me rephrase that
19 question.

20 The factors that you just
21 identified for the psychiatric evaluation,
22 are those factors that are examined for
23 purposes of determining whether or not a
24 person has a mental illness or are they
25 looked at for purposes of determining

1 VINOD DHAR, M.D.

2 whether or not that person is a danger to
3 themselves or to others or is it just a
4 combination of things?

5 A. Combination.

6 Q. So can you tell me what are the
7 factors under the Jamaica Hospital policy
8 that are looked at in order to determine
9 whether or not a patient is dangerous to
10 himself or herself or others?

11 A. Patients -- when patients are
12 brought in by any agency, and based on their
13 reports and what are the reasons why the
14 patient was coming in, brought to the
15 hospital and that would be the sort of the
16 starting point.

17 Q. So that's the beginning of the
18 information that's required to find out what
19 the relator or the provider of the
20 information says, right?

21 A. Yes.

22 Q. Can you tell me what other
23 factors are looked at in making this
24 assessment?

25 A. Well, there is you do the

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comprehensive psychiatric evaluation to see whether the patient has any history of mental illness. On dangerousness you have to see what are the circumstances under which the patient was brought to the hospital and were there any specific threats made or what was mentioned.

Q. I'm sorry, any specific what?

A. Threats.

Q. Anything else?

A. Well, we're also going to the background, history, if we have any information resources at that time to get the person's history.

Q. Are there any standard guides that are employed or used by Jamaica Hospital in making this assessment of dangerousness?

MR. RADOMISLI: Can you read that back.

(Record read.)

A. Yes.

MR. RADOMISLI: Just a second.

MR. LEE: Can we agree that all

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of your questions are as these policies existed in 2009, not as they currently exist since? The question was of a present tense question?

MR. SMITH: Was. They've all been like that.

MR. LEE: Obviously, what was the standard, if any, applied in 2009.

MR. SMITH: Well, once I figure out what the standard is, then I can ask.

MR. LEE: It may be different now.

MR. SMITH: Yeah, no, I know.

MR. RADOMISLI: Well, I've been interpreting it as 2009.

Q. Can you just answer my question?

MR. SMITH: I think your suggestion is a good one, Brian, so I will try and get to the bottom of the issue right now.

Q. Can you answer my question?

A. Can you repeat the question?

(Record read.)

1 VINOD DHAR, M.D.

2 MR. RADOMISLI: As part of the
3 policy in 2009.

4 MR. SMITH: Yes, okay fine.

5 MR. RADOMISLI: Objection to
6 form.

7 A. We have the policy in place
8 now --

9 MR. RADOMISLI: Not now. 2009.

10 A. 2009 I'm not sure. I'm -- I
11 don't recall of any checklist or any other
12 way of examining, other than based on the
13 history.

14 Q. The history is this
15 comprehensive psychiatric evaluation?

16 A. Yes.

17 Q. How long does that typically
18 last?

19 A. It lasts -- it can last anytime
20 anywhere from an hour or you may have to
21 redo the evaluation from time to time.

22 Q. So it can take an hour or more?

23 A. Yes.

24 Q. What is or what are the
25 guidelines or the factors that Jamaica

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Hospital looks at today in making this dangerousness assessment?

MR. RADOMISLI: I'm going to object and direct the witness not to answer.

MR. SMITH: Well, the only way for me to get this is to find out whether or not if he doesn't have a specific recollection of what the status was of a policy in 2009 I need to be able to find out what he knows about what the policy is today which he clearly is capable of providing me and then find out whether or not he has any reason to think that it's changed since 2009.

MR. RADOMISLI: Well, how could he know if it's changed or not if he doesn't recall what the policy is in 2009?

MR. SMITH: Well, the question as formed it's impossible, nobody has a photograph memory about what was going on in a particular place when you got a

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moving entity. So it's just -- if you want to interfere with the examination in this way, then you can go ahead and do so and we will just have to bring the doctor back.

MR. RADOMISLI: I don't want to interfere. I want to assert a legitimate objection and I believe him to testify about the policy today when the treatment was in 2009 is a legitimate basis for me to object and direct him not to answer the question.

MR. SMITH: Well, it's not a proper basis for direction not to answer the question. Since the judge is away on vacation, you're just taking advantage of that fact and we are just going to have the witness come back and come back to my office and I will make the application if you're going to stand by that instruction.

MR. RADOMISLI: How is what the policy is today relevant to what's pertinent in 2009?

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2 MR. SMITH: I want to be able to
3 find out what the policy is today, so I
4 could find out whether or not he has
5 knowledge about whether or not it's
6 changed in the last five years.

7 MR. RADOMISLI: Okay. So why
8 don't you ask him if he knows whether
9 or not it's changed before --

10 MR. SMITH: First, I need to
11 establish what it is. This is really
12 getting absurd. This is getting
13 absurd. You want to play games with
14 me --

15 MR. RADOMISLI: No, I don't want
16 to play --

17 MR. SMITH: Then we'll just cut
18 it out and I will just make the
19 application now.

20 MR. RADOMISLI: I don't want to
21 play games at all. I want to be able
22 to --

23 MR. SMITH: Well, you're playing
24 games --

25 MR. RADOMISLI: -- I don't --

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MR. SMITH: The witness can't tell me what the actual policy was five years ago, but the witness can certainly tell me generally what the policy has been over the past few years and whether or not it's changed. Okay.

MR. RADOMISLI: Ask him if he knows whether or not it's changed. Regardless what the policy is, you can ask him do you know --

Q. To your knowledge, sir, since you joined or started working at Jamaica Hospital, has its policy about assessing the dangerousness of a patient changed?

A. My knowledge it has.

Q. How has it changed?

MR. LEE: Just note my objection.

MR. SMITH: Great.

MR. RADOMISLI: Between 2007 and 2009?

MR. SMITH: No.

Q. How has it changed in the history of your career at Jamaica, how has

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the assessment of the dangerousness changed?

MR. RADOMISLI: I dont' believe he's permitted to answer or required to answer questions about things that occurred after 2009, including the policy.

MR. SMITH: So you're going to direct him not to answer the question.

MR. RADOMISLI: In that form. If you want to limit to anything that occurred while he was there --

MR. SMITH: You just told me because your co-counsel suggested it to him that he doesn't have any recollection about what the policy was in 2009, okay. So now I've asked the question broadly and you're objecting to that. So if you want to continue to interfere with my examination I'm going to stop and I'll call the judge and I will tell him what's going on and we will decide and we'll be here all day long with this nonsense.

MR. RADOMISLI: If you want to

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2 call the judge and get a ruling now,
3 that's fine with me.

4 MR. LEE: Let me just say I
5 didn't suggest anything, other than --

6 MR. SMITH: Yes, you did. You
7 did. You started this problem, Brian.

8 MR. LEE: This is what the
9 deposition is about. It's about the
10 policy --

11 MR. SMITH: It's about you
12 getting in the way of my finding out
13 basic information policy. That's what
14 it's about.

15 MR. LEE: I respectfully
16 disagree with that.

17 MR. RADOMISLI: If you're going
18 to call the court, please do in our
19 presence.

20 MR. SMITH: We are going off the
21 record.

22 (Discussion off the record.)

23 MR. SMITH: Going back on the
24 record. It's 11:21.

25 While we were off the record for

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1 about looks like 20, 25 minutes I
2 called the court at 10:54, I spoke with
3 Judge Sweet's law clerk, Adam Chen. We
4 had a -- I think it was an on the
5 record discussion or an off the record
6 discussion about instructions not to
7 answer certain questions and Mr. Chen
8 said that since Judge Sweet is away, he
9 didn't know whether or not he was going
10 to be able to get back to us with a
11 ruling and we've waited or I've waited
12 approximately 25 minutes and there has
13 been no indication from the court that
14 we will get a ruling. So I am going to
15 proceed with my examination and note
16 that I object to the needless
17 interference with the order and
18 methodology with which I wanted to take
19 this witness' deposition.
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21 Q. Can you turn, sir, to
22 Exhibit 130. You have that still in front
23 of you?

24 A. Yeah.

25 Q. Do you have an emergency

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admission status policy, which is the fourth, fifth and the sixth page of the exhibit?

A. The page number?

Q. It's page number -- start on page 17 and it goes through 19.

A. Okay.

Q. Yes.

MR. RADOMISLI: Starting at 17.

Q. Starting with 17, please.

A. Okay, sure.

Q. Are you familiar with this policy statement?

A. Yes, I'm familiar.

Q. When was the last time, other than just now, that you've read this statement?

A. This I read recently when I reviewed the policy on CPEP.

Q. So this was one of the policy statements that was part of the statements that you reviewed?

A. CPEP.

Q. Did you have any role in the

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2 creation of this document, this three-page
3 document, which is pages 17, 18 and 19?

4 A. No.

5 Q. Who created this document?

6 A. This is created by the
7 administration -- administrator and the
8 chairman.

9 Q. Who are those people?

10 A. Same people, Mr. Mule and Dr.
11 Vivek.

12 Q. The administrator. Is this what
13 we refer to as the 939 admission or
14 involuntary admission?

15 A. That's correct.

16 Q. In the second paragraph under
17 heading policy it says that the patient's
18 alleged to have a mental illness. Do you
19 see that reference there to a mental
20 illness?

21 A. Yeah.

22 Q. Am I correct that one of things
23 that's required in order to admit somebody
24 involuntary is a medical or psychiatric
25 determination that an individual has a

1 VINOD DHAR, M.D.

2 mental illness?

3 MR. RADOMISLI: Objection.

4 MR. CALLAN: Object to the form
5 of the question.

6 Q. Is that correct? You could
7 answer.

8 A. Yes.

9 Q. And am I correct that the
10 comprehensive psychiatric evaluation is the
11 means whereby a determination of this mental
12 illness issue is made?

13 A. Yes.

14 Q. You said the comprehensive
15 psychiatric evaluation, it takes an hour or
16 more? Right, remember saying that?

17 A. Yes.

18 MR. CALLAN: Objection to the
19 form. Are you talking about -- I just
20 want to know the timeframe you're
21 talking about. Are you talking about
22 currently or in general or --

23 MR. SMITH: I'm talking about in
24 general.

25 MR. CALLAN: This is in general?

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MR. SMITH: Yes, this is in general.

MR. CALLAN: I object to the form of the question and I also object on the grounds that it's not relevant as to what the current policy is.

MR. LEE: I join.

MR. RADOMISLI: Me too.

Q. You said that the comprehensive psychiatric evaluation takes an hour or more, right?

A. Yes.

Q. Is the hour or more, is that the assessment that's done by the professional of the patient?

A. By the psychiatrist.

Q. So the psychiatrist spends at least an hour with the patient; is that correct?

A. Yes.

Q. Does the psychiatrist spend time speaking with anybody else?

A. The psychiatrist has to spend time with the person who brings the patient

1 VINOD DHAR, M.D.

2 in, the staff that saw the patient, the
3 family members or any other source of
4 information that he can get information
5 from.

6 Q. Does the hospital policy provide
7 for the training for staff to conduct this
8 kind of assessment?

9 A. Yes.

10 Q. How?

11 A. Well, if you're a -- you've done
12 a residency in psychiatry that makes you --
13 that qualifies you to do a psychiatric
14 examination. Then there are from time to
15 time in-services and updates in the
16 psychiatry examination.

17 Q. How long does it take the
18 resident to become qualified to do this
19 evaluation?

20 MR. RADOMISLI: I am going to
21 object. It's beyond the scope. Don't
22 answer.

23 MR. SMITH: Don't answer the
24 question?

25 MR. RADOMISLI: It's beyond the

1 VINOD DHAR, M.D.

2 scope of the deposition.

3 MR. SMITH: So that's a
4 relevancy objection.

5 MR. RADOMISLI: There is a court
6 order limiting this examination to the
7 policy and procedure at Jamaica
8 Hospital regarding involuntary
9 hospitalization. That question does
10 not go to it.

11 MR. SMITH: It doesn't? What
12 does it go --

13 MR. RADOMISLI: Training.

14 MR. SMITH: It goes to how the
15 policy is effectuated at the hospital.
16 So I mean like I said before --

17 MR. RADOMISLI: It doesn't.

18 MR. SMITH: So how the hospital
19 or whether or not the hospital provides
20 any means for its personnel to figure
21 out whether or not somebody has a
22 mental illness isn't relevant to the
23 policy of hospital?

