IN THE SUPREME COURT OF THE STATE OF NEVADA

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DIPAK KANTILAL DESAI

Petitioner,

vs

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, COUNTY OF CLARK, THE HONORABLE KATHLEEN DELANEY, DISTRICT JUDGE,

Respondent,

and

THE STATE OF NEVADA,
Real Party in Interest.

Case No. 60038

District Court Case Number:

10C265107

ANSWER TO PETITION FOR WRIT OF PROHIBITION/MANDAMUS

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IN THE SUPREME COURT OF THE STATE OF NEVADA

DIPAK KANTILAL DESAI Petitioner, vs THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, COUNTY OF CLARK, THE HONORABLE KATHLEEN DELANEY, DISTRICT JUDGE, Respondent, and THE STATE OF NEVADA, Real Party in Interest.	Case No. 60038 District Court Case Number: 10C265107

ANSWER TO PETITION FOR WRIT OF PROHIBITION/MANDAMUS

COMES NOW, the State of Nevada, Real Party in Interest, by MARY-ANNE MILLER, Interim District Attorney, through her Chief Deputy, MICHAEL V. STAUDAHER, on behalf of the above-named respondents and submits this Answer to Petition for Writ of Mandamus in obedience to this Court's order filed January 18, 2012 in the above-captioned case. This Answer is based on the following memorandum and all papers and pleadings on file herein.

Dated this 23rd day of January, 2012.

Respectfully submitted,

MARY-ANNE MILLER
Interim Clark County District Attorney
Nevada Bar # 001419

BY *<u>/s/ Michael V. Staudaher</u>*
MICHAEL V. STAUDAHER
Chief Deputy District Attorney

MEMORANDUM OF POINTS AND AUTHORITIES

STATEMENT OF FACTS[1]

July 25, 2007

On July 25, 2007, Sharrieff Ziyad had an endoscopy procedure done at the Endoscopy Center of Southern Nevada on Shadow Lane. (Grand Jury Transcript) GJ1A at 75, 77. He arrived at the clinic at 7:00 am. GJ1A at 75. Dr. Dipak Desai was the doctor who performed his procedure. GJ1A at 78. Mr. Ziyad discussed the fact that he was Hepatitis C positive with Dr. Desai. GJ1A at 80. The Certified Registered Nurse Anesthetist ("CRNA") for the procedure was Ronald Lakeman. GJ5 at 58. Lakeman administered the anesthesia Propofol to Ziyad intravenously. Ziyad received more than one dose of anesthesia during the procedure. See GJ Exhibit 18, page 193.

The next patient who had a procedure done by Dr. Desai on July 25, 2007 was Michael Washington. GJ5 at 106-07. Mr. Washington underwent a colonoscopy at the Endoscopy Center of Southern Nevada. GJ1A at 119. The doctor who performed his procedure was Dr. Dipak Desai. GJ1A at 127. The CRNA who administered his anesthesia was Ronald Lakeman. GJ5 at 159. Weeks after the procedure, in September of that year, Mr. Washington began having health problems. His right side became swollen, his abdomen was tender, he lost his appetite, and his urine became dark. GJ1A at 131-32. He sought assistance from his primary care doctor at the VA hospital and was diagnosed with Hepatitis C. He had not been diagnosed with Hepatitis C before the procedure at the Endoscopy Center of Southern Nevada. GJ1A at 133.

September 21, 2007

Two CRNAs worked on September 21, 2007 at the Endoscopy Center of Southern Nevada: Ronald Lakeman and Keith Mathahs. GJ5 at 112.

[1] This statement of facts is based primarily on the grand jury presentation in this matter.

On September 21, 2007, Kenneth Rubino underwent a colonoscopy at the Endoscopy Center of Southern Nevada on Shadow Lane. GJ1A at 105. He arrived at the center for his procedure just after 7:30 in the morning. GJ1A at 107. The doctor who performed the procedure was Dr. Clifford Carrol. Years prior to this procedure, Mr. Rubino had been diagnosed as being Hepatitis C positive. GJ1A at 105. He had discussed this fact with Dr. Carrol. GJ1A at 106. On the day of the procedure, he again informed the staff at the center that he was Hepatitis C positive. GJ1A at 108. The CRNA for his procedure was Keith Mathahs. GJ5 at 64. Rubino was administered Propofol intravenously. Mathahs administered more than one dose of anesthesia to Rubino. See GJ Exhibit 18, page 193.

Rodolfo Meana had a colonoscopy performed at the Endoscopy Center of Southern Nevada on September 21, 2007. GJ1A. The doctor who performed his procedure was Dr. Desai. GJ Exhibit 41 The CRNA who administered his anesthesia was Keith Mathahs. GJ5 at 18. Sometime after the procedure, Mr. Meana felt nauseous, lost sleep, and suffered from depression, constipation, and diarrhea. His urine also became brownish in color. GJ1A at 99. He went to see his own doctor and was diagnosed with Hepatitis C. GJ1A at 100. He did not have Hepatitis C prior to having this procedure done at the Endoscopy Center. GJ1A at 102.

Sonia Orellana-Rivera had a colonoscopy done at the Endoscopy Center of Southern Nevada on September 21, 2007. GJ1A at 58, GJ Exhibit 35. The doctor who performed the procedure was Dr. Clifford Carrol. GJ1A at 63. The CRNA who administered her anesthesia was Keith Mathahs. GJ4A at 16. About six months after the procedure, Ms. Orellana-Rivera was notified of a possible problem by the Health Department. GJ1A at 66. She saw her family doctor and was informed that she had contracted Hepatitis C. GJ1A at 66.

Gwendolyn Martin had a colonoscopy performed at the Endoscopy Center of Southern Nevada on September 20, 2007. GJ1A at 158. She had an endoscopy done at the center the next day, on September 21, 2007. GJ1A at 159. Dr. Carrera

performed the endoscopy. GJ1A at 159. The CRNA who administered the anesthesia was Keith Mathahs. GJ5 at 25. Weeks after the procedure, Martin was sick and her urine became dark. GJ1A at 165. Ultimately, she went to a hospital emergency room and was diagnosed with acute Hepatitis C. GJ1A at 166. Since the diagnosis, she has had physical and mental problems. GJ1A at 170.

