

1 BY MS. WECKERLY:

2 Q Mr. Labus, Mr. Santacroce showed you State's  
3 Exhibit 165, which was the published article about this  
4 investigation, just a second ago on cross-examination. And he  
5 talked about the reference to the limitations of the  
6 investigation, I guess, in this case; is that right?

7 A Yes.

8 Q Is that unique to outbreak -- this particular  
9 outbreak investigation?

10 A No.

11 Q Why is that?

12 A In an outbreak investigation you're going in  
13 after something happened and trying to figure out what  
14 happened in the past.

15 Q Okay.

16 A So it's difficult to know. You weren't there to  
17 observe what happened on those days, and so there's always the  
18 potential that people will forget things or do things  
19 differently by the time you do your investigations.

20 Q So there's nothing unique about this particular  
21 investigation; those limitations occur all the time?

22 A Yes, that's correct.

23 Q And the -- the fact that there was some  
24 eyewitness observation of unsafe injection practices by  
25 yourselves -- by yourself and members of the CDC, I mean, was

1 that unique, actually?

2 A No, in an outbreak investigation sometimes you  
3 observe what you believe to be the cause of the outbreak.

4 Q So there's always sort of a combination of sort  
5 of observations and scientific conclusions?

6 A Yes.

7 Q Now, you were asked about -- or you were shown  
8 the -- the chart of all the procedures by Mr. Santacroce.  
9 When you and members of the CDC did the chart review in this  
10 case, were you able to establish an accurate order of  
11 procedures on September the 21st?

12 A The order, yes, we -- we're pretty sure that one  
13 is accurate.

14 Q Okay. And were you able to get, like, specific  
15 times as to each patient in that order?

16 A No.

17 Q Why not?

18 A There were a number of times recorded in the  
19 chart; there were a lot of things that just didn't add up and  
20 didn't seem to be correct. We had a lot of difficulty relying  
21 on most of the times that were in the chart to do anything  
22 meaningful.

23 Q And, I mean, the chart times are -- are  
24 variable, correct? Depending on which time you use?

25 A Yes.

1           Q     And because of that, is it possible to give a  
2 precise order of patients?

3           A     The order, probably, but exactly what time they  
4 started and stopped, no.

5           Q     Okay. And -- I mean, was there -- do you know  
6 if even the two rooms, as we know now, would have synchronized  
7 times?

8           A     There were clocks on the wall; they just looked  
9 to be standard clocks. They may have been set differently.  
10 We don't know, we didn't -- we didn't check the clocks on the  
11 wall, and if we did it was still five months after the fact,  
12 so...

13          Q     Now, you were asked about biopsy equipment as a  
14 possible source on -- of contamination or of transmission on  
15 July the 25th, and I thought I heard you say on  
16 cross-examination that you weren't -- you weren't able to do a  
17 statistical calculation on that date, like you were for the --  
18 the chart in State's 228, on -- that references September the  
19 21st; is that right?

20          A     Yes, that's correct.

21          Q     And why would that be, scientifically?

22          A     You want to compare people that were exposed to  
23 those who are unexposed. And if only one person got sick,  
24 he's either exposed or unexposed to each item. So there's  
25 really no way to do a comparison of just one person.

1           Q     And that's because the -- the sample of the one  
2 person who was exposed, or who tested positive on the 25th,  
3 there's -- there's no other way to -- to draw a comparison  
4 with him and someone else?

5           A     Right. You're trying to do a comparison of  
6 groups, and you have a group of one versus a group of zero.  
7 So there's no way to do a comparison or any calculations.

8           Q     Okay. But I think you did talk about how the  
9 source patient on the 25th went directly to the procedure  
10 room, and that was one of the reasons why you were able to  
11 conclude a saline flush was not likely to be the cause of  
12 transmission?

13          A     Yes, that's correct.

14          Q     And it doesn't matter whether or not the -- Mr.  
15 Washington, who was ultimately infected on that day, had a  
16 saline flush because you need contamination from the source  
17 patient; is that fair?

18          A     Yes, that's correct.

19          Q     When you -- when you learned of the -- the  
20 computer error that could help assign which patients were in  
21 which room, did you review your conclusions or did you  
22 consider whether or not that information would affect the  
23 conclusion you drew regarding how the disease was transmitted  
24 on the 21st?