24 MR. RADOMISLI: I thought you
25 already asked that question.

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MR. SMITH: I'm trying to find out what the hospital does to find out whether or not the people who are making this assessment about mental illness have any qualifications to do so. You don't think that goes to their policy? Or maybe their policy is to have people who have no medical training at all to make these assessments. You want to tell me whether or not that's an appropriate question?

Q. Doctor tell me this, do the people who make the assessments under Jamaica Hospital policy have any training or any qualifications for making the decisions they make?

MR. RADOMISLI: Asked and answered.

Q. You can answer it again. Do they have any training, do they have any experience, what experience do they have if they have any?

MR. CALLAN: Objection.

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MR. LEE: Objection.

MR. RADOMISLI: Objection.

That's beyond the scope and to the form.

MR. SMITH: You're telling him not to answer that question?

MR. RADOMISLI: It's an improper question based on the court order limiting this deposition.

MR. SMITH: This is beyond the -- you are doing whatever you can to interfere with my ability to ask basic questions --

MR. RADOMISLI: I am just asking you to comply with the court --

MR. SMITH: No, you're not. This is ridiculous. I can read the policy statement. What you're basically telling me is if I don't ask you what it says in black and white on the page he doesn't have to answer the question. I don't know how you're interpreting this court order and you haven't explained to me how.

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MR. RADOMISLI: I'll tell you. You could do what you did before, which is ask him to explain all the terms which are on the policy.

MR. SMITH: All right, well, the witness is going to have to come back and I'm not going to do this at your office any more.

MR. RADOMISLI: Do you think things would be going differently if we were at your office?

MR. SMITH: No, I am just not going to accomodate you in the way that you've requested that I accomodate you in the past, because I've come up here, brought my assistants and --

MR. RADOMISLI: Entourage --

MR. SMITH: -- And my files with me and this is what I get. So the cooperation that I've extended to you in the past is not going to come -- the witness will have to come and come back to my office.

MR. RADOMISLI: We will see.

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2 MR. SMITH: Right. We will see.

3 Q. So how does Jamaica make sure
4 that its policy about determining about
5 whether or not somebody has a mental illness
6 is complied with?

7 A. By psychiatric evaluation.

8 Q. How does Jamaica determine that
9 the people doing the evaluation have any
10 qualifications to do that?

11 MR. RADOMISLI: Objection.

12 Beyond the scope.

13 Q. You want to answer my question?

14 MR. RADOMISLI: No. I'm
15 objecting. I'm directing him not to
16 answer. It's beyond the scope of the
17 deposition given the court order.

18 Q. What is the mental illness
19 within the meaning of this policy statement?

20 A. Mental illness is any sort of
21 illness that meets the criteria of the
22 DSM-IV.

23 Q. What are those?

24 A. Well, there are different kinds
25 of mental illnesses.

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Q. Tell me all of them.

MR. RADOMISLI: All of them?

Q. Yeah, I want to know what the mental illnesses that fall within the scope of this policy scope are?

MR. RADOMISLI: If -- you can't ask him to go through and recite the DSM-IV, but you can certainly --

MR. SMITH: Excuse me, your function here is to object. If you want to interfere, you can tell him not to answer that question, but your speeches are inappropriate. Okay. So cut it out. I'm done with the interference. Completely done. You can instruct him not to answer the question. You can object to the form or you can leave. Those are your choices. Which is it going to be?

MR. RADOMISLI: Well, I'm not going to limit myself to those options. But for this particular question, I will object to the form.

Q. You want to answer the question,

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please? What are the mental illnesses that fall within the scope of this term that fall within this term that's in your policy statement?

MR. RADOMISLI: Objection to the form.

THE WITNESS: I can answer?

MR. RADOMISLI: Yes.

A. Okay. Mental illness is any person, who because of mental illness, mental illness means a number of diseases, number of problems. It could be from schizophrenia, psychosis to depression, to traumatic brain injury and that results in symptoms causing harm to self or others.

Q. Any other conditions that fall within the definition of mental illness within the policy statement?

MR. RADOMISLI: Objection to form, asked and answered. You can answer.

A. There are a number of diseases under the DSM-IV, but this criteria is specific for any condition that could lead

1 VINOD DHAR, M.D.
2 to a person being harmed self and others.
3 It could be from panic attack, it could be
4 from acute anxiety, it could be from brief
5 psychotic episode. So there are a number
6 illnesses which don't necessarily meet this
7 criteria.

8 Q. Can you explain that answer? I
9 don't understand that.

10 A. The patient is suffering from --
11 let me rephrase it. Patient comes with a
12 behavior, certain behavior, we have to
13 determine whether that patient -- whether
14 the behavior is because of mental illness.
15 We have to do an examination to figure out
16 what kind of mental illness this patient is
17 suffering from. But before we come to that,
18 we have to keep the patient in the emergency
19 room to figure out what's going on.

20 Q. In the second paragraph of this
21 policy statement there is a phrase that
22 reads: Patient's alleged to have a mental
23 illness for which immediate observation,
24 care and treatment in the hospital is
25 appropriate. That's the first part of that

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2 policy statement. You see that?

3 A. Yes.

4 Q. Do I understand you to be
5 telling me that any kind of mental illness
6 can qualify for the type of mental illness
7 which can lead to an involuntary commitment
8 to the patient?

9 MR. RADOMISLI: Objection.

10 Scope.

11 A. What I am saying is that patient
12 alleged to have mental illness for immediate
13 observation, care and treatment in the
14 hospital is appropriate can qualify for
15 that.

16 Q. What I want to know, what are
17 the kinds of mental illnesses that are being
18 referred to in this policy statement?

19 MR. RADOMISLI: Asked and
20 answered.

21 A. Same I mentioned before, any
22 kind of illness, any kind of behavior can
23 qualify for this statement.

24 Q. So any mental illness; is that
25 fair to say?

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A. Yes.

Q. And it says in the statement here it's a mental illness for which immediate observation, care and treatment is appropriate?

A. Yes.

Q. Why does it have to be for immediate observation, care and treatment?

A. Because of the dangerousness.

Q. When a patient is brought into Jamaica Hospital and is being assessed under this policy statement, does the comprehensive psychiatric evaluation have to be done right away?

A. Not necessarily. It can be done in an unspecified time. Immediately you have to see whether there is any acute symptoms that need to be controlled. If the patient is not cooperative, you cannot do it, you cannot examine the patient, the patient is not willing to be examined -- answer questions. So it has to be -- it's very -- it's actuality not specified what exactly means immediate evaluation. It

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could be as soon as the patient comes in you can start the treatment or it could be until the patient is willing to talk.

Q. Does Jamaica Hospital have a policy about when the comprehensive psychiatric evaluation has to be conducted by?

A. There is not a policy, but it's standard that within eight hours admission to the emergency room and it also depends on how busy the ER is.

Q. Do I understand what you're saying that there's no written policy at Jamaica Hospital for when the psychiatric evaluation has to be conducted by?

A. Not that I'm familiar with.

Q. But you're telling me there is a practice of doing so?

A. It's eight hours.

Q. And that's not in writing?

A. That's not in writing.

Q. And it's eight hours depending upon -- you also said it's eight hours, it was also depending upon how busy the ER was?

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VINOD DHAR, M.D.

A. How busy the eye ER was.

Q. When you're referring to the ER, you're referring to the medical ER or the --

A. No, referring to the psychiatric.

Q. So we're talking about the psychiatric ER; is that correct?

A. Yes.

Q. How is this eight hour practice communicated to the staff that are expected to comply with it?

A. It's done through in-services.

Q. I don't understand what that means.

A. It means when you have staff meetings, you talk about how -- within what timeframe the assessment should be done and how if there's a problem or anything whether you need a second staff member. That's how it is taught to the staff.

Q. So the eight-hour goal or practice objective is discussed at staff meetings; is that correct?

MR. RADOMISLI: Objection to the

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form. You can answer.

A. Yes, it's a in-service. It is our case conferences, in-services and staff meetings.

Q. This practice of the hospital of having this comprehensive psychiatric evaluation done within eight hours, depending upon how busy the psych ER, that evaluation has to be done by who under the --

A. The staff psychiatrist who has been given by the privileges in the hospital by credential committee and approved by the chairman.

Q. Who were the staff psychiatrists in 2009 that were the ones that were required to conduct this comprehensive evaluation?

MR. RADOMISLI: Objection to form and the scope.

MR. CALLAN: Join in the objection.

MR. LEE: Objection.

MR. RADOMISLI: But you can

1 VINOD DHAR, M.D.

2 answer.

3 A. The are a number of
4 psychiatrists who work in the emergency
5 room. Some who are called on-call, meaning
6 they provide extra services during evening
7 and night hours, but the main person during
8 the daytime was Dr. Bernier.

9 Q. Other than these on-call
10 psychiatrists and Dr. Bernier, was there
11 anybody else who could do the comprehensive
12 psychiatric evaluation in October or
13 November 2009?

14 MR. RADOMISLI: Objection to
15 form and scope.

16 A. I am not sure if we had
17 residents at that time, but if they're
18 residents, they could do it, resident
19 physician, under the supervision of the
20 attending psychiatrist.

21 Q. When you say a resident, what do
22 you mean?

23 A. Resident is a physician who is
24 undergoing postgraduate training in
25 psychiatry.

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VINOD DHAR, M.D.

Q. Is there any requirement that the resident have a certain level of experience before they do a comprehensive psychiatric evaluation?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to the form and beyond the scope.

A. They have to be observed for period of three months, six months and once they -- the attending says that they're qualified to -- that they can independently make an assessment, regardless of whether they make independent assessment or not, it still has to be done under the supervision of the psychiatrist.

Q. What is this threshold three to six month period called at Jamaica Hospital?

A. It's not actually Jamaica Hospital policy. It's what's known as residency program policy. That a resident will not be allowed to see patients independently until the attending psychiatrist supervising him or her is confident that the resident can be

1 VINOD DHAR, M.D.

2 independent evaluation.

3 Q. What is this threshold called at
4 Jamaica Hospital?

5 A. I'm not aware of any specific
6 name.

7 Q. Does Jamaica Hospital have any
8 requirements in it's policies for
9 documenting when a resident meets this
10 threshold so that they are considered
11 qualified to conduct a comprehensive
12 psychiatric evaluation?

13 A. Not that I'm aware of.

14 Q. So it's not the kind of thing
15 that gets put in the personnel file of the
16 resident?

17 A. No.

18 Q. Going back to the policy
19 statement on the emergency admission status
20 subject line. It also says that there is a
21 reference here that patient alleged to have
22 mental illness and which is likely to result
23 in the serious harm to himself and others.
24 You see that?

25 A. Yes.

1 VINOD DHAR, M.D.

2 Q. What is that policy statement
3 based on?

4 A. That's based on the New York
5 State Mental Hygiene Law Article 9.

6 Q. Did a lawyer assist Jamaica
7 Hospital in crafting this policy statement?

8 A. I'm not aware of it.

9 Q. I am sorry?

10 A. I'm not aware.

11 Q. Have you ever read the New York
12 Law on the Section 9.39?

13 A. Yes, I have to. Yes.

14 Q. Does Jamaica Hospital's policy
15 endeavor to comply with Section 9.39 of the
16 Mental Hygiene Law?

17 MR. RADOMISLI: As it existed in
18 2009?

19 MR. SMITH: Yes.

20 A. Yes.

21 Q. Has the mental Hygiene Law
22 Section 9.39 changed since 2009?

23 MR. RADOMISLI: Don't answer the
24 question.

25 Q. Do you know whether or not

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VINOD DHAR, M.D.

Section 9.39 of the Mental Hygiene Law has changed since 2009?

MR. RADOMISLI: Read that back.
(Record read.)

MR. RADOMISLI: I am going to object. He's not a lawyer.

MR. SMITH: I am not asking for a legal opinion. I want to know whether or not he knows if the statute changed. I have a copy of it. You want me to show it to him. It hasn't changed.

MR. RADOMISLI: Are you representing that it hasn't changed?

MR. SMITH: Here's a copy of the statute obtained from Lexis. The alleged date of history shows it was created in '77 and it was amended most recently in 1986.

MR. RADOMISLI: Okay.

MR. SMITH: I would still like to know whether or not he thinks it's changed 'cause there's so much at stake here about moving target of the Jamaica

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VINOD DHAR, M.D.

Hospital over the past 15 years.

MR. RADOMISLI: Well, but you've already represented that it hasn't and you have the policy in front of you.