Carole Grueskin had a colonoscopy done at the Endoscopy Center of Southern Nevada on September 21, 2007. Her doctor was Dr. Carrera. GJ1A at 141. The CRNA who administered her anesthesia was Ronald Lakeman. GJ5 at 49. Before this procedure, she had not been diagnosed with Hepatitis C. GJ1A at 144. After the procedure, she became jaundiced. GJ1A at 150-51. After that, she was diagnosed with Hepatitis C. GJ1A at 153.

Stacy Hutchinson also had a colonoscopy performed at the Endoscopy Center of Southern Nevada on September 21, 2007. GJ1A at 173. Dr. Dipak Desai was her doctor. GJ1A at 174. The CRNA who administered her anesthesia was Ronald Lakeman. GJ5 at 42. Three weeks after the procedure, Hutchinson was ill, could not hold down food, and lost weight. GJ1A at 185. She was admitted to the hospital and became jaundiced. GJ1A at 186. Later, she was diagnosed with Hepatitis C. Five months earlier, she had been tested for Hepatitis C and the results were negative. GJ1A at 186-87.

On September 21, 2007, Patty Aspinwall underwent a colonoscopy at the Endoscopy Center of Southern Nevada. GJ1A at 200. Dr. Carrera performed the procedure. GJ1A at 208. The CRNA who administered anesthesia to her was Ronald Lakeman. GJ5 at 69. A few weeks after the procedure, Ms. Aspinwall felt nauseous and had no appetite. GJ1A at 211. A few weeks after that, she was jaundiced and was admitted to the hospital. She later tested positive for Hepatitis C.

Procedures: Endoscopy and Colonoscopy

The procedures all of these individuals underwent were out-patient procedures known as an endoscopy or colonoscopy.

An endoscopic exam involves inserting an endoscope into the patient's mouth. The scope has a camera on one end and it displays images on a monitor for the doctor to view. The scope is passed through the patient's mouth, esophagus, stomach, small intestine and duodenum. GJ1 at 35. A colonoscopy entails passing a scope through the patient's rectum and into the large bowel. GJ1 at 35. If polyps or other abnormalities are found, the doctor either removes them or takes a biopsy sample. GJ1 at 39. During both procedures, the patient is typically sedated. GJ1 at 36. For both procedures, the patient is interviewed about their medical history prior to sedation. Once the history has been taken, the patient is sedated and the scope is inserted. GJ1 at 37.

At the Endoscopy Center of Southern Nevada, nurses in the pre-op area of the facility would typically start the IV on the patient. GJ1 at 44. The CRNA would be responsible for obtaining the patient's medical history and administering Propofol to sedate the patient. GJ1 at 43-44. At the conclusion of the procedure, the CRNA would monitor the patient and, once satisfied that the patient was stable, would transfer the patient to the recovery room. GJ1 at 54.

Propofol

The medication used to sedate patients at the Endoscopy Center of Southern Nevada in 2007 was almost always Propofol. Propofol is rapidly metabolized by the body so additional dosing is often required during procedures. GJ1 at 47. Vials of Propofol come in various sizes. Propofol can act as a growth medium for bacteria if contaminated so it is labeled and directed to be single use only. GJ1 at 50.

Administering Propofol or any injected medication safely requires the practitioner to utilize "aseptic technique" which means prevention of infection or bacterial contamination; therefore, any device that enters the body cannot be reused. GJ1 at 48. To administer Propofol safely, the practitioner uses a new needle and new syringe to draw up the medication from a new vial and injects it into the patient via an intravenous catheter. If additional medication is needed, the practitioner can access

the vial again and repeat the process. GJ1 at 49. The needle and syringe can be reused on the same patient only. It is common knowledge that syringes are to be used only on one patient. GJ3 at 53. It would never be professionally acceptable to use the same syringe on two patients. GJ3 at 55. Moreover, a vial of Propofol should not be used on more than one patient because of potential for contamination. GJ1 at 49-50.

At the Endoscopy Center, Propofol was reused from patient to patient. GJ4A at 153. In fact, Keith Mathahs instructed another CRNA to reuse Propofol on subsequent patients, contrary to packaging instructions and aseptic technique. GJ4A at 82. CRNAs at the Endoscopy Center would be offered opened or used bottles of Propofol to use on subsequent patients. GJ6 at 47.

Transmission of Infection

The Southern Nevada Health District tracks cases of Hepatitis C infections. By law, doctors are required to report cases of Hepatitis C infections. GJ3A at 30. In an average year, the district receives reports of two to four cases. GJ3A at 30. Each case of Hepatitis C is investigated according to the District's protocol. GJ3A at 31. In December 2007, the Health District received reports of two cases of individuals who had both contracted Hepatitis C and who both had gone to the Endoscopy Center of Southern Nevada on different days—one in July and one in September. GJ3A at 34, 36. The Health District officials contacted the Centers for Disease Control ("CDC") for technical advice to investigate this matter. While the District was in contact with the CDC, a third case was identified. GJ3A at 36-37. At that point, the District requested assistance from the CDC in investigating these cases. GJ3A at 39.

Ultimately, investigators from the Health District and CDC went to the Endoscopy Center of Southern Nevada and observed procedures and investigated. GJ3A at 50-53. While at the clinic, investigators observed a number of unsafe practices.