25          A     Yes.



1 Q And did it affect your conclusion at all as to  
2 the mode of transmission?

3 A No, it did not.

4 Q Mr. Wright asked you about that -- I think it  
5 was a notification that was sent out on -- on, I can't  
6 remember which day, but it was February of 2008?

7 A February 7, 2008.

8 Q Okay. You have a better memory than me. Was  
9 that notification issued before you finalized the Health  
10 District report regarding this outbreak?

11 A Yes.

12 Q So that was sort of a preliminary warning?

13 A It wasn't really a warning, it was kind of a  
14 separate -- we discovered a problem upon doing the outbreak  
15 investigation, and did the notification as a result of that  
16 problem that we identified.

17 Q Okay. And your -- your ultimate report was  
18 issued some -- some months later, correct?

19 A Yes.

20 Q Mr. Wright asked you about that -- that second  
21 Epi-Aid, that -- that, I guess, took place after the one you  
22 were involved with, correct?

23 A Yes.

24 Q And I think he asked you if you were aware of  
25 whether or not the Epi-Aid revealed that there was multiuse of

1 propofol or multiuse of a certain medication. And I think you  
2 said you -- your understanding was that that was the case?

3 A Yes.

4 Q To your knowledge was -- did that also include  
5 the combination of syringe reuse within a patient, or was it  
6 limited to -- to multiuse of medication?

7 A I don't remember the specific details of that  
8 investigation. Like I said, I wasn't involved in that one.  
9 It was a different agency, and they did a separate response  
10 that we weren't involved in.

11 Q Okay. And I -- I think when you were asked  
12 about ambulatory surgical centers and whether or not there  
13 were regulations or whether or not they were properly  
14 supervised before this outbreak, really wasn't something that  
15 you were involved with or even became aware of until this  
16 investigation?

17 A Yes.

18 Q So you would have -- I -- limited knowledge of  
19 what the issues were with those centers prior to the outbreak?

20 A Yes, I -- I had seen a report at a conference  
21 before about an outbreak at an endoscopy center, but really  
22 didn't quite understand how ASCs work or regulated or what  
23 their role in medicine really is.

24 Q Okay. Mr. Wright asked you about your  
25 conversations with Dr. Carrol and -- and the notification

1 process. And if -- if I understand you correctly, the  
2 notification is a -- is a response to a -- a public health  
3 issue; is that fair?

4 A Yes.

5 Q And the -- the purpose of that is so people get  
6 treatment or find out what their status is?

7 A The purpose was for people to get tested, and  
8 then, if they're positive, get treated or managed as  
9 appropriate.

10 Q Okay. And it really, as -- as you discussed  
11 with Mr. Wright, didn't relate to your conclusions regarding  
12 the mode of transmission?

13 A That's correct.

14 Q When you were speaking with Dr. Carrol, he  
15 brought you, I guess, a chart that was based on anesthesia  
16 time?

17 A I'm not sure exactly what he based his chart on,  
18 but he did have a chart that he showed me.

19 Q Okay. Did anything that he showed you make you  
20 doubt your conclusions, or make you think, boy, I got to  
21 relook at this whole thing because Dr. Carrol here, you know,  
22 seems to have a point? Or was it something that you had  
23 already considered or...

24 A I think the biggest thing I took away from him  
25 showing that chart was we identified an additional patient

1 that we hadn't identified earlier because he had somebody  
2 listed as a case that was a name we didn't see.

3 Q Okay. So it actually --

4 A It gave us one more case, but that really didn't  
5 change anything at that point.

6 Q Okay. Did it -- did it at all make you question  
7 your conclusions regarding the source of transmission?

8 A No.

9 Q And as -- as you sit here now, you know, some  
10 five or so years later, is your conclusion or belief the same  
11 regarding what caused the transmission of the hepatitis C  
12 virus to these individuals?

13 A Yes, it is.

14 Q It's the same? Thank you.

15 THE COURT: All right. Mr. Wright, any recross?

16 MR. WRIGHT: Yeah, just on that.

17 RECROSS-EXAMINATION

18 BY MR. WRIGHT:

19 Q Questions about the second Epi-Aid and whether  
20 it dealt with any findings of reuse of syringes, do you recall  
21 that another clinic was closed down because an  
22 anesthesiologist M.D. was multidosing with vials and reusing  
23 syringes?