MR. SMITH: I know what the law is, but he's the witness. If he thinks that the policy had changed or the law has changed, which was the basis for the policy, then he can tell me, but I suspect that if you let him answer the question he's going to say I don't know if it's ever changed, it's been the same ever since I have been at Jamaica Hospital in 1996. But maybe he will say something else. I don't know.

MR. RADOMISLI: Do you know whether it has changed?

A. I'm not aware of any change, no.

Q. Would you like to see a copy of the law?

MR. RADOMISLI: Well --

Q. You said you read it before?

A. Yeah.

MR. SMITH: All right, so let's

1 VINOD DHAR, M.D.
2 mark it. Let's show it to the witness.
3 (Plaintiff's Exhibit 151,
4 document, was marked for identification
5 as of this date.)
6 Q. Have you had the chance to look
7 at 9.39?
8 A. Yes.
9 Q. And you've said you read it
10 before?
11 A. I have gone over it.
12 Q. And you're not aware of any
13 changes in this statute, are you?
14 A. I'm not aware, no.
15 Q. It says at the bottom of the
16 first page, it says the director shall admit
17 such person. You see that, sir?
18 A. Hmm-mm.
19 Q. You have to say or no. Just yes
20 or know. Uh-huh comes out --
21 A. Yes.
22 Q. Okay. It says only if a staff
23 physician of the hospital. So that's a
24 staff physician that you're referring to
25 earlier, right?

1 VINOD DHAR, M.D.

2 A. That's the attending
3 psychiatrist.

4 Q. Attending psychiatrist. Okay.

5 A. Yes.

6 Q. It says that the director under
7 the statute shall admit the person. Does
8 Jamaica have a director or somebody who
9 makes this decision or is that basically the
10 staff physician or attending who makes that
11 decision?

12 A. It's the attending who makes the
13 decision.

14 Q. So is there a director of the
15 hospital who is required to make the final
16 decision on admitting a patient pursuant to
17 Section 9.39?

18 A. No. There is no director or any
19 other person who is required to approve or
20 -- but it is done on the -- because director
21 -- it's staff psychiatrist in the hospital
22 -- in the emergency room is the one who
23 makes the decision.

24 Q. Is there anybody who holds the
25 title of director at the hospital or is it

1 VINOD DHAR, M.D.

2 really chairman?

3 A. Well, it's actually, there is a
4 medical director in the ER, psych ER.

5 Q. Who is that?

6 A. Dr. Bernier was the medical
7 director at that time.

8 Q. What's the role of a medical
9 director, other than making these final
10 sign-off decisions on involuntaries?

11 A. Basically overseeing, reviewing
12 all the cases and supervising residents and
13 nurses and other physicians.

14 Q. All right, and then going back
15 to the policy statement, page 17, Exhibit
16 130 at the bottom of that page it says the
17 admitting physician must be licensed in New
18 York State. You see that?

19 A. Yes.

20 Q. All right. Is the admitting
21 physician within this policy the same as the
22 attending physician and the staff physician
23 as we have been discussing, is that all the
24 same person?

25 MR. RADOMISLI: Objection to

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VINOD DHAR, M.D.

form.

A. Admitting physician would be same, yes.

Q. So the admitting physician is the same as the staff physician, right?

A. Well --

MR. RADOMISLI: Objection to form.

A. -- it could be the staff physician or it could be the director, any of the physicians.

Q. On the same page there is a phrase likely to result in serious harm. Do you see that?

A. Hmm-mm.

Q. You have to say yes.

A. Yes. I'm sorry.

Q. And then the policy defines likelihood to result in serious harm in two ways, numbered one and two. You see that?

A. Yeah.

Q. And am I correct that the first definition deals with categories of dangerousness to oneself and the second

1 VINOD DHAR, M.D.
2 category deals with dangerousness to others?
3 A. Yes.
4 Q. You see the phrase manifested
5 by?
6 A. Yes.
7 Q. What does that mean?
8 A. It could be any kind of behavior
9 that is out of control or violent behavior
10 or threats to some other people.
11 Q. Am I correct that manifested by
12 requires that the patient either engage in
13 some conduct or makes some sort of statement
14 that suggests that the person is dangerous
15 to themselves?
16 A. Yes.
17 Q. It also goes on to say "Or other
18 conduct demonstrating that he is dangerous
19 to himself." You see that?
20 A. Yes. Can you specify where?
21 Q. In sub one --
22 A. Yeah.
23 Q. -- in the definition of
24 likelihood to result in serious harm there
25 is a phrase or other conduct demonstrating

1 VINOD DHAR, M.D.

2 that he is dangerous to himself. You see
3 that?

4 A. Yes.

5 Q. What kind of conduct under the
6 Jamaica policy is the kind of conduct that
7 demonstrates that a person is a danger to
8 himself or herself?

9 A. Any kind of behavior that a
10 person puts himself into any physical harm,
11 not able to provide for himself food,
12 clothing, shelter or medical treatment.

13 Q. Is there any other conduct,
14 other than what you've just said, that is
15 the kind of conduct that demonstrates a
16 person that's a danger to themselves or --

17 A. I am not aware of anything.

18 Q. Does the conduct under this
19 policy have to be conduct that the admitting
20 or the staff physician observes?

21 A. No. It's based on the report
22 that we get from the person who brings the
23 patient in.

24 Q. Is there any policy at Jamaica
25 about determining the reliability of the

1 VINOD DHAR, M.D.

2 reported information?

3 A. Well, there is no policy, but in
4 general, we, as the staff psychiatrist or
5 director, will try to get information from
6 other sources, but people who come to us
7 generally is reliable.

8 Q. Why do you say that people who
9 come to you are generally reliable?

10 A. The people who bring the
11 patients in.

12 Q. No, I understand that's what
13 you're saying, but I'm saying why do you say
14 that they're generally reliable?

15 A. Well, because we are -- we take
16 patients from police or from agency, they
17 bring the patient in there or family
18 members.

19 Q. So is it the policy of Jamaica
20 Hospital to accept without question the
21 information that's provided by the police or
22 family members or some other provider or
23 relator of information?

24 MR. RADOMISLI: Objection to the
25 form, asked and answered. You can

1 VINOD DHAR, M.D.

2 answer.

3 A. Yes. Until we find any other
4 resource that we have collateral
5 information. Until then we are obligated to
6 keep that information as valid information.

7 Q. You say that you're obligated to
8 keep that information as valid information,
9 what is that information based on?

10 A. It's based on New York State
11 9.39. That 9.39 emergency room under the
12 order of the commissioner we can receive and
13 retain a person until all the evaluations
14 are done.

15 Q. No, I understand that 9.39 gives
16 Jamaica Hospital the ability to involuntary
17 commit somebody, but what I am trying to
18 find out is what's the basis for you saying
19 that you're obligated to accept as valid the
20 information that's provided to you by the
21 people who are relating the information to
22 you?

23 MR. RADOMISLI: Objection to
24 form. You can answer.

25 A. Until we get the other

1 VINOD DHAR, M.D.

2 information from collateral.

3 Q. So if a family member comes into
4 Jamaica Hospital and relates information
5 about somebody it's Jamaica's practice or
6 policy to accept that information as true
7 without any assessments or attempt to
8 independently verify it?

9 A. Yes.

10 MR. RADOMISLI: Objection.

11 MR. LEE: Objection.

12 MR. RADOMISLI: And to form.

13 Q. The next page of the policy
14 statement has under the headings procedure
15 number of categories, you see that?

16 A. Yes.

17 Q. Number one, there's a reference
18 here to following examination and interviews
19 other informants, which may be available
20 should the examining physician consider the
21 patient to meet the criteria above, he
22 should certify his finding on form OMH 474.
23 Do you see that?

24 A. Yes.

25 Q. There's a reference here to the

1 VINOD DHAR, M.D.

2 examining physician. You see that?

3 A. Yes.

4 Q. Is the examining physician the
5 same person as the staff physician or
6 attending physician?

7 A. Yes.

8 Q. That's the same person who
9 conducted the comprehensive psychiatric
10 evaluation, right?

11 MR. RADOMISLI: Objection to
12 form.

13 A. Yes.

14 Q. And the form, what is this form
15 OMH 474?

16 A. It's a form that when a
17 psychiatrist, attending psychiatrist in his
18 or clinical opinion finds that the patient
19 can be admitted on an involuntary basis and
20 there's a form there, you have to fill that
21 form with the justification why you think
22 the patient should be admitted and based on
23 information and whatever the collateral
24 information, what other sources of
25 information, that's form 474.

1 VINOD DHAR, M.D.

2 Q. And the staff physician or the
3 attending physician, the one who has
4 conducted the comprehensive psychiatric
5 evaluation, they fill out the form if they
6 make the decision that the person should be
7 involuntarily committed; is that correct?

8 A. Yes.

9 Q. Are they required, under Jamaica
10 policy, to fill out that form at any
11 particular time in relation to when they
12 make their decision?

13 A. As soon as the decision is made,
14 the patient needs to be admitted.

15 Q. So the policy at Jamaica is to
16 have the form executed as soon as the
17 decision by the psychiatrist is made; is
18 that correct?

19 A. Yes.

20 Q. In the next paragraph there is a
21 reference to a number two. Do you see that?

22 A. Number two?

23 Q. Yes.

24 A. Yeah.

25 Q. It says here the admitting

1 VINOD DHAR, M.D.

2 doctor will record on the form the names of
3 the people. You see that?

4 A. Yes.

5 Q. And that's the admitting doctor
6 is the same as the examining doctor?

7 A. As the examining doctor, yes.

8 Q. I want to the show what's been
9 previously marked as Exhibit 131. This came
10 from the chart or the file from this
11 particular patient, Schoolcraft was his
12 name.

13 A. Okay.

14 Q. I am not going to ask about
15 that, but I am going to ask you about the
16 form itself; okay? All right?

17 A. Okay.

18 Q. So can you tell me what this
19 document is?

20 A. This is a document known as
21 notice of status and rights to the emergency
22 admission. This information is given to the
23 patient. Copy of this information is given
24 to the patient explaining his rights and
25 what the protocol is going to be.

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VINOD DHAR, M.D.

Q. And is this document also supposed to be given to the patient at the same time as the 474 form is the filled out by the staff physician?

A. Yes.

Q. And so is it policy at Jamaica Hospital for the staff physician, if they make a decision to involuntary commit, to sign page 1 of the 747 and then hand the patient this form notice of status and rights?

A. Yes.

Q. And in this notice it says here, in the form, in the printed form -- by the way, this is a printed form that's created by Jamaica Hospital or by?

A. Department of the Office Mental Health, New York State.

Q. So Jamaica Hospital just gets the form from the Department of Mental Health?

A. Yes.

Q. So this form here says based upon -- "base upon an examination by a staff

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VINOD DHAR, M.D.

physician you have been admitted as an emergency status patient to this hospital for persons with mental illness for immediate observation, care and treatment. Within 48 hours of the time of your admission, you will be examined by another physician, who is a member of the psychiatric staff of this hospital." You see that, sir?

A. Yes.

Q. Now, the phrase within 48 hours of the time of your admission. You see that?

A. Yes.

Q. Under Jamaica's policies, when does this 48-hour time period begin?

A. It starts from the time this form is filled -- the 747, the form is signed, that is the time given for that.

Q. Am I correct that the hospital policy and practice is that the comprehensive psychiatric evaluation is done subject to the busyness of the emergency room within eight hours; is that correct?

1 VINOD DHAR, M.D.

2 A. Yes.

3 Q. And then the evaluation should
4 be conducted within that eight-hour period,
5 correct?

6 A. Yes.

7 Q. Then after that comprehensive
8 psychiatric evaluation is done, then the
9 form for 747 is filled out and this notice
10 of rights is provided to the patient at that
11 time; is that correct?

12 A. Yes.

13 MR. LEE: Objection to the form.

14 Q. And then is it the Jamaica
15 Hospital policy that within 48 hours of the
16 signing of the 474 form that a member of
17 psychiatric staff of the hospital has to
18 then do an evaluation of the patient?

19 A. Yes.

20 Q. Why is the second evaluation of
21 the patient by a member of the psychiatric
22 staff required?

23 MR. RADOMISLI: Objection to
24 form. Go ahead.

25 A. It's a process of checks and

1 VINOD DHAR, M.D.

2 balances and make sure that admission was
3 done properly and that the patient met
4 criteria for admission.

5 Q. If the initial or staff
6 physician gives a diagnosis and the
7 psychiatric staff member's diagnosis
8 disagrees with the initial assessment, is it
9 the Jamaica Hospital policy to then
10 discharge the patient?