The Health District investigated how the infection could have been transmitted. The Health District tested all employees at the clinic to discern whether an employee

could have transmitted the virus. GJ3A at 61. Evidence of Hepatitis C was not found in any of the clinic staff. They considered whether the biopsy equipment was used on an infected patient and then used on a subsequent patient. This also was not found to be the cause of the Hepatitis C transmission. They considered whether the endoscopes were cleaned improperly and thus caused the transmission. This was also determined not the cause of the transmission. They looked at procedures in the pre-op area of the center and found no indication that any of these practices caused the transmission. GJ3A at 62-67. The last thing the District investigators looked at was anesthesia injection safety issues. GJ3A at 69. Ultimately, the Health District investigators concluded that vials of Propofol and syringes were being reused. On July 25, 2007, there were 20 Propofol bottles used on 65 patients. GJ5 at 137. On September 21, 2007, there were 24 vials used on 63 patients. GJ5 at 137. They were able to rule out everything else. GJ3A at 71.

The investigation was somewhat challenged by the fact that the patient chart times were inconsistent. The nurses' charts and anesthetist chart times were not in agreement, indicating that patients and staff were in two places at one time. GJ3 at 25. In the procedure room, however, CDC representatives actually observed individual Propofol bottles being used on multiple patients, even though the medication is labeled as a single use only drug. An investigator also saw syringe reuse on an individual patient. GJ3 at 34. The CRNA who was observed reusing a syringe was Mathahs. GJ3 at 35. Mathahs's method was dangerous based on the following: if a CRNA opens a new Propofol bottle and has a new needle, the CRNA injects the syringe and needle into the patient; there can be some flush back from the patient's blood into the needle or syringe. If the CRNA removes the needle but keeps the same syringe, whatever blood was in the needle could have flushed back into the syringe. If the CRNA then puts a new needle on that syringe and returns to the Propofol bottle for additional anesthesia, the CRNA has a contaminated syringe and needle going into a vial of medicine. The vial of medicine can then be contaminated.

If that bottle is then used on the next patient, there is possible transference of the Hepatitis C virus. GJ3 at 37. From what the CDC observed, that is the only way the transmission of Hepatitis C could have occurred in this instance. GJ3 at 37-38. The common factor was shared Propofol and the fact that source patients were identified as having more than one dose of Propofol. GJ3A at105-109.

When a CDC investigator spoke to Mathahs, he claimed not to understand that the procedure he used was dangerous. He stated that he believed discarding the needle was enough of a precaution. He claimed that he did not understand that the syringe could be contaminated as well and should not be reused for a subsequent draw of medication. GJ1 at 39.

Another CDC investigator spoke with Petitioner Lakeman telephonically. Lakeman was cooperative with the investigator, but said he would deny that the conversation ever took place down the line. GJ3 at 85. Lakeman told the investigator that he would not use medication that had been drawn up by another CRNA, but he would use partially used vials of Propofol. GJ3 at 90. In other words, if he walked into a room and there was a partially used vial of the medication, he would use it. GJ3 at 90. He also acknowledged that he would "double dip," or use the same syringe to draw up medication from a vial and then use those same vials on other patients. GJ3 at 91. He even acknowledged to the CDC investigator that he was aware of the risk, but felt he was careful and maintained pressure on the syringe plunger such that he prevented any backflow into the syringe or contamination of the syringe into the vial. GJ3 at 91.

Epidemiology

Hepatitis C has RNA genome. From the arrangement of the RNA genome, scientists can tell Hepatitis A from C and B. GJ3 at 142. As the Hepatitis C virus replicates in an individual, it mutates. GJ3 at 144. Because areas of the Hepatitis C genome mutates rapidly, scientists can look at these highly variable regions to see

how closely two viruses are related. GJ3 at 144. In this manner, different strains of Hepatitis C can be identified. GJ3 at 145.

In the instant case, the forms of Hepatitis C from the two source patients—Ziyad (July 25, 2007) and Rubino (September 21, 2007)—varied greatly. GJ3 at 147. The patients from September 21, 2007, however, all were closely related to the strain of the virus which was present in Rubino. GJ3 at 158. Likewise, the Hepatitis C virus strains infecting both Ziyad and Washington were the same (July 25, 2007).

The Endoscopy Center Business/Insurance Fraud

Dr. Dipak Desai started the business of the Gastroenterology Center decades ago. GJ1 at 33. By 2002, the business included the Endoscopy Center of Southern Nevada at Shadow Lane and the Endoscopy Center of Southern Nevada II located on Burnham Lane. GJ1 at 33-34. The Shadow Lane location included medical offices as well as a procedure location where doctors performed endoscopy exams and colonoscopies.

The Endoscopy Center of Southern Nevada utilized the services of Certified Registered Nurse Anesthetists (CRNA), rather than medical doctor anesthesiologists. A CRNA is a registered nurse with training in anesthesia services. GJ1 at 40. The CRNAs were under the supervision of Dr. Desai. GJ1 at 79.

Dr. Desai was a micro-manager with regard to all aspects of the practice. GJ2 at 79. Dr. Dipak Desai was very concerned with expenses. He would caution doctors not to use too many surgical gowns. GJ1A at 45. Some of the equipment used for procedures included bite blocks and biopsy forceps. Most of the equipment was intended for single use, or was disposable. GJ1 at 56. Nonetheless, at the direction of Dr. Desai, this equipment was cleaned at reused. GJ1 at 57. Desai also complained when he believed too much surgical tape was being used by nurses to secure IV lines. GJ1 at 95. At the center, surgical pads, or "chux" were cut in half so the center would get double use from them. GJ8 at 50.

There also was a heavy caseload at the Shadow Lane facility. GJ1 at 64. Dr. Desai insisted on scheduling four patients for the 7:00 am start time, creating an immediate backlog at the start of the day at the facility. GJ1 at 64. Dr. Desai was very demanding of technicians that they clean equipment quickly so that it could be used on the next patient. GJ2 at 43. Dr. Desai would also tell doctors that they were too slow with procedures and that they were not seeing a sufficient number of patients. GJ1 at 68. He would sometimes mention a particular doctor's lack of speed in front of other colleagues. GJ1 at 70.

Dr. Desai also was concerned about the amount of medication given to a patient during a procedure. GJ1 at 71. He thought Propofol was expensive. GJ1 at 74.

