

EXERCISE

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Below is an example of an expert witness report:

The following represents my Rule 26 Report in the matter of Hurt v. Brown & Drecker. It is based on review of materials submitted to me by your office (enumerated later), my involvement in cases involving accidents while using Brown & Drecker and other brands of miter saws, my education and experience as a mechanical engineer and my experience designing and using miter saws and other power tools as well as my knowledge of Brown & Drecker” policies and procedures during and subsequent to my employment there. I reserve the right to amend this report if other evidence becomes available.

Summary of Accident:

Mr. Hurt was operating a Brown & Drecker Model 100 power miter saw at the time of the accident. He was cutting an approximately six inch length off the right end of a long piece of shoe molding. With his left hand Mr. Hurt was holding the molding against the saw’s table and fence while his right hand operated the saw’s trigger and brought the saw blade downward to cut the wood.

Mr. Hurt was using the saw in an expected manner to cut wood molding that the saw was designed to cut. Nothing that Mr. Hurt was doing during or immediately prior to the accident was unusual or unexpected to a qualified design engineer designing a power miter saw.

Shoe molding is a standard wood molding which approximates an unequal one-fourth of a circle. It is approximately three-quarters of an inch high, three-eighths of an inch thick and the other side is a smooth curve. Normally it is made of a soft wood such as white pine.

Professional Opinions and Basis for these Opinions:

In my professional opinion the subject miter saw was unsafe and unreasonably dangerous when it was designed and manufactured for one or more of the following reasons: It should be noted that contact of a hand or other body part with a spinning saw blade has been recognized for many

years in the industry as a hazard which can result in serious injury, amputation or death. Therefore, safe design of a miter saw requires that the operator be protected from that spinning blade during all foreseeable uses and misuses of the saw. Obviously, part of the blade must be exposed to the workpiece in order to cut wood, but exposing additional blade to accidental contact with the operator is an unsafe practice.

1. Because the lower blade guard is retained in its guarding position only by the force of gravity the lower blade guard is easily and readily moved from its guarding position by a small force imparted from the workpiece and/or hand. The spinning saw blade is thereby exposed to the operator allowing them to be injured. Prior to the date of manufacture of this saw and prior to the date of the accident, Brown & Drecker and other manufacturers have made miter saws using a lower blade guard which is moved by a linkage assembly. This type of guard will not move from its guarding position when hit by the workpiece or a hand. If the link-driven guard had been installed on this saw Mr. Hurt would not have been injured.

2. The lower blade guard, as provided on this saw, rests of the top of the fence when small cross-section pieces of wood are being cut. This raised the lower blade guard higher than required to cut the wood and thereby exposes saw blade teeth to accidental contact by the operator's hand. If the miter saw had a larger opening in the fence, or the lower guard were of the linkage-driven design, no extra blade would have been exposed.

3. It is most likely that prior to being injured Mr. Hurt released the trigger switch that controls power to the saw's motor. Had the saw been equipped with an automatic blade brake which is actuated by releasing the trigger switch, the blade would have stopped or slowed prior to Mr. Hurt's contacting the blade. Brown & Drecker made miter saws with such an automatic blade brake as early as 1976. These would stop a saw blade typically in less than two seconds. As the time between releasing the trigger switch and contacting the saw blade is not known, the speed of the saw blade at the moment of hand contact cannot be determined but any decrease in blade speed would have resulted in a less-serious accident.

4. One of the requirements of proper safety engineering is to evaluate the adequacy of the safety systems during actual consumer usage. Specifically, the adequacy of the blade guarding to prevent accidental contact with the spinning saw blade. To do this properly a company must collect and analyze accident information to determine how an accident happened, detect trends in accidents, evaluate alternative designs including those used by other manufacturers, determine whether an alternative design would provide superior safety and, if so, rapidly incorporate this change into production

saws. Brown & Drecker failed to do this because their Records Retention Policy required them to destroy all information on an accident immediately after a lawsuit was settled or otherwise closed thereby denying them the ability to detect long-term trends in accidents. Further, as evidenced by Brown & Drecker failing to produce any record of analysis of miter saw accidents or discussions of alternate guard designs and their effectiveness, clearly reveals that the required feedback and evaluation step was lacking at Brown & Drecker.

It was recognized by some miter saw manufacturers in the early to mid-1970's that one of the more common accidents was caused by the operator's arm, hand or finger(s) moving the lower blade guard out of its guarding position and allowing contact with the spinning saw blade. Analysis of the method of injury of the lawsuits filed against Brown & Drecker as early as early to mid-1970's would have come to the conclusion that a gravity-actuated guard was inadequate since it can readily be deflected from its guarding position and was therefore unsafe and that a link-actuated lower guard was a much safer type of guard for all miter saws. However, no evidence has been forthcoming that this analysis was ever performed and, therefore, Brown & Drecker still sold miter saws with the gravity actuated guard as late as 1996 when other miter saw manufacturers had all but abandoned that type of guard.

Information considered in Formulating the Above Opinions:

1. Video deposition of Mr. Hurt, volume 2.
2. Report of Dr. Lance Sherwood
3. Report of Dr. Margie Mullins
4. Deer Park Hospital Emergency Department triage Record, Operative Report, Post-operative Report and Consultation.
5. Inspection and testing of miter saws made by Brown & Drecker and other manufacturers including the B&D model 100 miter saw.
6. Knowledge, training and experience as a Mechanical Engineer including fourteen years experience in designing power tools including the first B&D miter saw.
7. Training and experience as a safety engineer and applying that to power tool design.

8. Knowledge of Brown & Drecker's policies and procedures during and subsequent to my employment there.

Attachments:

Attached and made a part of this report are my Curriculum Vitae (Exhibit A) and a list of cases I have testified, by deposition and/or during trial, in the past four years (Exhibit B). Also attached is a copy of Brown & Drecker's Records Retention Policy (Exhibit C) and selected pages from "Fundamentals of Industrial Hygiene" (Exhibit D).