11 MR. RADOMISLI: Read that back,
12 please.

13 (Record read.)

14 MR. LEE: Note my objection to
15 the form.

16 MR. RADOMISLI: Objecting to the
17 form and also, beyond the scope of the
18 deposition, which deals within
19 involuntary admission.

20 MR. SMITH: That's what the
21 subject matter of the question is.

22 MR. RADOMISLI: Subject of the
23 matter of the question is discharging.
24 It's different. Can you rephrase the
25 question?

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VINOD DHAR, M.D.

MR. SMITH: Are you instructing him not to answer the question?

MR. RADOMISLI: It's beyond the scope.

MR. SMITH: I'm not sure I understand.

MR. RADOMISLI: It's a little nit picky.

MR. SMITH: Yeah, to me it seems very nit picky.

MR. RADOMISLI: But I'll -- just read it back one more time.

(Record read.)

MR. LEE: Note my objection to the form for the record.

MR. RADOMISLI: Can you rephrase the question in such a way that it squarely fits within the scope of this deposition?

MR. SMITH: No, I can't. This is -- this is the -- you're mincing words here. Do you want to split hairs? Then you can split hairs all you want.

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VINOD DHAR, M.D.

MR. RADOMISLI: Then I will because I am just going by what the court order says and what you asked for and what you asked for was a witness to testify about the policy on involuntary admissions.

MR. SMITH: Right, okay, and so you're telling me that the only time that's relevant to make an inquiry about the hospital's policy is the moment that the staff physician signs the piece of paper saying that yes, we are going keep this person against their will and that anything that happens thereafter is completely irrelevant to the scope of this examination? If you're saying that, which is what I think you're saying then you're taking an extremely narrow view of the court order and needlessly interfering with my deposition.

MR. RADOMISLI: That isn't what I'm saying. Number two, it's not an exceedingly narrow interpretation of

1 VINOD DHAR, M.D.

2 the court order, because when you
3 applied to -- when you served the
4 30(b)(6) and when -- subject to the
5 motion, you only asked about policies
6 regarding involuntary admission. You
7 didn't say anything about the discharge
8 either in the application to the court
9 or in response to my objection or
10 during conference and therefore, there
11 is no court order -- the court order is
12 limited to involuntary admission.

13 MR. SMITH: The second page of
14 the involuntary admission policy talks
15 about the second evaluation needing to
16 be done under the Jamaica policy. So
17 you're telling me I can't ask questions
18 about the second assessment because the
19 patient has already been admitted.
20 Then I think we should really stop the
21 examination and I will make my
22 application.

23 MR. RADOMISLI: I'm not saying
24 that you can't ask questions about the
25 second evaluation. You can ask the

1 VINOD DHAR, M.D.

2 question you just asked.

3 MR. SMITH: Well, you don't get
4 to decide that.

5 MR. RADOMISLI: No, the court
6 does and the court order says
7 involuntary admissions and that's what
8 you noticed in your 30(b)(6) and that's
9 what was subject of the court order is.

10 MR. SMITH: So you're splitting
11 hairs and now you have it.

12 MR. RADOMISLI: Not splitting
13 hairs. Going by exactly what you asked
14 for.

15 Q. If the second doctor disagrees,
16 what happens to the patient?

17 MR. LEE: Objection to the form.

18 MR. RADOMISLI: Disagrees with
19 what?

20 MR. SMITH: The initial
21 assessment.

22 MR. LEE: Objection to the form.

23 MR. RADOMISLI: Objection to the
24 form, but you can answer it.

25 A. If the second physician

1 VINOD DHAR, M.D.
2 disagrees with opinion of the first
3 physician, the second physician has to come
4 up with his own opinion as to why he thinks
5 the patient should or should not be kept in
6 the hospital.

7 Q. Am I correct that if the staff
8 psychiatrist disagrees with the assessment
9 to keep the patient involuntarily in the
10 hospital, the patient is not discharged?

11 MR. LEE: Objection.

12 MR. RADOMISLI: Objection to the
13 form.

14 A. If the second physician
15 disagrees with the diagnosis, then the
16 physician has to come up with a reason for
17 keeping the patient.

18 Q. And is that burden on the second
19 physician based on a Jamaica policy
20 statement?

21 A. Yes.

22 Q. Where is that statement?

23 A. It's part of the evaluation
24 because the reason this is done is to make
25 sure that all the information has been

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VINOD DHAR, M.D.

received, that the collateral information, and all other information from other sources is also reviewed and then a decision is made after 48 hours.

Q. So you're telling me that the initial decision really isn't the final decision. That the final decision is really made once the staff psychiatrist makes the decision within the 48-hour period?

MR. RADOMISLI: Objection to form.

Q. Is that correct?

A. Yes.

MR. LEE: Objection.

Q. And you're telling me that the final decision by the staff psychiatrist is made after additional information is obtained from collateral sources?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to form.

A. Yes.

Q. What collateral sources is the information obtained from?

1 VINOD DHAR, M.D.

2 A. It could be anything, any family
3 member, any agency, anywhere a patient can
4 say that you can get the information from
5 this source and whatever helps in making the
6 assessment and decision of the patient.

7 Q. Are there any policy statements
8 laid out in Jamaica Hospital for how an
9 attending or staff psychiatrist makes this
10 investigation into this collateral source
11 information?

12 A. There's no specific policy, but
13 there's practice that collateral information
14 has to be obtained.

15 Q. And what is the practice about
16 getting collateral information?

17 A. Any resources.

18 Q. Did you say any resources?

19 A. Any resources that the patient
20 has that you can get information about the
21 patient's condition.

22 Q. So is Jamaica policy for doctors
23 to get any reasonable information that could
24 be relevant to their decision?

25 A. Yes.

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VINOD DHAR, M.D.

Q. In the second page of the emergency admission status policy there is a paragraph number 4. It says that the admitting doctor is responsible for assuring the second examination is conducted within 48 hours. You see that?

A. Yes.

Q. How does the admitting doctor go about effectuating this policy of making sure the second evaluation is done within 48 hours?

A. The general practice is that when a patient is admitted, the admitting physician will inform the attending physician, who is receiving the patient, that this patient is being admitted and give information and then also based on any new patient that comes to the unit the time, the signature and the time on page 1 will determine what time the certification has to be made.

Q. So the date and the time is a pretty important entry in the patient's chart as to when they were involuntary

1 VINOD DHAR, M.D.

2 admitted; is that right?

3 MR. RADOMISLI: Objection to
4 form.

5 MR. LEE: Objection.

6 A. Yes.

7 Q. Does the Jamaica Hospital policy
8 require that the admitting doctor consult
9 verbally with the second physician or can it
10 be done by simply having a file forwarded to
11 the second physician?

12 A. General practice is to verbally
13 inform the attending. Sometimes you don't
14 know who the attending is going to be. So
15 you give the report to the nurse. Nurse
16 gives the report to the nurse on the unit
17 and then they inform the doctor. If it's
18 after-hours, in the morning.

19 Q. In that same paragraph of the
20 policy statement it says that if the
21 admission occurs during routine weekday
22 hours, the admitting doctor will arrange for
23 the psychiatrist who has admitting
24 privileges to conduct the second examination
25 immediately. You see that?

1 VINOD DHAR, M.D.

2 A. Yes.

3 Q. Why is it the policy of Jamaica
4 Hospital to have that second evaluation done
5 immediately?

6 A. I'm not sure why the policy is
7 that.

8 Q. The last sentence says that any
9 difficulty in making such arrangements is to
10 be immediately referred to the chairman or
11 one acting on his behalf. You see that?

12 A. Yes.

13 Q. Is the reference to the chairman
14 is that Mr. Vivek -- Dr. Vivek?

15 A. Dr. Vivek, yes.

16 Q. And who are the individuals at
17 Jamaica Hospital who would be acting on the
18 chairman's behalf under this sentence?

19 A. That would be me.

20 Q. Have you been involved in making
21 sure that the second evaluation happens
22 immediately after the first one?

23 A. Yes.

24 Q. Is the reason why the second
25 evaluation has to be done as soon as

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possible after the first one, because the patient is being held against their will?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to form and asked and answered. Go ahead.

A. I guess, yes, that's the reason.

Q. Next paragraph number 5, there is a statement in the Jamaica Hospital policy to the effect that "should the patient reject this suggestion to convert to voluntary status and should the psychiatrist find that the patient does not meet the above criteria for emergency hospitalization, he must immediately contact the chairman or one acting on his behalf prior to the completion of page number 2 of OMH 474." You see that reference?

A. Yes.

Q. Is this the second -- no, that's a bad question. Let me rephrase that.

Why does the Jamaica Hospital policy provide that the psychiatrist should immediately contact the chairman or somebody acting on his behalf if he

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disagrees with the initial assessment.

MR. LEE: Objection to the form of the question.

A. Because there are two physicians from the same institution in giving two different opinions. So it's responsibility of the chairman to make sure that the right decision is made.

Q. Is that responsibility of the chairman, is that laid out in, to your understanding, New York State Law 9.39?

A. I'm not sure.

Q. I gave you a copy of 9.39. Would you mind looking at it and tell me whether or not your understanding of this provision for having the chairman referee disagreements is part of the state law or not?

MR. RADOMISLI: Objection. He's not required to interpret the law.

MR. SMITH: I'm not asking for his interpretation of the law.

MR. RADOMISLI: You are.

MR. SMITH: No, I'm not. I'm

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asking if he knows anything about the law.

MR. RADOMISLI: He answered that question.

MR. SMITH: More specifically, I want to know whether or not his function of the chairman refereeing disputes is, to his understanding, part of New York State Law.

MR. RADOMISLI: That's beyond the scope.

MR. SMITH: So you're going to direct him not to answer --

MR. RADOMISLI: I am going to direct him not to answer questions that requires him to interpret the law. That's correct.

Q. Doesn't your job as acting chairman of the psychiatric department at Jamaica Hospital require that you interpret 9.39 properly?

A. My job is to make sure that the clinical decisions are made properly.

Q. My question is don't you think

1 VINOD DHAR, M.D.

2 your job is to make sure that your staff is
3 complying with 9.39 when they involuntarily
4 commit people?

5 A. Yes.

6 Q. And in service of that
7 objective, you have familiarized yourself
8 with the statute, right?

9 A. Yes.

10 MR. SMITH: You're still going
11 to instruct this witness not to answer
12 those questions?

13 MR. RADOMISLI: He can answer
14 that.

15 Q. Does the policy statement about
16 having the chairman refereeing or be
17 consulted by this psychiatric attending
18 about a disagreement with the initial
19 assessment comply with New York State Law,
20 to your understanding?

21 MR. RADOMISLI: Objection to
22 form. You can answer.

23 A. Say it again, can you repeat it?

24 Q. Yes. You have in front of you
25 9.39, right?

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A. Yes.

Q. Is there a provision in the law, to your understanding, that provides that when the initial assessment and the second assessment disagrees that the chairman is to be consulted?

A. Every hospital has a departmental policy and a hospital policy because we're working under the hospital. So there's an internal policy to make sure that all decisions are made according to the law and based on the clinical decisions.

Q. This is my question, Doctor, I thought that the hospital policy was that you need to have a initial assessment confirmed by a second assessment as a precaution to protect the patient; is that right?

A. Yes.

Q. But the policy statement says that if there's a disagreement, the patient is not discharged, it says that there is a conferral with the chairman and what I want to know is whether or not you think that

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this practice or this policy of conferring with the chairman when there is a disagreement is consistent or inconsistent with your understanding of Section 9.39 of the Mental Hygiene Law.

MR. RADOMISLI: Objection to the form.

A. I won't be able to answer that question whether it's consistent with 9.39, but every hospital has an internal policy and we are required, the chairman has the responsibility of the entire department. He has to make sure that all decisions are made correctly and he delegates that authority to either me or the duty (phonetic) chief or the attending physician.

Q. Have you had occasion in the past as the acting chairman or the assistant chairman to act in this referee function?

MR. SMITH: Can you just hold that question a second. This is the court calling back I think.

Hello, oh, hi, yeah. This is Mr. Smith. Mr. Chan?

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VINOD DHAR, M.D.

CALLER: This is Adam Chen from Judge Sweet's Chambers. How are you doing?

MR. SMITH: I'm doing well. We're at the deposition and thank you for getting back to me and you're on speakerphone. All counsel and the witness and the court reporter are present.