Timing of Procedures

As an industry practice, anesthesia for procedures such as endoscopies and colonoscopies is billed in 15 minute increments or units. If a procedure lasts one to 15 minutes, it is one unit. If it lasts 16 to 30 minutes, it is two units. If it goes over 30 minutes, it is three units.

CRNAs were responsible for documenting the anesthesia used, times, and quantities. GJ1 at 60. Dr. Desai, however, made mention of the times that needed to be placed on the records in 2005. GJ6 at 54. The directive was to note 31 minutes for a procedure time regardless of how long it took. GJ6 at 55. There was pressure to note 31 minutes. GJ6 at 60.

The actual procedure time was 5 to 6 minutes for an endoscopy and 8 to 9 minutes for a colonoscopy. GJ4A at 140. Keith Mathahs told another CRNA that Dr. Desai insisted that the procedure times be 31 minutes. So, the CRNAs "juggled" the numbers to make sure it always came up to around 31 minutes. GJ4A at 99. Thus, Mathahs was well aware that he and others were falsely reporting anesthesia times.

The Endoscopy Center of Southern Nevada had an associated business called Health Care Business Solutions handle its billing with insurance companies. GJ4A at 119. The owner of Health Care Business Solutions was Tonya Rushing, the business

manager of the Endoscopy Center of Southern Nevada. GJ4A at 119-20. Employees for Rushing entered the data from anesthesia records submitted by the Endoscopy Center of Southern Nevada and transmitted it to insurance companies for billing. GJ4A at 121. An employee who physically entered the data noticed a dramatic change in the times reported for procedures in 2008. GJ4A at 127. The times which were previously reported to be 31 minutes, GJ4A at 124, suddenly changed to around 10 or 12 minutes per procedure in 2008. GJ4A at 128. Interestingly, this change corresponded with the Health District's Investigation of the Endoscopy Center.

In fact, in 2008, Dr. Clifford Carrol was alerted to the times recorded by CRNAs as a result of unrelated litigation. GJ2 at 51. Sometime after that, Dr. Carrol performed an endoscopy and looked at the anesthesia chart and noticed the times for the procedure were pre-written and that the amount of time indicated was longer than what the actual procedure time would take. GJ2 at 54. During the time period alleged in the Indictment, almost all of the anesthesia records indicated a time of 31 to 32 minutes. GJ2 at 55. The notes on the records suggested that the patient was still in the procedure room when the patient could not have been, illustrating the records had been falsified. GJ2 at 57. If they had lasted as long as the recorded time, there would not have been enough hours in the day to do all of the procedures. GJ2 at 68. At one point, Dr. Carrol went to Dr. Desai to discuss the issue. GJ2 at 62. Dr. Desai acknowledged the false timing had been a practice at the Center, but agreed to start recording the correct times. GJ2 at 63.

In 2007, however, as alleged in the Indictment and before the Health District investigation, the times of procedures were reported to be 31 minutes or slightly more. During that time period, Blue Cross/Blue Shield was the insurance provider for Sharrieff Ziyad, Kenneth Rubino, and Patty Aspinwall. The company paid $206.82 on Ziyad's claim. The listed charge was $560. GJ5 at 59. For Kenneth Rubino, the company paid $245.12 on the $560 charge. GJ5 at 63. For Patty Aspinwall, the company was a secondary payer. The charged amount for the procedure was $560.

GJ5 at 69. The primary payer, United Health, paid $249.92. GJ5 at 71. Blue Cross paid $56.48. GJ5 at 72.

Carole Grueskin and Stacy Hutchinson were insured by HPN and Sierra Health, or the company Sierra Health Services. Grueskin's procedure was charged at $560 and the payment was $70. GJ5 at 49-50. Hutchinson's bill was $560 and $90 was paid on the claim. GJ5 at 45.

Michael Washington was insured by the Veterans Administration. His bill was for $560. The amount paid on the claim was $100. GJ5 at 164. Gwendolyn Martin was insured by Secure Horizons/Health Care partners. The amount of her bill was $560 and $304 was paid on the claim. GJ5 at 25-6. Sonia Orellana's insurance was through the Culinary Union. Her bill was $560 and the amount paid on the claim was $306. GJ4A at 18.

Events Following the Outbreak

On February 27, 2008, a press conference took place at the Southern Nevada Health District offices announcing that a Hepatitis C outbreak had occurred in Las Vegas, Nevada. Dr. Dipak Desai did not attend. Dr. Eladio Carrera represented the Endoscopy Center of Southern Nevada as their spokesperson and delivered a prepared statement. GJ1 at 101-105.

Just prior to that press conference, however, Dr. Carrera had been on vacation with his family and was in the process of returning to Las Vegas. During his drive back to Las Vegas, Dr. Carrera received a phone call from the endoscopy clinic asking him to return to Las Vegas immediately and attend a group meeting at the clinic. Id. When Dr. Carrera arrived at the endoscopy offices Dr. Desai asked him to be their spokesperson and to deliver a prepared statement concerning the Hepatitis C outbreak. Id. Dr. Desai told Dr. Carrera that, although he was the medical director and CEO of the clinic, his Cardiologist would not allow Dr. Desai to read the prepared statement. Id. Dr. Carrera believed that Dr. Desai was being disingenuous and that Dr. Desai looked "hale and hardy" according to Dr. Carrera. Id.

Dr. Desai was present for and participated in all meetings prior to the press conference, with the exception of one at R&R partners. Id. Dr. Carrera did not want to be the lone doctor reading the prepared statement and insisted that Dr. Desai stand by Dr. Carrera as he delivered the statement. Id. **Dr. Desai agreed, but just before they were to go to the press conference, Dr. Desai conveniently developed an illness which prevented him from attending.** Id.

With regard to Dr. Desai's prior history of strokes, it is true that Dr. Desai had suffered a stroke a couple of years before the Hepatitis C outbreak. This stroke apparently affected the sensation and the strength in one of his hands and arms for a period of time. GJ1 at 81-82. Although Dr. Desai was purportedly disabled following this stroke, he was able to manage the office, come in every day and watch everything at the clinic very closely. Id. Dr. Desai recovered completely from that stroke and returned to his full duties. Id.