24 A Yes, but it wasn't from that report.

25 Q Okay. It -- it was from BLC inspections?

1           A     Yes, it was a separate BLC inspection of that  
2 facility.

3           Q     Okay.

4           A     It wasn't the -- the -- I don't think it was the  
5 CDC response on that one.

6           Q     It -- that -- that incident predated the second  
7 Epi-Aid?

8           A     I'm not exactly sure. I think so, but I'm not  
9 exactly sure.

10          Q     Okay.

11          MR. WRIGHT: No further questions.

12          THE COURT: Mr. Santacroce?

13                         RE CROSS-EXAMINATION

14          BY MR. SANTACROCE:

15          Q     When you said you had no statistical comparison  
16 for July 25th as to the biopsy forceps being reused, is that  
17 the same analysis for the propofol contamination? If you only  
18 had one infected patient, can you do a statistical analysis?

19          A     I hadn't done a statistical analysis on the  
20 propofol contamination before. All patients received  
21 propofol, so there was no non-propofol group. If there were  
22 multiple medications used, you could have done a comparison,  
23 but I couldn't do it on September 21st because everybody was  
24 exposed to propofol. There's no way to compare it to anything  
25 else.

1 Q No, I said, July 25th?

2 A The same thing on July 25th.

3 Q Okay. You testified that you had problems with  
4 the times, but in front of the grand jury you testified that  
5 you came to the conclusion that the nurses' times were the  
6 most accurate, correct?

7 A Right.

8 Q Okay. And you testified that the sequence of  
9 the patients was correct; is that your testimony?

10 A Yes.

11 Q So we know, for example, that the source patient  
12 Kenneth Rubino, was before this patient in yellow, correct?

13 A Yes.

14 Q Okay. And then we know that this next patient  
15 happened after that, this one, this one, this one, this one,  
16 and down the line, correct?

17 A Generally, yes.

18 Q The -- well, you're confident, and you testified  
19 that that was correct. Is it correct or --

20 A Yes.

21 Q -- not correct?

22 A Yes, it is.

23 Q Can you see the CRNAs on -- on what's displayed  
24 there?

25 A Yes, I can.

1           Q     Okay. Can you point to which column that's in?  
2 Because I can't see it from here.

3           A     It's the --

4           Q     Just point on your screen.

5           A     Oh, my --

6           Q     Okay.

7           A     That's a --

8           Q     I want to --

9           A     -- CRNA --

10          Q     -- move that over --

11          A     -- okay.

12          Q     -- so we can get -- you can -- tap the bottom of  
13 the screen, if you would.

14               MR. STAUDAHER: On the right-hand corner.

15 BY MR. SANTACROCE:

16          Q     There you go. Okay. So the sequence is  
17 correct, and we know that the CRNAs, according to your  
18 testimony, only changed rooms at lunch breaks and at potty  
19 breaks, and we know that Kenneth Rubino, Stacy Hutchinson,  
20 were contaminated in different rooms, correct? Who were the  
21 CRNAs in Room 1 with Kenneth Rubino?

22          A     Keith Mathahs.

23          Q     Who was the CRNA for Stacy Hutchinson?

24          A     Ronald Lakeman.

25          Q     And when did -- and if you look down below Stacy

1 Hutchinson, who was the CRNA for that procedure?

2 A Keith Mathahs.

3 Q So Mathahs didn't come over to relieve Mr.  
4 Lakeman for a potty break until after Stacy Hutchinson,  
5 correct?

6 A These times, yes.

7 Q Times or chronology or sequence of --

8 A Or the --

9 Q -- patients?

10 A -- according to the sequence, yes.

11 MR. SANTACROCE: Nothing further.

12 THE COURT: Ms. Weckerly?

13 MS. WECKERLY: Nothing further.

14 THE COURT: I'll see Counsel at the bench.

15 Any additional juror questions?

16 (Off-record bench conference.)

17 THE COURT: All right. I have a question on --  
18 changing a little bit.

19 THE WITNESS: Okay.

20 THE COURT: Did you video or audio record any of the  
21 interviews during your investigation at the endoscopy center?