CALLER: Okay. So I have instructions from the judge. He told me to let you guys know that all objections can be made, but there are no objections can be made not to answer except on grounds of privilege.

MR. SMITH: Okay. Thank you very much.

CALLER: No problem. Have a good day.

MR. SMITH: Okay, bye. Did you get that down?

All, right, I'm going to take a five-minute break.

MR. CALLAN: Yes. Just in terms

1 VINOD DHAR, M.D.

2 of how much longer are we going to
3 lunch break, break now or are we going
4 to have lunch?

5 MR. SMITH: I just want five
6 minutes to just regroup and see where I
7 need to come back. This is
8 unfortunately -- we are going to go off
9 the record. It's 12:35.

10 (Whereupon, a recess was taken.)

11 MR. SMITH: Going on the record.
12 It's 1:41.

13 Q. When we left off, Doctor, we
14 were talking about this conferral with the
15 chairman or the person acting on behalf of
16 the chairman.

17 A. Yes.

18 Q. When the situation where the
19 initial assessment gives a diagnosis and the
20 second assessment has a disagreement about
21 what that assessment is. That was the
22 subject matter. Have you in the past ever
23 acted as an intermediary for these types of
24 situations?

25 A. Yes.

1 VINOD DHAR, M.D.

2 Q. So what is the hospital policy
3 with respect to how to address the
4 disagreement between the initial assessment
5 and the second assessment?

6 MR. RADOMISLI: Object to the
7 form and substance, but you can answer.

8 A. Well, it's always been the
9 customary practice of the hospital to get a
10 second opinion, because it's a question of
11 safety and we want to make sure that the
12 right decision is made. And it has happened
13 before.

14 Q. So do I understand you to be
15 saying that the hospital policy will be to
16 make sure that the second assessment is, in
17 fact, correct?

18 A. If the second assessment is --
19 if there's a difference of opinion, then
20 there will be a second opinion.

21 Q. Meaning third opinion actually?

22 A. A third opinion, yes -- well --
23 okay, a third opinion, yeah.

24 Q. And if the third opinion agrees
25 with the first opinion, will a patient then

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be maintained in an involuntary status?

A. If there is sufficient grounds and the person who is doing the third consultation or opinion will document that in their notes or write a new form.

Q. I'm not sure I asked the question clearly, so I am going to restate it. If the first assessment is the person should be involuntary committed and attending psychiatrist says no, I don't think so, I think this person is either not suffering from a mental illness or has not demonstrated through words or conduct or some other means, dangerousness, and so I think the person should be released. Under those circumstances, the hospital practice and policy is to go to the chairman or somebody acting on behalf of the chairman, right?

A. Yes.

Q. And that chairman or that person acting on behalf of the chairman is another medical professional, right?

A. Yes.

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Q. And they will hear the pros and the cons about the two different opinions, right?

A. Exactly.

Q. What I want to know is if the third person to make this assessment agrees with the first assessment, that the person should be involuntarily committed, will the person be maintained in an involuntary status or will they be discharged?

MR. RADOMISLI: Objection to the form and has no connection to the case, but go ahead.

A. It's not an option of discharge, because you can keep a person on a voluntary commitment. So the option there is either to convert the involuntary to voluntary. The patient is willing to stay or yes, if the third opinion is that the patient should stay and we will keep the patient -- we may even go for the fourth opinion, because we are always acting for the safety of the patient. We would always -- err on the side of the safety.

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2 Q. When you say err on the side of
3 safety, what you say is err on the side of
4 maintaining them in the hospital against
5 their will?

6 MR. RADOMISLI: Objection to
7 form.

8 Q. Is that right?

9 MR. RADOMISLI: Objection to
10 form.

11 A. Depending on the circumstances
12 to what they came, safety if they are
13 dangerous to themselves or others, yes.

14 Q. You recognize that dangerousness
15 is an assessment about what somebody may do
16 in the future, right?

17 A. No, actually, no. Dangerousness
18 is what the patient came in for.

19 Q. So in order to make an
20 assessment about whether or not somebody is
21 dangerous, the medical professional has to
22 look into the past, right?

23 A. Yes.

24 Q. So they're not trying -- they
25 don't have a crystal ball and they're not

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trying to look in the future to make a determination about what the person may do in the future; is that correct?

A. No. We try to see what the status is right now, what is the level of dangerousness right now, and whether there needs to be any treatment or any intervention until we find that the patient is safe to be discharged.

Q. So my understanding is you're saying that if, in the past, somebody had acted in a way that suggested that they were dangerous, but if they're no longer currently acting under those conditions, then everything else being equal, they would be considered not dangerous?

MR. RADOMISLI: According to hospital policy.

Q. According to hospital policy; is that correct?

A. Yes.

Q. So that the critical time for the initial decision under the 9.39, the condition of the patient at the time that

1 VINOD DHAR, M.D.

2 the comprehensive psychiatric evaluation is
3 being done; is that correct?

4 A. Yes.

5 Q. You mentioned earlier today that
6 there was in-service training, do you
7 remember that?

8 A. Yes.

9 Q. What is that?

10 A. In-service training is you can
11 say it's a class where the staff is updated
12 on the hospital policy or the recent
13 treatment changes or recent intervention.
14 That is like giving training.

15 Q. Are there classes or training on
16 making assessments about dangerousness?

17 A. Now, yes.

18 Q. Are those handouts or Power
19 Point or some other form of communication?

20 MR. RADOMISLI: Objection to the
21 extent that you're asking for
22 currently, but given the judge's
23 ruling, I have no choice but to let him
24 answer the question.

25 Q. You can answer the question.

1 VINOD DHAR, M.D.

2 THE WITNESS: I can?

3 MR. RADOMISLI: I am obligated
4 to let you answer the question.

5 A. Yes, we do have. Now we have.

6 Q. When did Jamaica Hospital start
7 having written presentations for in-service
8 training on the issue of dangerousness?

9 MR. RADOMISLI: You're going
10 beyond the scope.

11 MR. SMITH: No, I'm not at all.
12 I'm trying to understand what the
13 policy is, how the policy is
14 effectuated, and how its intent is
15 communicated to a physician that
16 actually implements it, so I don't
17 think I'm going beyond the scope.

18 MR. RADOMISLI: You could answer
19 the question.

20 A. Could you repeat the question?

21 Q. I can't, but I will reformulate
22 it.

23 When did Jamaica Hospital start
24 having these in-service training sessions
25 with the staff, where the subject matter of

1 VINOD DHAR, M.D.

2 dangerousness was taught?

3 A. When we have actually at Jamaica
4 Hospital we have what's called grand rounds
5 and case conferences. It started since
6 1995. We have two to three grand rounds a
7 week.

8 MR. RADOMISLI: He asked you
9 when. Read back the question, please.

10 A. We started earlier 1995, 1996.

11 Q. So if I went to Jamaica Hospital
12 and I want to get a copy of this
13 presentation, could I do that?

14 A. I don't know whether we used to
15 keep any records of those at that time or
16 not.

17 Q. Does Jamaica Hospital have any
18 records today of what the training sessions
19 look like over the past five years?

20 MR. RADOMISLI: Now I am going
21 to object because one of the things
22 that you asked to talk about was to
23 have a witness testify on this issue
24 and that was not permitted by the
25 court.

1 VINOD DHAR, M.D.

2 MR. SMITH: I don't remember
3 that, frankly. All I am trying to do
4 is find out -- I will make the request
5 for the documents, if they exist, and
6 I'm not going to ask the witness any
7 more questions about the contents of
8 these documents, but if they do exist
9 and they had existed at the time, then
10 I think you should produce them.

11 MR. RADOMISLI: Take that under
12 advisement.

13 MR. SMITH: I'm just trying to
14 establish if they exist.

15 MR. RADOMISLI: Then just -- you
16 haven't asked that, do you know whether
17 -- you didn't ask the when question.
18 You skipped over that.

19 MR. SMITH: I did ask the when.
20 I just didn't get an answer. I think
21 the answer was since 1995.

22 MR. RADOMISLI: That was when --
23 Q. Let me ask you this question, in
24 2009 there were in-service training classes
25 at Jamaica Hospital; is that right?

1 VINOD DHAR, M.D.

2 A. Yes.

3 Q. In 2009 or as of 2009, those
4 in-service training session included
5 dangerousness assessment; is that right?

6 A. Yes.

7 Q. And those training sessions
8 were, among other things, done verbally and
9 in writing; is that correct?

10 MR. RADOMISLI: In 2009.

11 Q. In 2009?

12 A. Yes. I can recall verbally and
13 not in the writing there is case
14 presentation, a slight Power Point
15 presentation.

16 MR. SMITH: So I am going to
17 make a request for the production of
18 any written presentations that were in
19 effect and utilized as of the end of
20 2009 at Jamaica Hospital.

21 MR. RADOMISLI: Taken under
22 advisement, please follow-up in
23 writing, but it appears to me that this
24 has come up and has already been ruled
25 against and I'd appreciate that if I

1 VINOD DHAR, M.D.

2 show you that, then you'd agree to
3 withdraw the demand.

4 MR. SMITH: If you can show me
5 that the judge has considered this
6 issue and rejected my request for that
7 information and have also convinced me
8 that no new information has come to
9 light, which ought to make the judge
10 reconsider that, if, in fact, he's
11 taken that position and I will gladly
12 withdraw it.

13 MR. RADOMISLI: I can show you
14 where the judge considered it and not
15 granted it.

16 MR. SMITH: Moving on.

17 Q. Now, earlier we talked about two
18 ways that the individual is involuntary
19 admitted to the hospital. You remember that
20 generally?

21 A. Yes.

22 Q. Am I correct that there is a
23 third way, which is commonly known as the
24 CPEP way; is that a correct description?

25 A. CPEP?

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Q. Yeah.

A. How do you spell it?

Q. C-P-E-A -- not --

A. CPEP?

Q. CPEP?

A. Yeah.

Q. Okay. Maybe I'm just a little bit confused. There is the involuntary under 9.39, which we already talked about and then there was involuntary under 9.27, which is the two physicians involuntary and then is there is a third way known as this CPEP?

MR. RADOMISLI: CPEP.

Q. CPEP?

A. Comprehensive psychiatric emergency program.

Q. What is that?

MR. RADOMISLI: Going beyond the scope of the policy. It's not in there of --

MR. SMITH: I'm going to save you some breath.

Q. Was this CPEP program instituted

1 VINOD DHAR, M.D.

2 sometime after 2009?

3 A. Yes. It has been only for a
4 year now.

5 Q. Only for one year at Jamaica
6 Hospital?

7 A. Yes.

8 Q. If you don't mind, please turn
9 back to 130 of the involuntary emergency
10 admission status procedure. We were on page
11 18. Then bottom there is a number 6 and
12 this relates to a request for a court
13 hearing.

14 A. Yes.

15 Q. Can you describe for me what
16 this policy is in number 6 about the request
17 for a court hearing?

18 A. Every patient that is admitted
19 on an involuntary basis has -- admitted to
20 the inpatient unit, has access to mental
21 health legal services. And if they wish to
22 be discharged or the family wants, they want
23 to discharge the patient, they will discuss
24 with the doctor and if the physician
25 disagrees with them and feels that the

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1 patient is not ready for discharge, then if
2 the patient or the family members can give
3 in writing to the mental health legal
4 service attorney, a notice that they wish to
5 be discharged, they will file a petition and
6 we will respond to that petition and within,
7 I think within seven days or five days of,
8 we will be going to the court in front of
9 the judge, supreme court judge.

11 Q. Does the request to be
12 discharged have to be given by the mental
13 health legal services bureau or can it be
14 given by the patient?

15 A. The patient gives it to the
16 mental health legal services. He presents
17 them. Or it could be their own attorneys.

18 Q. The paragraph that I am
19 interested in, it says that if at any time
20 after, it's after admission of the patient,
21 a relative or a friend or the MHLs gives
22 written notice to the director of a request
23 for a court hearing, the director will
24 immediately deliver to the Supreme Court of
25 Queens County and to the mental health legal

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2 services, a copy of the notice and a copy of
3 patient records. That's what the policy
4 statement says, right?

5 A. Yes.

6 Q. So do I understand the policy to
7 permit the patient to give the notice
8 required under this section to the
9 physician?

10 A. I mean, according to the policy,
11 yes, but it generally comes from -- the
12 request generally comes from the attorney
13 who starts the process.