Dr. Carrol said that this stroke had occurred in October of 2007 while Dr. Desai was on a trip to India. GJ2at 26. Dr. Carrol said that Dr. Desai did not return to Las Vegas for a week because of the stroke and when he did return to the practice, he informed the staff that he would not be running the practice or making day to day decisions for approximately three to six months. GJ2 at 27-28. However, within two weeks Dr. Desai was back at the clinic and took over making all decisions pertaining to the practice. GJ1 at 36. Dr. Desai made a fast recovery and not only took over the management of the practice, but he also saw and treated patients. Dr. Desai did not, however, return to performing endoscopy procedures for five to six weeks following his stroke. GJ2 at 38-39, 44.

Dr. Carrol also said that following the October 2007 stroke, Dr. Desai did not appear to have any difficulty speaking, recognizing objects, or understanding conversation. GJ2 at 45. In fact, Dr. Carrol said Dr. Desai was lucid, clear and intelligent during that time. Id. Dr. Carrera was asked his opinion about Dr. Desai's health as of the time of his grand jury testimony in March of 2010 following a second

stroke which had occurred in September of 2007. **Dr. Carrera stated that based on his knowledge of the type of stroke that Dr. Desai had previously experienced, that Dr. Desai had fully recovered from that stroke, that his most recent stroke was very similar in nature, and for other reasons, he felt that Dr. Desai was not as sick as he was making himself out to be.** GJ1 at 127.

PROCEDURAL HISTORY

On June 4, 2010, defense counsel for Petitioner Dipak Desai appeared before the honorable Donald Mosley in Department 14 of the Eighth Judicial District Court and represented that Petitioner Desai was medically fragile. At that hearing, defense counsel provided to the court and the State a list of medications that Petitioner was taking along with a list of medical events and conditions that Petitioner had experienced since 1987.

In fact, defense counsel cited Nevada Rule of Professional Conduct 1.14 regarding the representation of a client with diminished capacity and said that his client, Dipak Desai, was mentally impaired. Defense counsel went on to state that both he and Petitioner's wife were acting for Petitioner Desai because he was unable to do so for himself. Defense counsel also requested and was granted special leave to facilitate the processing of Petitioner at the Clark County Detention Center (CCDC) because of his alleged medically fragile condition.

On June 11, 2010, Petitioner Desai made his initial appearance in district court and entered a plea of not guilty to the charges outlined in the amended criminal indictment. Once again, counsel represented that Petitioner Desai was suffering from various medical conditions and could not address the Court. Defense counsel answered for Petitioner Desai as to all inquiries by the Court despite the fact that Petitioner Desai walked into the Court under his own power and appeared to be unimpaired.

During the June 11, 2010 hearing, the State raised the issue of a need for a competency determination because of the representation made by counsel for the

Petitioner. Respondent subsequently filed a motion in district court on June 16. 2010 which was subsequently heard on June 28, 2010. As Petitioner points out, he did not oppose the case being transferred to Department 5 for the purposes of determining the competency of the Petitioner to proceed to trial.

Desai filed his Petition for Writ of Mandamus or Prohibition on January 12, 2012. On January 18, 2012, the Court ordered the State to file an answer. The State's answer follows:

I. This Court stated in Sims, Ferguson and Calvin that a defendant may submit independent competency evaluations and other relevant evidence to a court for consideration during a NRS 178.415(3) competency hearing

There are three related cases in Nevada which address the issue of what a defendant may present in way of evidence at a competency hearing before commitment under NRS 178.415(3). Those cases are: Calvin v. State, 122 Nev. 1178, 147 P.3d 1097 (2007); Ferguson v. State, 124 Nev. 795, 192 P.3d 712 (2008); and Sims v. State, 125 Nev. 126, 206 P.3d 980 (2009).

In each of these cases, this Court has stated that in a NRS 178.415(3) competency hearing, a district court can consider other relevant evidence related to competency, including independent competency evaluations. This broad pronouncement does not, however, "compel the district court to consider 'every record and hear testimony from every witness the State or defense may wish to present; all evidence must still be relevant to the ultimate issues of whether the defendant understands the nature of the proceedings against him and can assist his counsel in his defense.'" Sims, 125 Nev. at 131, 206 P.3d at 983., citing Calvin, 122 Nev. at 1183, 147 P.3d at 1100. The Court went on to state that "[e]ven if the evidence being proffered is relevant, the district court may still exclude the evidence 'if its probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence.'" Id., citing NRS 48.035(2).

NRS 178.415(3) states that:

> 3. The court that receives the report of the examination shall permit counsel for both sides to examine the person or persons appointed to examine the defendant. The prosecuting attorney and the defendant may:
>
> (a) Introduce **other evidence including, without limitation, evidence related to treatment to competency** and the possibility of ordering the involuntary administration of medication; and
>
> (b) Cross-examine one another's witnesses.
>
> (emphasis added)

This Court has interpreted the language from NRS 178.415(3) *supra* as being unambiguous and expansive and "in no way limits the prosecuting attorney's or defense counsel's ability to introduce evidence" during a NRS 178.415(3) hearing. Sims, 125 Nev. at 130, 206 P.3d at 983. In fact, this Court emphasized in Sims that the language "other evidence" and "without limitation," shows that the legislature was clear in their intent to be expansive with what evidence could be utilized in a NRS 178.415(3) hearing. Id. The State does not dispute this Court's interpretation of the parameters of NRS 178.415(3).

All of these cases dealt specifically with what evidence could be presented at a competency hearing under NRS 178.415(3). None of these three cases, however, addressed what specific evidence, could be presented at a competency hearing under NRS 178.460(1), with the exception of Ferguson, where the Court was mainly addressing the manner in which the NRS 178.460(1) took place.