22 THE WITNESS: No, we did not.

23 THE COURT: All right. Is that something you  
24 normally do, or no?

25 THE WITNESS: No, that's --



1 THE COURT: Or ever do?

2 THE WITNESS: -- that's not normal in our procedures.

3 THE COURT: Okay. All right. Any followup to that  
4 last question? Ms. Weckerly?

5 MS. WECKERLY: No, Your Honor.

6 THE COURT: Any followup, Mr. Wright?

7 MR. WRIGHT: No, Your Honor.

8 THE COURT: Mr. Santacroce.

9 MR. SANTACROCE: No, Your Honor.

10 THE COURT: Any additional juror questions for this  
11 witness?

12 All right. Sir, thank you for your testimony. I'm  
13 about to excuse you, but I must admonish you not to discuss  
14 your testimony with anyone else who may be a witness in this  
15 matter.

16 Thank you, sir. And you are excused.

17 Does the State have any other witnesses scheduled  
18 for today?

19 MS. WECKERLY: No, Your Honor.

20 THE COURT: All right. Ladies and gentlemen, we're  
21 going to go ahead and take our evening recess. We will be  
22 reconvening tomorrow morning at 10:30.

23 May I see the bailiff at the bench.

24 We'll reconvene at 10:30. During the evening recess  
25 you are reminded that you're not to discuss the case or

1 anything relating to the case with each other or with anyone  
2 else. You're not to read, watch, listen to any reports of or  
3 commentaries on this case, any person or subject matter  
4 relating to the case. Do not do any independent research by  
5 way of the Internet or any other medium, and please do not  
6 form or express an opinion on the trial.

7 Notepads in your chairs, and follow the bailiff  
8 through the rear door. We'll see you back tomorrow at 10:30.

9 (Court recessed for the evening at 3:47 p.m.)  
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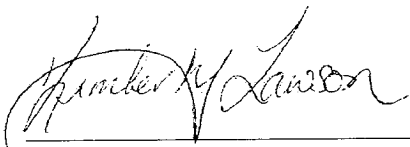
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I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

**AFFIRMATION**

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

**KARR REPORTING, INC.  
Aurora, Colorado**

  
KIMBERLY LAWSON

**Table 20-1. Modes of Transmission and Sources of Infection Considered**  
Patients who were infected on September 21, 2007

Transmission Mode/Source	Result	Rationale
Staff-to-Patient	Ruled Out	No staff members were positive for HCV infection, and source patient was identified through genetic testing
Provider: Physician	Ruled Out	Patients were treated by three physicians, none of which placed the patient at a statistically significant increased risk of infection
Provider: CRNA	Ruled Out	Patients were treated by both CRNAs, neither of which placed the patient at a statistically significant increased risk of infection
Provider: Technician	Ruled Out	Several technicians assisted on the procedures, none of which placed the patient at a statistically significant increased risk of infection
Biopsy Equipment	Ruled Out	Not all infected patients had a biopsy, and those who had a biopsy were not at a statistically significant increased risk of infection
Endoscope	Ruled Out	Five different scopes were used on the infected patients, none of which was the same as the source patient.
Procedure Type	Ruled Out	Infected patients had both colonoscopies and EGDs, neither of which placed the patient at a statistically significant increased risk of infection
Reuse of Bite Blocks	Ruled Out	Infected patients had both colonoscopies and EGDs (which require bite blocks), and the use of a bite block for a patient did not result in a statistically significant increased risk of infection
IV Placement	Ruled Out	Staff were not observed to re-flush heparin-locks, and none reported doing so. Clean needles and syringes were observed to be used for each flush
Sedation Injection Practices	Not Ruled Out	CRNAs were observed reusing syringes on one patient, reusing propofol vials for multiple patients, reported being directed to do so, and reported routinely doing so. CRNAs observed or reporting such practices were the same CRNAs responsible for administering anesthesia on September 21, 2007.



1 Q Okay. And so as far as her -- they were using  
2 syringes to draw up the propofol, correct?

3 A Yes.

4 Q And so she would get a new needle, new syringe,  
5 draw up propofol, inject a patient, correct?

6 A Yes.

7 Q Okay. And then, if the patient needed a second  
8 dose of propofol, she would get a new needle, new syringe,  
9 draw up, and dose the patient a second time?