14 Q. If a patient is in the
15 in-patient ward or unit and the attending is
16 talking with the patient and the patient
17 says I don't think I belong here, I want to
18 get out. Is that sufficient to trigger this
19 policy for having the hospital petition the
20 supreme court?

21 MR. RADOMISLI: Objection to
22 form.

23 A. No, it's not sufficient.

24 Q. Why not?

25 A. Because based on the patient's

1 VINOD DHAR, M.D.
2 condition, depending on the diagnosis,
3 patient can change their mind 24 hours a
4 day. Generally, when a patient says
5 something like that, you talk to them, you
6 talk to the family and they will agree to
7 take medication or not medication, unless we
8 come up with a safe discharge plan, most
9 patients stay back. They will not insist
10 upon leaving, but at the same time we will
11 ask them or tell the mental health legal
12 service to please contact this patient, talk
13 to him and see what he deserves -- what he
14 wants.

15 Q. So the notice that's required to
16 trigger this obligation on the part of the
17 hospital to go to supreme court, this must
18 be in writing?

19 A. Yes.

20 MR. RADOMISLI: Objection to
21 form.

22 Q. It must be in writing?

23 A. Yes.

24 Q. Other than it being in writing,
25 does it have to say anything or do anything?

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A. Well, it has to show the supreme court why the physician thinks medical necessity of the patient needs to stay in the hospital.

Q. No, I am talking about the patient. The patient's request to get out. This section 6 here, as I understand it, is a mechanism for involving the court, where a patient says I want to leave and the hospital says no, we think you should stay. So there's a disagreement, right?

A. Right.

Q. So this section provides a mechanism for petitioning the court to resolve the issue about whether or not the patient should be kept against his or her will, right?

A. Right.

Q. What I want to know, it says here if at any time the patient or relative or the mental health legal services gives written notice, then this process starts. What I want to know is, other than this notice being in writing, is there anything

1 VINOD DHAR, M.D.

2 else about the notice that's required under
3 this policy?

4 A. No, from the patient.

5 Q. So if a patient were to write on
6 a piece of paper and hand it to his
7 physician, I want to leave right now. That
8 would be sufficient?

9 A. That would be sufficient as long
10 as it's written, the notice will be process,
11 yes.

12 Q. How long does the hospital take
13 under this policy to petition the court?

14 A. As soon as possible.

15 Q. In your experience, what is
16 that?

17 A. It's about a week, because court
18 is only held on Tuesdays. So by Friday of
19 that day if all the paperwork and everything
20 is ready, the court hearing will be on
21 Tuesday.

22 Q. Turn to the next page of the
23 exhibit that you have in front of you.
24 There's a admissions from emergency room
25 policy statement.

1 VINOD DHAR, M.D.

2 A. 44?

3 Q. Yes, page 44. You have that in
4 front of you?

5 A. Hmm-mm.

6 Q. What is this policy?

7 A. This is the protocol involved in
8 transferring the patient or admitting the
9 patient from emergency room under the
10 inpatient unit.

11 Q. From the medical emergency room?

12 A. No. We're talking about from
13 psychiatric emergency room to psychiatric
14 inpatient unit.

15 Q. I see. So where it says here
16 the policy a patient may be admitted from
17 the emergency room to the psychiatric
18 inpatient unit only after the evaluation in
19 the emergency room by a member of the
20 department of psychiatry?

21 A. Right.

22 Q. The references in that policy
23 stating to the emergency room, are referring
24 to psychiatric emergency room?

25 A. Psychiatric emergency room.

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Q. And this case, Jamaica Hospital has medical ER and a psychiatric ER; is that right?

A. That's right.

Q. And in 2009, that was also true, Jamaica Hospital had a medical ER and a psychiatric ER?

A. Yes.

Q. In the procedures it says each patient admitted to the psychiatric inpatient unit should have a medical clearance documented in the medical records by the emergency room staff. You see that?

A. Yes.

Q. Does that mean that all of the patient's medical records are taken from the psych ER and then sent up to the ward. Is that what this means?

A. Yes. I think what this means is that before admitting the patient to the psychiatric inpatient, we had to do what's called a medical clearance, meaning patient has to go on physical and medical clearance and that's done by a internist, not by a

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psychiatrist or a primary care physician.
And if they are medically stable and don't
need any acute medical treatment, they will
be admitted to psychiatric inpatient. Or
they will be followed by medical attending.

Q. If a patient comes to the
hospital through the medical ER --

A. Yes.

Q. -- unit and is there a policy in
place for having a patient medically cleared
by the medical ER unit before the patient is
transferred to the psychiatric emergency
room?

A. Yes.

Q. Why is that?

A. Because when a patient comes to
the medical ER, that's considered as a
medical emergency and before we transfer the
patient to psychiatric ER, we want to make
sure that they don't need any acute medical
care.

Q. Does this policy that we are
looking at right here, page 44, does this
policy require that the records of the

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VINOD DHAR, M.D.

documents in the medical records obtained when the patient goes into the medical ER that those records be transmitted to the psychiatric ER?

A. Yes.

Q. So in the circumstances when a patient comes into the hospital first through the medical emergency room, am I correct then that it's the policy to have that entire file sent to psychiatric emergency room?

A. Yes.

Q. And then in the procedures, there is a list of A, B, C and D. Do you see that?

A. Yes.

Q. There are these references to these tests CBC, CMP and any other blood test felt by the examining physician to be clinically indicated, you see that?

A. Yes.

Q. What is CMC and CMP?

A. CBC means basically your blood count, about the red cells and the white

1 VINOD DHAR, M.D.

2 cells any differential count. CMP means
3 your comprehensive metabolic profile, means
4 your liver enzymes, your kidney enzymes,
5 your muscle enzymes, all comprehensive
6 testing is done.

7 Q. Why is that done?

8 A. Because psychiatric patient who
9 take medications, like any other medication,
10 can have some side-effects and in order to
11 make sure that there are no changes, so we
12 need to have a baseline workup. So that if
13 there are any changes we know that it's
14 because of this treatment or this medication
15 and also, to rule out any condition that has
16 been silent there and patient not knowing.
17 In our patients -- most of our patients
18 don't take care of themselves. They are
19 chronically sick patients. They don't care
20 of their medical problems and that's why
21 this provision was made that they would have
22 a separate physical examination.

23 Q. On the next page is number 5,
24 talks about the admitting psychiatrist will
25 be responsible for determining that valid

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VINOD DHAR, M.D.

legal papers are completed, what is that referring to?

A. That's referring to same form that we talked about, form 747.

Q. And it goes on to say "in the case of involuntary admission a licensed emergency room physician may act as a certifier." What is that a reference to?

A. It's the same thing that certifier in this emergency room will be admitting psychiatrist.

Q. Then the next paragraph says "the emergency room staff calls the inpatient unit for bed assignments."

A. Yes.

Q. What is that?

A. Well, when you admit the patient you need to have a bed on the inpatient unit. And so once you admit the patient, you need to know what bed patient will be assigned. They say the patient going to bed 204 because that bed is available right now. So the patient will be admitted to bed 204. You could see on the record there is

1 VINOD DHAR, M.D.

2 admitted to bed 204.

3 Q. Would that availability of a bed
4 assignment have an impact on whether or not
5 somebody is going to be admitted
6 involuntarily to the hospital?

7 MR. RADOMISLI: Objection to
8 form.

9 A. Yes.

10 Q. Why?

11 A. I'm jumping here. Because if we
12 need to admit the patient on an involuntary
13 basis, we have to have a bed available
14 inpatient. If we don't have a bed, then we
15 make arrangements for the patient to be
16 transferred to some other hospital where
17 beds are available.

18 Q. What other hospitals does
19 Jamaica Hospital avail itself of to
20 effectuate this practice or policy?

21 A. Well, we available all the
22 hospitals in Queens. We call LIJ, Elmhurst
23 Hospital, there used to be this hospital
24 that's closed now and whatever hospital --
25 Gracey Square, we sent patients sometimes.

1 VINOD DHAR, M.D.

2 Q. What about the availability of
3 insurance, does that have any impact on
4 whether or not a patient will be
5 involuntarily admitted to the hospital?

6 MR. RADOMISLI: This is now
7 beyond what's already been covered. So
8 I am going to direct him not to answer.

9 MR. SMITH: The judge's ruling
10 was very clear.

11 MR. RADOMISLI: Well -- doesn't
12 mean it's beyond the scope of court
13 order.

14 MR. SMITH: Well, I think the
15 judge was very clear that no objections
16 with instructions not to answer will be
17 made except to preserve privilege.

18 MR. RADOMISLI: I'm sure he was
19 not considering whether it would be
20 within the scope of the EBT. I mean,
21 there is still some basic parameters
22 and that's what the -- what's the
23 purpose -- that's what needs to be
24 adhered to.

25 Q. Turn back to page 17, the

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emergency admission status policy, there's a phrase substantial risk of physical harm. You see that?

A. Yes.

Q. How is that risk measured?

A. Like I mentioned before, there is no specific tools. It is measured based on the history available, circumstances patients coming to the emergency room and the collateral information.

Q. How does the hospital go about measuring whether or not the risk of physical harm is substantial?

MR. RADOMISLI: Objection to the form. You could answer.

A. It's not really defined. It's clinical judgment and based on that clinical judgment, you make a determination.

Q. Can a patient be held pursuant to this emergency status policy if the patient is acting bizarre?

A. Yes.

Q. Can a patient be involuntarily committed under this policy if they're

1 VINOD DHAR, M.D.

2 acting in an agitated manner?

3 MR. RADOMISLI: Objection to the
4 form.

5 A. Any other conduct what's
6 mentioned in the law based on the clinical
7 judgment, any other behavior can be
8 considered as a risk. Yes, patients can be
9 put in the emergency room if they're
10 agitated or they're acting bizarre.

11 Q. Is there anything more that is
12 required, other than a label or the
13 conclusion that the person is acting
14 bizarre?

15 MR. RADOMISLI: Object to the
16 form. Go ahead.

17 A. That is a sense of the
18 evaluation that when a patient comes or the
19 person comes, any definition by others, the
20 admitting physician has to determine what
21 does it mean by being bizarre and how does
22 that impact the dangerousness of the
23 patient.

24 Q. Can you define for me what kind
25 of the behavior qualifies as bizarre

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VINOD DHAR, M.D.

behavior that is sufficient to involuntarily
commit somebody under this policy of
Jamaica's?

MR. RADOMISLI: Objection to
form.

A. I can give a number of examples.
Patient is at home, locks himself up,
threatens his mother or he goes out, takes
his clothes off, runs around the
neighborhood, stands in front of -- on the
traffic light and starts preaching Bible and
any -- or starts running around the traffic
or highway, walking on the highway.

Q. Is it your view that all of that
behavior would qualify somebody for
involuntary commitment in the hospital?

MR. RADOMISLI: Under this
policy?

Q. Under this policy?

MR. RADOMISLI: Objection to
form.

A. Yes. Whatever called them to
come to the hospital and then determination
will be made whether they remain risk or

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VINOD DHAR, M.D.

dangerousness. Then they will qualify for admission.

Q. I don't understand that answer. Can you explain that?

A. All patients that come with bizarre behavior doesn't necessarily qualify for inpatient hospitalization. If we determine that it's because of a mental illness or some emotional disturbance, then we can make assessment of patient being admitted to the hospital or in the absence of mental illness, if the behavior causes potential risk of harm to himself, then we can admit the patient.

Q. Is it a potential risk or is it a substantial risk that is required under the hospital's policy for involuntary --

A. Substantial risk. I'm sorry.

Q. It's a substantial risk; is that correct? So it's not sufficient if there is a potential risk, in other words to admit; isn't that right?

MR. RADOMISLI: Pursuant to the policy.

1 VINOD DHAR, M.D.

2 Q. Pursuant to the policy?

3 A. Substantial risk is to prevent
4 the potential risk.

5 Q. My question is if you have a
6 risk, but it's only a potential risk, is
7 that sufficient to qualify as a substantial
8 risk under the policy?

9 A. Under the policy, yes.

10 Q. So any risk is a substantial
11 risk under the policy?

12 A. Under the policy for 9.39, yes.

13 Q. Why is that?

14 A. Safety.

15 Q. The safety of whom?

16 A. The person.

17 Q. What does the term substantial
18 risk mean to you, Doctor?

19 A. It's a very undefined term that
20 is used by different agencies by different
21 professionals. There's a patient in the
22 nursing home, there is a patient coming from
23 -- patient living in the home by himself, he
24 is -- has no food, has no heat, and if the
25 neighbors complain that he's smelling. So

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VINOD DHAR, M.D.

somebody will go there and make an assessment and if what they find there is potentially a dangerous situation, they will remove the patient and bring to the emergency room. So there is a substantial, as well as, potential.