Nonetheless, this Court has implied that the district court has wide discretion to consider issues of competency at all stages of the proceeding. In Fergusen, the defendant was committed to Lakes Crossing which ultimately deemed him competent to stand trial. Id. at 798, 192 P.3d at 798. Upon his return court date, a public defender asked that his case be continued so his assigned public defender could be present. The district court denied the request and conducted the competency hearing and sent the case to the trial department. Once in front of the trial judge, defense counsel argued, among other issues, that Fergusen was still not competent to stand trial. The trial court instructed counsel to file a motion. Two months later, defense counsel filed her motion. Id. at 799, 192 P.3d at 715. Department 5 heard the

arguments on the motion which challenged the Lake's Crossing findings. The State objected to the motion as it was untimely pursuant to statute. The State also argued that the alleged new evidence in possession of the defense concerned evaluations completed prior to Fergusen's commitment to Lake's. Ultimately, Department 5 informed counsel that it would not grant defendant's motion. Department 5 then transferred the case back to the trial department, Department 7.

Once in Department 7, defense counsel filed another motion for a competency hearing. The trial court held a hearing on the motion and denied the motion. Shortly before trial, defense counsel informed the court that it was having Fergusen talk to some doctors who would possibly deem him incompetent to stand trial. The district court stated that trial would proceed and it would not consider evidence relating to competency from doctors who were not appointed by Department 5. Id. at 800, 192 P.3d at 716. On the first day of trial, defense counsel filed a motion to strike all determinations as to competency and to compel a competency hearing. Id. Trial proceeded and a jury convicted Fergusen. At sentencing, defense counsel asserted that Fergusen was not competent and should be sent to Lakes for an evaluation. The district court disagreed. Id. at 801, 192 P.3d at 717.

Among other issues, on appeal Fergusen argued that the district court erred by not allowing him a hearing to challenge the report as to competency under NRS 178.455 and 178.460 after he returned from Lake's Crossing. He also argued that the court's refusal to grant a hearing as to competency violated his due process rights. In describing Fergusen's claims, this Court explained, "in addition to his right to a hearing as to competency under NRS 178.460, which allowed him to examine and contest the report prepared by Lake's Crossing, he should have been afforded a hearing because counsel had also raised competency concerns as to his ability to aid and assist counsel at that time." Id. at 803, 192 P.3d at 718.

With regard to Fergusen's claim that NRS 178.460 afforded him a right to challenge the Lake's Crossing conclusions, this Court noted that "NRS 178.460

provides that 'the judge shall hold a hearing after the defendant has returned from a mental health facility such as Lake's Crossing, which would allow counsel to examine and contest the report prepared by the treatment team. And as we have recently recognized in Calvin v. State, evidence received at every stage of the competency proceedings may be relevant to the defendant's competence and should be considered at such a competency hearing." Id. at 804, 192 P.3d at 719.

This Court found fault with Department 5 because upon Fergusen's return from Lake's Crossing, the district court did not allow Fergusen a continuance for his counsel to be present to challenge the findings. Id. at 805, 192 P.3d at 719. Thus, the Court found Fergusen "was denied a meaningful opportunity to be heard and was denied a meaningful opportunity to challenge the findings made in the Lake's Crossing report." Id.

The court also addressed Fergusen's second claim, that the district court erred in not granting him a competency hearing upon his counsel's motion, presumably under NRS 178.455. With regard to this issue, the court stated that Department 5 should have afforded defense counsel the opportunity to present their evidence relating to Fergusen's competency during a hearing." Id. at 805, 192 P.3d at 720.

Again, in conducting a competency hearing, however, the district court has wide authority regarding what evidence is admissible. Sims, 125 Nev. at 131, 206 P.3d at 983. The Nevada Supreme Court has stated that "the competency process will be much better 'served when the district court and any appointed experts consider a wide scope of relevant evidence at every stage of the competency proceeding.'" Id., citing Calvin v. State, 122 Nev. 1178, 147 P.3d 1097 (2006). Again however, "[t]his does not compel the district court to consider 'every record and hear testimony from every witness the State or defense may wish to present; all evidence must still be relevant to the ultimate issues of whether the defendant understands the nature of the proceedings against him and can assist his counsel in his defense.'" Id., citing Calvin v. State. Further, "[e]ven if the evidence being proffered is relevant, the district court

may still exclude the evidence 'if its probative value is substantially outweighed by considerations of undue delay, waste of time or needless presentation of cumulative evidence." Id. citing NRS 48.035(2).

In Ferguson, the defendant returned from commitment at Lake's Crossing and the district court held a NRS 178.460(1) hearing to determine his competency. One significant issue of concern to this Court was the fact that at that hearing, counsel for the defendant (who was just "covering" for the defendant's actual counsel who was not present) requested a continuance. The court denied that request and proceeded with the hearing despite the request for a continuance. In addition, defense counsel, in subsequent competency related hearings before the trial judge, stated that they had not received the competency report from Lake's Crossing which the judge in competency court had used to make her determination. Id. at 799, 192 P.3d at 715. Clearly, if this were the case counsel for the defense would not have been able to effectively cross-examine the treatment team. In fact, this Court stated that Ferguson was denied a meaningful opportunity to either confer with counsel prior to the hearing or to challenge the findings made in the Lake's Crossing report since they apparently did not have the report. Id. at 805, 192 P.3d at 719.

It is important to reiterate that the defense request for an NRS 178.460(1) hearing was filed over two months after his return from Lake's Crossing and after his case had been transferred back to the trial judge. It is also important to note that issues of competency were subsequently being raised to the trial judge. The distinction here is that once a case is transferred back to the trial judge, any competency hearings then necessarily fall under NRS 178.415(3) not NRS 178.460(1). As this Court pointed out most recently in Sims, district courts can and should consider additional evidence including independent competency evaluations in any NRS 178.415(3) hearing. Sims, however, did not in any way address the issue of the scope of evidence which could be presented at a NRS 178.460(1) hearing.