10 A Yes.

11 Q Okay. And so -- and then she was taught  
12 throwing away her needles and syringes in the Sharps  
13 container?

14 A I don't know that she was taught, but that's  
15 what we observed.

16 Q Okay.

17 A We did observe her recap a needle at one point,  
18 which was a concern more for her safety than anything else,  
19 but it wasn't a risk to the patient.

20 Q Okay. And so what is "recap a needle"? In  
21 other words --

22 A So you have the -- the plastic cap on the  
23 needle, you pull it off, you do the injection, taking the cap  
24 and putting it back on the needle. Kind of like putting a cap  
25 on a pen. You have a -- you should just put the whole thing

1 right in a Sharps container instead of accidentally poking  
2 yourself while you're doing that.

3 Q Okay.

4 A So it's more of a workplace safety issue for the  
5 staff than it would be -- we also saw her remove the cap for  
6 one needle, put it in her mouth and pull it off with her  
7 teeth, and then do it that way. So again, that's a no-no.

8 Q Okay. Like this?

9 A Yes.

10 Q Okay. And so that's -- the danger in that is...

11 A Well, there's a contamination risk from that,  
12 and then, she could also poke herself with it as well. It's  
13 just a bad practice all around.

14 Q Okay. And so other than those -- I don't want  
15 to call them trivial, but not -- not serious transgressions by  
16 Linda Hubbard, all of her injection practices, meaning, clean  
17 needle, clean syringe, injection into patient, not reusing  
18 needles and syringes, on all of that she was fine?

19 A Yes.

20 Q Okay. And what you did observe her doing was  
21 taking propofol, using it on a patient, but there's still some  
22 left in the vial, and so she'd set it aside --

23 A Yes.

24 Q -- correct? And so then a new patient comes in  
25 and she starts with a new propofol vial and injects them

1 safely, and then sets aside another partially emptied one?

2 A Yes, that's correct.

3 Q And so after a number of procedures she had four  
4 or five vials, all with a little bit of propofol in them,  
5 still sitting there, correct?

6 A Yes.

7 Q Okay. And so then she took a syringe -- needle  
8 and syringe and filled up a needle and syringe by taking the  
9 remnants out of the four or five propofol vials?

10 A It was multiple syringes, but yes, that basic  
11 idea.

12 Q Okay. So she filled a couple of brand new,  
13 clean needles and syringes out of the four or five propofol  
14 remnants?

15 A Yes.

16 Q Okay. And so you -- you were observing her  
17 multi-using -- using propofol on multiple patients out of one  
18 vial --

19 A Yes.

20 Q -- is what would have occurred --

21 A Treating the vial --

22 Q -- right?

23 A -- like a multidose vial, basically --

24 Q Okay.

25 A -- yes.

1 Q And she -- she was doing that, knowing that you  
2 all are standing there watching her, correct?

3 A We were in the room, so I assume so, yes.

4 Q Okay. And so then did -- did you talk to her at  
5 that time?

6 A No.

7 Q Okay. Her, meaning Linda Hubbard. And the --  
8 this -- using propofol as a multidose vial, it caused you  
9 concern?

10 A Yes.

11 Q Okay. Now, you had -- you had already known  
12 that from Wednesday, correct?

13 A Potentially, yes.

14 Q Okay. And so now you're actually seeing it,  
15 correct?

16 A Yes.

17 Q And did -- did you -- other than Linda Hubbard  
18 on that Friday, did you observe other CRNAs?

19 A I did not, no.

20 Q Okay. So you -- your sole observations were  
21 Linda Hubbard on Friday morning?

22 A Yes, that's correct.

23 Q Okay. And I know you came back a number of  
24 times during the next couple of weeks to the clinic for  
25 various purposes. Did you come in and do any other procedure



1 observations?

2 A No, it was all records review when I came back.

3 Q Now, your -- you had a conversation with Vincent  
4 Mione?

5 A Yes.

6 Q Okay. And is that after your observations of  
7 Linda Hubbard?

8 A Yes, it was.

9 Q Okay. And did you -- did you observe any  
10 procedures of Vincent Mione?

11 A I did not, no.

12 Q Okay. Can you describe Vincent Mione?

13 A Average height, I believe he had gray hair, I  
14 think it was shaved kind of like a buzz cut, from what I  
15 remember.