Q. Isn't there a difference in your mind between any risk and substantial risk?

MR. RADOMISLI: I'm going to object to the extent you're asking for his mind. If you want to ask whether it's a policy --

MR. SMITH: Okay. Fine. I will ask what the policy is and see if he thinks there's any distinction either because we are mincing words here.

Q. Under the Jamaica Hospital policy, is there any difference between a potential or any potential risk of dangerousness and a substantial risk of dangerousness?

A. Again, it's a clinical judgment. I don't think it's defined in the policy.

Q. In your opinion, is there a

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VINOD DHAR, M.D.

difference between any potential risk and a substantial risk of dangerousness?

MR. RADOMISLI: He is here as a 30(b)(6) witness.

Q. Okay. You can answer the question.

MR. RADOMISLI: No, he can't.

MR. SMITH: You're instructing him not to answer that question?

MR. RADOMISLI: It's not proper of a 30(b)(6) witness. You know that.

MR. SMITH: No, I don't.

MR. RADOMISLI: I cited a case. Don't answer that question. It's not proper.

Q. Does the term substantial risk, as defined in the Jamaica Hospital policy, include any risk of harm?

A. Yes.

Q. So under Jamaica's policy, any possible risk is a sufficient basis in which to involuntarily admit somebody, because of the conclusion that they are dangerous to themselves or others; is that correct?

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MR. RADOMISLI: Objection to the form.

A. Yes.

Q. Is part of Jamaica's policy in making this assessment about risk of dangerousness to seek out to protect the community, as well as, the patient?

A. Both.

Q. I'm sorry?

A. Both patient, as well as, the community.

Q. Why is the hospital involved in seeking out to make the community safe?

MR. RADOMISLI: Objection to form.

A. Because article 9.39 is safety for patient and others.

Q. So Jamaica Hospital views one of its roles under 9.39 is to make the community safe?

MR. RADOMISLI: Objection to form.

A. I don't think it's question of making the community safe. It's making --

1 VINOD DHAR, M.D.

2 actually, yes, it's a mental and as a
3 patient rule in the Jamaica Hospital will
4 not discharge the patient if we find out
5 that the patient can be potentially risk of
6 the community. Yes, we hold him.

7 Q. But you not only hold him, but
8 you will admit him involuntary if you think
9 there's a risk to the community, right?

10 MR. RADOMISLI: Objection to
11 form.

12 A. Right.

13 Q. And you will do so even if you
14 think there is only a potential risk to the
15 community; is that right?

16 MR. RADOMISLI: Objection to
17 form.

18 A. Yes.

19 Q. Is there a distinction in your
20 mind between admitting a patient involuntary
21 and committing a patient involuntarily?

22 MR. RADOMISLI: Objection.

23 A. Involuntary commitment is the
24 legal term and admission is the medical
25 term.

1 VINOD DHAR, M.D.

2 Q. But the way we have been using
3 it today, they both mean the same thing?

4 A. Same thing, yes.

5 Q. Does Jamaica's policy on the
6 assessment of patients for dangerousness,
7 include within it, a concept of hold and
8 stabilize a patient?

9 A. Hold and admit. Not stabilize.

10 Q. What does that mean, hold and
11 admit?

12 A. Hold, evaluate and if necessary,
13 admit.

14 Q. Are you familiar with the phrase
15 hold and stabilize?

16 A. There is, but emergency rooms
17 are not meant for stabilizing. There is a
18 timeframe and the volume and if I may add,
19 that's why new CPEP came into being.

20 MR. RADOMISLI: You're talking
21 about psychiatric?

22 THE WITNESS: I'm talking about
23 psychiatric, yeah.

24 Q. Why did the CPEP come into play?

25 MR. RADOMISLI: Objection, but

1 VINOD DHAR, M.D.

2 he's already --

3 A. Because CPEP has a provision for
4 72-hour observation.

5 Q. What is that about?

6 MR. RADOMISLI: We are really
7 getting beyond.

8 MR. SMITH: I know, but I'm
9 trying to understand -- the phrase hold
10 and stabilize was used in case with
11 respect to this plaintiff. I am trying
12 to understand whether or not that's
13 part of the policy and practice of
14 Jamaica Hospital.

15 MR. RADOMISLI: Can you just
16 tell me where it was used 'cause it
17 doesn't sound familiar to me?

18 MR. SMITH: You have the chart
19 right there.

20 THE WITNESS: I can -- I can --

21 MR. RADOMISLI: Nat, I will talk
22 to you outside.

23 MR. SMITH: Okay, good. We're
24 going off the record. It's 2:28.

25 (Whereupon, a recess was taken.)

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VINOD DHAR, M.D.

MR. SMITH: Back on the record.

It's 2:37.

Q. This term hold and stabilize, can you tell me what that means?

A. Well, actually it doesn't mean much. The term actually is hold and reevaluate. Some people use this term and I'm not familiar why they use this term. It's possible sometimes the patient can be treated within 24 hours or until all the information is available to make a final determination.

Q. Doesn't Jamaica Hospital's policy require that when a patient's brought in reportedly with a mental illness and reportedly engaging in conduct and making statements that create a substantial risk of physical harm, that a staff doctor conduct a comprehensive psychiatric as soon as possible, right?

MR. RADOMISLI: Objection, asked and answered.

A. Right.

Q. And there's no room in Jamaica

1 VINOD DHAR, M.D.

2 policy for holding a person for a period of
3 time while an assessment is yet to be done;
4 isn't that correct?

5 MR. RADOMISLI: Objection to the
6 form. You could answer.

7 Q. You can answer.

8 MR. RADOMISLI: If you
9 understand.

10 A. Yeah. Technically after 24
11 hours in the ER the standard of care, I
12 don't think it's in the policy, that gives
13 you time to make an evaluation and
14 assessment and determination whether or not
15 you want to admit the patient or discharge
16 the patient.

17 Q. So this 24-hour period, you're
18 saying there's no policy that's laying out a
19 24-hour period?

20 A. There is no time determination
21 about that.

22 Q. So in 2009, there was no policy
23 at the hospital that required that a patient
24 brought in for an alleged mental illness be
25 evaluated as soon as possible?

1 VINOD DHAR, M.D.

2 MR. RADOMISLI: Objection to
3 form.

4 A. As soon as possible.

5 Q. The policy was to do the
6 evaluation as soon as possible, right?

7 A. Yeah.

8 Q. But earlier when I was asking
9 you questions about the difference between a
10 potential risk or any risk or substantial
11 risk, I think you said if there's any risk
12 that the patient would act in the dangerous
13 manner that the hospital could admit; do you
14 remember that?

15 MR. LEE: Objection to the form.

16 MR. RADOMISLI: Objection to the
17 form.

18 Q. Do you remember that?

19 A. Yes.

20 Q. When you said, yes, it's
21 possible for the hospital to the admit, did
22 you mean that it was possible for the
23 hospital to admit on an involuntary basis?

24 A. Yes.

25 Q. So just to be clear, you weren't

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saying that the patient could be admitted on a voluntary basis when we were talking about doing assessments about dangerousness; is that right?

A. Yes. Only involuntary, yeah.

Q. When a patient is brought to the hospital as potential involuntary admission under 9.39, was there any policy at the hospital with respect to restraining that person or patient?

MR. RADOMISLI: Objection to the form.

A. Depends upon the circumstances, the patient is out of control and poses a danger to the staff, yelling, he will be restrained. Now there is a difference between restrained, a mental health restrained and restrained by other means. We do restrain the patients, yes.

Q. How does Jamaica restrain patients?

A. If patient is out of control according to OMH guideline, it's called a four point restrain. We tie the patient

1 VINOD DHAR, M.D.
2 with the help of the staff, the clinical
3 staff, and until make sure they are safe and
4 meanwhile, they're given treatment,
5 medication, counseling and then they are
6 released and it should not last more than
7 one hour.

8 MR. SMITH: I want to show you
9 what's being marked as Exhibit 152.

10 (Plaintiff's Exhibit 152,
11 document, was marked for identification
12 as of this date.)

13 MR. SMITH: This is a seven-page
14 policy statement produced by Jamaica
15 Hospital in this case in discovery.

16 Q. Is this the Jamaica Hospital
17 department of psychiatry policy on the use
18 of restraints?

19 MR. RADOMISLI: Don't answer the
20 question. You know this is beyond the
21 scope. It wasn't even part of your
22 application. This deposition is to
23 deal with involuntary admission and
24 this is beyond the scope.

25 Q. Is it consistent with the

1 VINOD DHAR, M.D.

2 hospital's policy to permit a patient to be
3 handcuffed using steel handcuffs?

4 MR. RADOMISLI: Beyond the
5 scope. You know it's beyond the scope.
6 Don't answer the question.

7 Q. Is it consistent with the
8 hospital's policy to double-cuff a patient
9 to a hospital gurney?

10 MR. RADOMISLI: It's beyond the
11 scope of the deposition and the court's
12 order.

13 Q. When a patient is being assessed
14 for involuntary admission, is it consistent
15 or inconsistent with hospital policy to
16 permit restraints to be used, such that,
17 circulation of the patient is being
18 interfered with?

19 MR. RADOMISLI: It is beyond the
20 scope of the deposition, which is
21 limited to policy on involuntary
22 admission, per court order.

23 MR. SMITH: That's what I'm
24 asking about.

25 Q. Can locked restraints ever be

1 VINOD DHAR, M.D.

2 used on involuntary patients?

3 MR. RADOMISLI: Objection.

4 Don't answer the question. It's beyond
5 the scope according to the court.

6 MR. SMITH: Does not go beyond
7 the scope.

8 MR. RADOMISLI: Has nothing to
9 do with involuntary admission.

10 MR. SMITH: Just asking if it
11 has to do with involuntary admission.
12 I will ask it again, just so it's
13 clear.

14 Q. Are the use of locked restraints
15 consistent or inconsistent with Jamaica's
16 policy with respect to involuntary
17 admissions or people being considered for
18 involuntary admissions to the hospital for
19 dangerousness assessments?

20 MR. RADOMISLI: That's beyond
21 the scope, because you're going to a
22 policy other than a policy on
23 involuntary commitment.

24 MR. SMITH: The judge has
25 already directed you not to instruct

1 VINOD DHAR, M.D.

2 the witness not to answer questions,
3 other than for privileged purposes and
4 now you're vagrantly violating the
5 judge's orders.

6 MR. RADOMISLI: It's not my
7 intention to violate the judge's order.
8 I don't think what was anticipated is
9 that you abuse this deposition to go
10 beyond what was a previously court
11 ordered limited scope deposition, and
12 actually, come to think of it, it's my
13 position you're violating the prior
14 court order by asking these questions
15 because the scope of this examination
16 was specifically limited to the policy
17 on involuntary commitment --
18 involuntary hospitalization.

19 MR. SMITH: Well, I know. I
20 understand, you've just said that. I
21 don't think how what the policies of
22 the hospital are -- you know, Greg, I
23 will try one more time and this
24 document that I have just shown this
25 witness was produced by your office.

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It comes from the department of psychiatric. It says department of psychiatric, psychiatry manual and it's governing the use of restraints for patients who are there, among other things, involuntarily and so I don't know what else to say.

MR. RADOMISLI: I don't know what else to say either. I am not disputing that. You didn't ask for the witness to testify about this policy when it was discussed before the court, as far as I recall. If you did ask for it, it wasn't granted because there are only four topics that are permitted to ask this 30(b)(6) witness about. This is not one of those topics. The use of restraints is not one of those topics.

I'd also add that you already asked Dr. Lewin about this issue because she did her evaluation while your client was in the handcuffs, where I did not restrict you, because there was no prior court order. Here there

1 VINOD DHAR, M.D.

2 is.

3 MR. SMITH: We are going to go
4 off the record. I want to talk with my
5 colleague and see how we're going to
6 proceed. It's 14:50.

7 (Whereupon, a recess was taken.)

8 MR. SMITH: Going back on the
9 record. It's 14:54.

10 Q. Doctor, I just have a few more
11 questions then I'm done. Subject to having
12 you brought back, because your counsel has
13 interfered with some of my questions, but
14 for today at least.