Although Ferguson specifically references a NRS 178.460(1) hearing stating

that the district court "should have afforded defense counsel the opportunity to present their evidence related to Fergusson's competency," Respondent respectfully suggests that this Court was actually referencing a NRS 178.415(3) hearing where it would be proper to bring in such evidence. Ferguson, at 805, 192 P.3d at 719. This point is illustrated by the unusual fact scenario in Ferguson. When all of these issues are raised, the case was not being heard before any district court judge, trial or otherwise, until long after the NRS 178.460(1) hearing had taken place. Any subsequent competency hearing, therefore, would fall under NRS 178.415(3) since a defendant can continue to raise issues of competency at any time. Until and unless the defendant is once again sent to Lake's Crossing and again returns for a initial competency hearing following his commitment, only then would the provisions of NRS 178.460(1) apply.

II. The Legislative Intent of NRS 178.460(1) is aimed at limiting the scope of challenges to competency findings to just cross-examination of the treatment team and their report upon an initial return from Lake's Crossing

Although the issue of the competency of a defendant may be raised at any time pursuant to NRS 178.405, the provisions of NRS 178.400 which apply to an evaluation of a defendant vary depending upon where that individual is in the proceedings against him. That is, whether there has been a suspension in the underlying case while efforts are made to determine a defendant's competency or whether that individual has been committed for restoration of competency and subsequently returned after restoration or lack thereof.

The two statutes which address these issues are NRS 178.415 and NRS 178.460. NRS 178.415 addresses specifically the issue of competency determination during the pendency of a criminal action, while NRS 178.460 deals exclusively with determinations of competency immediately following return from commitment.

In stark contrast to NRS 178.415(3), NRS 178.460(1), the statute dealing with a post-commitment return from Lakes Crossing situation, does not have expansive

language. The statute only allows the parties to "examine the members of the treatment team on their report." NRS 178.460(1). Unlike NRS 178.415(3) (a), NRS 178.460 contains no provision for the introduction of "other evidence" . . . "without limitation." NRS 178.460 restricts the inquiry to allowing each side to question the experts on the report they provided to the court.

If a statute is clear and unambiguous, courts must give their terms their plain meanings and do not resort to rules of construction. Cromer v. Wilson, 225 P.3d 788, 790 (Nev. 2010); MGM Mirage v. Nevada Ins. Guaranty Ass'n, 209 P.3d 766, 769 (Nev. 2009); State v. Cantanio, 120 Nev. 1030, 1033, 102 P.3d 588, 590 (2004). Thus, when the language of a statute is plain and unambiguous, courts should not construe that statute otherwise. Nevada Power Co. V. Public Serv. Comm'n, 102 Nev. 1, 4, 711 P.2d 867, 869 (1986).

Respondent contends that Petitioner is limited by the provisions of NRS 178.460(1) to cross-examine the Lake's Crossing doctors on their report. If defense counsel's position is that Petitioner is not competent, the proper course is for defense counsel to file a motion for a competency hearing. Assuming a hearing were granted, the district court has wide discretion regarding what type of evidence will be allowed to be presented. The court can consider issues of intentional delay and a waste of resources in limiting such evidence.

Because the language of NRS 178.415(3) and NRS 178.460(1) vary so greatly in their scope, Respondent reviewed the legislative history pertaining to each statute and their subsequent amendments. In 1981, both NRS 178.415(2) (which later became NRS178.415(3)) and NRS 178.460(1) were amended. In fact, the essential language at issue in this matter in NRS 178.460(1) was added while that same language was not included in NRS 178.415(2). It is important to note that during this legislative session, that the expansive language "may introduce other evidence and cross-examine one another's witnesses" of NRS 178.415(2) was already present in that statute.

In 1991 and in 1999, NRS 178.415(2) was again amended, but the original language described *supra* remained unchanged. In 2003, NRS 178.415(2) was further amended and expanded to include subsections (a) and (b). Also, in that same session a new section two was added and the expanded NRS 178.415(2) became NRS 178.415(3). It was in this session that the phrase "other evidence" was specifically expanded to include the words "without limitation." It should be noted that NRS 178.460 was also amended in this session, but section one remained unchanged and there was no additional expansive language added even though expansive language was added to what became NRS 178.415(3).

This distinction between the statutes is important in determining the legislature's intent behind the changes or lack of changes that were made. The pivotal year seemed to be 2003. In 2003, the legislature amended both statutes, specifically expanding the language pertaining to the scope of evidence that could be introduced and utilized during a NRS 178.415(3) competency hearing. The legislature, however, specifically did not add that expanded language to NRS 178.460(1) despite the fact that NRS 178.460 was also amended. The legislature addressed both statutes during that session and greatly expanded the scope of what evidence could come in during a NRS 178.415(3) hearing. Respondent contends, therefore, that had the legislature intended that NRS 178.460(1) also be so extended, that they would have amended the language of NRS 178.460(1) to reflect that intent. Because the legislature specifically did not change that language, Respondent asserts that the legislature intended for NRS 178.460(1) to remain more restrictive. Respondent further contends that Respondent's interpretation of this legislative intent is supported by the fact that although NRS 178.460(1) was further amended in 2007 and again in 2009 following the decisions in Calvin and Ferguson, the restrictive language of NRS 178.460(1) remained intact.

Respondent also points out the important public policy considerations at stake in this determination. Balancing the administration of justice and protecting the

constitutional rights of the accused by affording them equal protection under the laws and due process are always important public policy considerations. A plain reading of the statutes shows that NRS 178.415(3) is clearly much more expansive than NRS 178.460(1) in terms of delineated evidence which can be presented at a competency hearing. Respondent asserts that the public policy reason behind this differnce is that the statutes deal with two completely different time periods. NRS 178.415(3) addresses competency concerns which are raised at any time during the pendency of a criminal proceeding with the exception of the single instance where NRS 178.460(1) comes into play. NRS 178.460(1) is only applicable during the initial hearing following the return of an individual who was previously committed to Lake's Crossing for evaluation and treatment to competency.

Respondent asserts that the reason there is a difference between the two statutes is based in the purpose behind having an entity such as Lake's Crossing evaluate an individual in the first place. As the Court is aware, Lake's Crossing is the only secure facility in Nevada where such evaluation and treatment to competency can take place. Individuals committed to Lake's Crossing for that purpose typically undergo evaluation and/or treatment which can include the forced administration of medication. Each committed individual is assessed and/or treated by a treatment team. It is that treatment and that team approach which are ultimately successful or unsuccessful at restoring one to competency. If that process is unsuccessful, that same team may make a determination that the individual is incompetent without any possibility of restoration. In either case it is that treatment and that team which are the subjects of the limited NRS 178.460(1) hearing.

During that limited window of time (the 10 days after the report by the Administrator or the Administrator's designee is sent) the judge holds a NRS 178.460(1) hearing where the members of the treatment team may be examined on their report. The main public policy concern here and the reason for the limitation on what can be introduced at this hearing pertains directly to maintaining the integrity of

the process. If the prosecution or the defense were allowed to stop this hearing from taking place in order to begin their own separate evaluation process, the purpose behind sending and individual for evaluation and/or treatment at Lake's Crossing would be thwarted. Under that set of circumstances, any party dissatisfied with the results of a Lake's report could effectively disrupt the administration of justice by requesting and engaging in a never ending evaluative process. Respondent asserts that this is exactly what Petitioner is attempting to do in the instant case.

This situation is illustrated by defense counsel's statement at the December 13, 2011 hearing before the Honorable Kathleen Delaney that he wanted to delay the NRS 178.460(1) hearing so he could have Petitioner undergo a separate evaluation. Defense counsel further stated at that same hearing and that he wanted to present a number of experts to both counter the Lake's evaluators and to educate the court on the medical issues. This is not a situation where Petitioner is trying to introduce evidence obtained subsequent to Petitioner's return from Lake's Crossing, but prior to the hearing which may have a bearing on his current competency status.

Respondent asserts that one of the main public policy reasons for the limitation on the evidence which can be presented at a NRS 178.460(1) hearing is because the statute is specifically crafted to prevent a delay in the process of that competency evaluation. The fact that under the statute the hearing is to take place within 10 days of the request which also must be made within 10 days of the return of the report (20 days in total) further illustrates that the legislature did not intend to allow for further evaluation and consideration of evidence beyond that provided by the treatment team. Further, it seems unlikely that within that 20 day window the individual in question would sufficiently deteriorate such that there would be a necessity for any further evaluation within that period of time.

Despite Petitioner's assertion to the contrary, this limitation does not impose upon or otherwise affect his constitutional rights to equal protection and due process. The Petitioner can at anytime following the NRS 178.460(1) hearing raise the issue of

competency if necessary and request a NRS 178.415(3) hearing where he can introduce expanded evidence. This is a continuing process of evaluation of a defendant's current competency status.

In short, the single limited hearing following a return from Lake's Crossing preserves the integrity of the judicial process by moving the proceedings back before the trial judge where any new competency concerns may be addressed. This Court even stated as much in Ferguson when it said that "the determination of a defendant's ongoing competency during trial must vest with the trial judge who has been assigned to hear the matter." Id. at 802, 192 P.3d at 715.

In the instant case, the Lake's Crossing doctors evaluated Petitioner for months. Included in their review were the initial competency evaluations done by local doctors, as well as the prior competency evaluators. In addition, Petitioner's treatment team also carefully reviewed all of Petitioner's prior medical records and reports. Because Petitioner's claim of incompetency specifically related to his impairment secondary to a stroke, as well as other medically related factors, his evaluation included specific observation over an extended period of time. In addition, to further evaluate the possible medical aspects of Petitioner's claimed impairment, the Lake's evaluators sent Petitioner out for additional medical testing. These medical evaluations where performed specifically to see if there was some other evidence that would change their opinion regarding Petitioner's competency. The evaluation was extensive.

There is simply no reasonable or rational basis to delay the NRS 178.460(1) hearing in this matter or to allow the defense to have Petitioner undergo another competency evaluation immediately following his return from Lake's Crossing. To do so would not only thwart the process, but would open the flood gates to those wishing to abuse the system. In effect, anyone who received a report from Lake's Crossing finding them competent could delay the competency determination process by requesting leave of the court to grant them their own independent evaluation to

counter the Lake's findings. It is not a stretch to see how those with the resources, such as in the instant case, could derail the process in an effort to prevent themselves from ever going to trial. It is also not a stretch to anticipate that indigent defendants could also flood the courts with requests to have the State fund these separate evaluations which would further tax already tight budgets and eviscerate the current neutral evaluation process being performed by Lake's Crossing.

CONCLUSION

One of the main concerns Respondent had in this case prior to Petitioner's commitment to Lake's Crossing for evaluation and/or treatment was that he was faking the severity of his impairment and malingering with regard to his condition. These concerns were raised early in the investigative stage of this case and further raised after the advent of Petitioner's supposed marked deterioration in his ability to function without any apparent anatomical or physiological progression of his condition. In June of 2010, Petitioner, through his attorney claimed to understand the nature of the charges against him, who the participants in the process were and could communicate to some degree with his attorney. From that point to the present, Petitioner, through his attorney, now claims to be so impaired that he supposedly doesn't know any of those things and he can no longer communicate with his attorney in any meaningful way. This is despite no objective medical evidence that Petitioner suffered any evolution of his prior stroke or any subsequent medical event or injury which might cause such a deterioration in his condition.

In fact, one of the reasons why Petitioner was evaluated at Lake's Crossing for a longer than usual period of six months, was to afford the evaluators a sufficient opportunity to observe, test and address these concerns. It should be noted that after that extensive evaluation, all three of the evaluators came to essentially the same conclusion, that Petitioner was malingering and that he was markedly embellishing the severity of any legitimate deficits he may actually have. They found no objective data to support Petitioner's claims of such marked impairment. The State requests,

therefore, that the Petition be denied.

Dated this 23rd day of January, 2012.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify and affirm that this document was filed electronically with the Nevada Supreme Court on January 23, 2012. Electronic Service of the foregoing document shall be made in accordance with the Master Service List as follows:

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