15 If a patient is brought into the
16 medical emergency room, is there anything in
17 the Jamaica Hospital policy that includes
18 the comprehensive psychological evaluation
19 being conducted while a patient is in the
20 medical emergency room as opposed to waiting
21 until the patient is the transferred, if the
22 patient is transferred to the psychiatric
23 emergency room?

24 MR. RADOMISLI: Objection to
25 form.

1 VINOD DHAR, M.D.

2 A. You cannot do a comprehensive
3 evaluation. You can do what's called a
4 psychiatric consult. That means based on
5 the information and based on the mental
6 status, you make a determination whether the
7 patient will stay in the medical ER or he
8 can be transferred to psych ER needing
9 psychiatric treatment.

10 Q. Who makes that decision?

11 A. Psychiatrist.

12 Q. So why can't the psychiatrist do
13 the full blown comprehensive psychiatric
14 evaluation in the medical ER?

15 MR. RADOMISLI: Objection to
16 form.

17 A. It's a comprehensive evaluation.
18 Medical ER is very busy, don't have all the
19 information and especially if there is a
20 risk of dangerousness and if there is no
21 need for medical treatment, then the patient
22 will be transferred to psychiatry.

23 Q. Who does this consultation as
24 opposed to this comprehensive psychiatric
25 evaluation?

1 VINOD DHAR, M.D.

2 A. It is done by a psychiatrist, a
3 staff psychiatrist.

4 Q. Then does that consultation then
5 trigger the 48-hour period and the
6 requirements that the patient be given the
7 notices and the rights that we talked about
8 earlier?

9 A. No.

10 Q. Why not?

11 A. The 48 hours starts the minute
12 the patient is admitted and registers in the
13 psych ER.

14 Q. What authority is there in
15 Jamaica's policies to hold somebody in the
16 medical ER prior to a comprehensive
17 psychiatric examination being conducted?

18 MR. RADOMISLI: Objection to
19 form. Go ahead.

20 A. Because patient is kept in the
21 medical emergency room only to make sure
22 that there's no acute medical problems and
23 necessity for discharge or medical -- or
24 psychiatric treatment. That is the premise
25 of the consultant. Based on the information

1 VINOD DHAR, M.D.

2 that the patient can be discharged, whether
3 the patient doesn't have an acute illness or
4 suffered some illness and there's a sense of
5 dangerousness. Then that will be taken to
6 the psychiatric emergency room.

7 Q. My question is what authority in
8 Jamaica's policy is there, if there is any,
9 to hold somebody against their will
10 involuntarily in the medical ER before the
11 comprehensive psychological evaluation is
12 conducted?

13 MR. RADOMISLI: Objection to
14 form.

15 A. They have the patient is --
16 until the patient is medically cleared, they
17 will hold the patient.

18 Q. What I want to know is what
19 authority does the hospital have for holding
20 the patient under those circumstances?

21 MR. RADOMISLI: Objection.

22 A. I think medical ER policy.

23 Q. Is there a written policy that
24 authorizes Jamaica Hospital to hold a
25 patient pending a psychiatric consult?

1 VINOD DHAR, M.D.

2 A. Yes.

3 MR. RADOMISLI: Objection.

4 Q. And is that in writing, that
5 policy?

6 A. It has to be, but if you look
7 at 9.39 there is a provision there that any
8 psych emergency room doctor can transfer the
9 patient to psychiatric emergency room. Any
10 medical emergency room physician can
11 transfer patient to psychiatric emergency
12 room per 939.

13 Q. But if that was done under
14 Section 939, then Section 939 would have
15 been invoked and the timeframes required by
16 939 would start running; isn't that right?

17 A. That's right, but the hospital
18 policy is patient not to be -- until the
19 patient is transferred to psychiatric
20 emergency room, the 939 will start at that
21 time.

22 Q. I understand that, Doctor. What
23 I want to know, if the patient is brought
24 into the medical ER and is being held
25 against their will, but they have not been

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VINOD DHAR, M.D.

evaluated by a psychiatrist, either in an informal consultation or a comprehensive, is there any authority in the hospital's written policies for holding that person against their will prior to them being assessed by a psychiatrist?

MR. RADOMISLI: Objection to form.

A. I am sure there is a policy. It again, depends on the clinical judgment of the medical ER doctor. If they feel that the patient needs to be restricted pending a psychiatric evaluation, they have that authority to keep the patient under observation.

MR. SMITH: I'm going to make the request for the production of that policy statement.

Q. What authority are you referring to?

MR. RADOMISLI: Objection to form.

A. The hospital -- I'm not sure about what authority the medical people

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have, but there has been policy.

Q. Other than Section 9.39, are you aware of any other rule that allows a hospital to hold somebody against their will for purposes of an involuntary commitment for mental illness that has a substantial risk of dangerousness associated with it?

MR. RADOMISLI: Objection.

A. 939 is only for mental health. Emergency rooms, medical emergency rooms, have their own policy by department of health, DOH. So that will be covered under their jurisdiction. 939 starts only when a patient is transferred to psychiatric emergency room, which is the designated 939 hospital. Every hospital does not have a 939 room.

Q. In 2009, did Jamaica have a 939 room?

A. Yes.

Q. And a 939 room is a separate psychiatric emergency room, right?

A. Yes.

Q. And that's what it was in 2009,

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correct?

A. Yes.

Q. In this case, the patient was brought into the hospital on late in the evening of October 31, 2009 and he was not evaluated by Dr. Bernier until November 2, 2009 and then the form was not executed by Dr. Bernier until November 3, 2009. What I want to know is during the period from when the patient was first brought into the hospital up until the point that Dr. Bernier signed the form 7 point -- 474, what was the authority that the hospital had for holding that patient?

MR. RADOMISLI: Objection.

A. I cannot answer.

Q. You can't answer it.

MR. SMITH: All right, subject to the questions that weren't answered, I don't have any more questions at this time. I am going to make an application to the court to have the witness brought back. The judge is away. We waited for more than a half

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an hour to get a ruling the first time and so I'm not going to hold the deposition for that purpose now.

MR. RADOMISLI: Well, we did get a ruling and so if there are questions that you want to ask, other than the ones that I objected to on the ground that they were beyond the scope of the deposition, I suggest you ask them. Otherwise, they should not part of your application, because you have the opportunity now.

The only objections I would be asserting is if it's beyond the scope pursuant to a prior court order or under privilege.

So do you have anything that doesn't fall within that?

MR. SMITH: I don't have any more questions, other than the questions that you refused to let the witness answer and any rational follow-ups from the answers that he gave.

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MR. RADOMISLI: On the grounds -- refused to let the witness answer on the grounds that they were beyond the scope of the deposition. Correct.

MR. SMITH: Well, you've instructed him not to answer a lot of questions. I don't know if you were so clear about the scope, but I think we're on the same page here. If I had something else that was clearly not in an area that you and I had a disagreement about, I'd ask it, but nothing else comes mind.

MR. RADOMISLI: What I'm saying is if you want to make your application, you can make the application insofar as I objected to questions and didn't let him answer questions on the grounds that they were beyond the scope of the deposition. Any other objections that I may have made, I am not permitted to make pursuant to the court's order. So if there are any other questions, other

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than the ones I objected to on the grounds of beyond the scope, those you have the opportunity to ask now and if you don't, then I am going to argue that they should not be part of your application.

MR. SMITH: Okay.

EXAMINATION BY

MR. CALLAN:

Q. Doctor, I represent Dr. Aldana-Bernier in this lawsuit. Can you tell me, sir, do you have a recollection back in November 2009, what your general work schedule was, what hours you'd be at the hospital?

A. Generally 8:30 to 4:30. I am on-call all the time.

Q. Do you get into the hospital on the weekends, as well as Monday to Friday?

A. I do come on the weekends if there is a need.

Q. And your position in the chain of command in psychiatry is you were the number two person; is that correct?

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2 A. Number two, right.

3 Q. So Dr. Aldana-Bernier would
4 report to you in the chain of command?

5 A. She does report to me, yes.

6 Q. With respect to the Adrian
7 Schoolcraft matter, I think you've said you
8 had no involvement in the case; is that
9 right?

10 A. I had no involvement in the case
11 as far as legal proceedings and the
12 treatment is concerned.

13 Q. Is it possible that you spoke to
14 Dr. Aldana-Bernier about Adrian Schoolcraft
15 at any time during his treatment in the
16 psychiatric emergency room?

17 MR. SMITH: Objection to form.

18 Q. You could answer.

19 A. It's possible.

20 Q. Now, you made some general
21 comments about comprehensive psychiatric
22 evaluation of patients. Is it accurate to
23 say, sir, that a comprehensive evaluation of
24 a psychiatric patient would include
25 reference to matters that may have happened

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2 in the initial admission stage to the
3 medical emergency room, would that be part
4 of the whole evaluation process?

5 A. Even before that. Certainly
6 proceeding --

7 Q. So certainly anything that the
8 ER residents became aware of, if noted in
9 the record or communicated to the
10 psychiatric staff, would certainly be
11 considered, that could be considered in a
12 comprehensive evaluation; is that correct,
13 sir?

14 MR. SMITH: Objection.

15 Objection to form. Leading.

16 A. Yes.

17 Q. And if hypothetically, the
18 police said something indicating that the
19 patient was a threat to himself or somebody
20 else, and I'm not just talking about Mr.
21 Schoolcraft, I'm talking about patients in
22 general, that would be something that would
23 be considered in a comprehensive evaluation?

24 MR. SMITH: Objection. Leading.

25 A. Yes.

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2 MR. CALLAN: I have no further
3 questions.

4 MR. LEE: I just have one.

5 EXAMINATION BY

6 MR. LEE:

7 Q. Under the Jamaica policy under
8 939, once the first doctor signs the form,
9 that patient is admitted to the hospital,
10 correct?

11 A. Yes.

12 MR. SMITH: You mean once the
13 patient or once the doctor?

14 THE WITNESS: Patient doesn't
15 sign any forms. The doctor.

16 Q. Once the first doctor signs the
17 form under 9.39, even pending the 48-hour
18 evaluation, once the first doctor signs, the
19 patient is admitted to the hospital?

20 A. Yes. I mean, that form is
21 signed only when the determination is made
22 that the patient needs to be admitted.

23 MR. LEE: Thank you.

24 MR. SMITH: Just a follow-up on
25 that.

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2 EXAMINATION BY

3 MR. SMITH:

4 Q. Is there any reason why a doctor
5 at Jamaica would make a decision on one day
6 and then delay signing the form until the
7 next day?

8 MR. RADOMISLI: Objection,
9 speculation, but go ahead.

10 A. When you make a decision that
11 patient needs to be admitted on the
12 psychiatric grounds, then you had to do all
13 this blood work and everything else to get
14 the medical clearance. So the actual
15 admission date or time is different than
16 when the doctor says that patient needs to
17 be hospitalized, because all the other
18 things are to be considered.

19 Q. I am not sure you're answering
20 my question. My question is if the
21 patient's assessment has been conducted and
22 the comprehensive evaluation has been
23 conducted and medical examination has been
24 conducted, is there any reason why this
25 staff psychiatrist in the psych ER would

1 VINOD DHAR, M.D.

2 wait a day when signing the form admitting
3 the patient?

4 MR. RADOMISLI: Objection to the
5 form and substance, but you can answer.

6 A. There are number of factors,
7 yes. Availability of the bed. We don't
8 know whether the patient admitted to Jamaica
9 or transferred somewhere else and if the
10 patient has insurance, we need to get the
11 authorization approved for the insurance
12 company.

13 Q. Any other reasons?

14 A. Not that I am aware of.

15 Q. In this case, the patient was a
16 member of the police department. Are you
17 aware of any practices or policies at
18 Jamaica that requires that a involuntary
19 admission of a police officer has to be
20 reviewed by somebody else, other than the
21 initial assessment conducted by the staff
22 physician?

23 A. As far I am concerned, there is
24 no such policy, the physician does clinical
25 work and they do the determination.

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Q. Is there anything about a patient being a member of the police department that changes the hospital policy with respect to how an involuntary admission is conducted?

A. Absolutely not. There is relevance.

MR. SMITH: All right, thank you. Going off the record. It's 15:12.

(Time noted: 3:12 p.m.)

VINOD DHAR, M.D.

Subscribed and sworn to before me this

----- day of ----- 2014.

-----, Notary

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CERTIFICATE

I, DENISE ZIVKU, a Professional Reporter and Notary Public within and for the State of New York, do hereby certify:

That VINOD DHAR, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that the within transcript is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 28th day of July, 2014.



DENISE ZIVKU

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