16 Q It was what?

17 A Shaved kind of -- a short haircut, from what I  
18 remember.

19 Q Okay. Like a --

20 A It's been a long time. I don't really remember  
21 him that well.

22 Q -- okay. Well, you -- there's a couple of  
23 Vinnie's that were CRNAs; is that correct?

24 A Yes.

25 Q Okay. And do you know which Vinnie you talked

1 to?

2 A I believe we spoke with Vincent Mione. I think  
3 Vincent Sagendorf came in at a different time. I don't think  
4 he was working. I think he came in that afternoon, and they  
5 had talked to him, but he wasn't working at that clinic on  
6 that day.

7 Q Okay. The -- could it be you have your Vinnie's  
8 mixed up?

9 A I'm sure it's possible, but I -- from what I  
10 remember on the notes and the things I took, it was Vincent  
11 Mione.

12 Q Okay. I didn't see it in your notes.

13 A I --

14 Q Do you have some notes I haven't seen--

15 A I'd have to look back --

16 Q -- is what I'm saying.

17 A -- what I have. It's been a long time since  
18 that conversation. So it's possible that the two were mixed  
19 up, but I don't think so.

20 Q Well, do you have any -- did you write anything  
21 down anywhere regarding that conversation with Vincent Mione?

22 A I don't know if I did or not. If it's not in  
23 the notes, then -- then maybe I didn't. It was a brief  
24 conversation. It was 30 seconds or a minute or so.

25 Q Okay. Well, I -- the -- don't take my

1 representation for it when I tell you it's not in the notes.  
2 The -- I didn't see it, but I don't know that I have all of  
3 your notes, okay? Do you think anywhere you made a note of  
4 that? Have you seen anywhere your conversations where you  
5 noted it on January 11 with Vincent Mione?

6 A I really don't remember.

7 Q Okay. Now, are you aware that Vincent Mione  
8 denies the conversation with you?

9 A No.

10 Q Okay. The -- and who else was present?

11 A Melissa Schaefer.

12 Q Okay. Now, in your -- one of your interviews, I  
13 believe the one -- you were interviewed by the Metropolitan  
14 Police Department, correct?

15 A Yes.

16 Q Okay. Have you read that transcript lately?

17 A No, not lately.

18 Q Okay. My recollection of that is when you were  
19 trying to determine who the Vinnie was you may have talked to,  
20 you said it was the Vinnie who was brand new there.

21 A I don't remember that. It's possible.

22 Q Okay. Do you know which Vinnie was new -- had  
23 been recently hired?

24 A No, I don't.

25 Q Well, the evidence has been that it's -- it -- I

1 mean, Mr. Mione testified in here and Mr. Sagendorf testified  
2 in here -- the two Vinnies, okay? And Mr. Mione had worked  
3 for a number of years at the clinic, mainly Burnham, and Mr.  
4 Sagendorf had just been hired in October 2007.

5 A Okay.

6 Q Do you remember which of the two you talked to?

7 A This far after? No, I don't.

8 MR. WRIGHT: Page 28, Metro.

9 BY MR. WRIGHT:

10 Q This is a transcript from your interview  
11 Metropolitan Police Department, on May 19, 2008.

12 A Okay.

13 Q Look at page 28. Look at that to yourself.

14 A (Witness complied.) Okay.

15 Q Does that refresh your recollection as to which  
16 Vinnie you talked to?

17 A From the conversation here it was the newer one,  
18 and I don't know enough details to say if that was Mione or  
19 Sagendorf.

20 Q Okay. But the -- this was in May 2008?

21 A Yes.

22 Q So this was literally four months later,  
23 correct?

24 A Right.

25 Q And you couldn't remember the last name of the

1 Vinnie you talked to, correct?

2 A That looks correct.

3 Q And what you believed was that -- whoever is the  
4 newer Vincent, the one who had been there a short amount of  
5 time, correct?

6 A That looks correct, yes.

7 Q So if -- if the evidence is that the person who  
8 has been there the short amount of time is Vincent Sagendorf  
9 and not Vince Mione, that would have been the person you spoke  
10 with; is that fair?

11 A Possibly, yes.

12 Q Okay. Well, is that correct?

13 A Like I said, it's been a long time. I don't  
14 remember exactly which one it was.

15 Q Okay. And you made no report of it and no notes  
16 whatsoever?

17 A None that I remember, but I haven't looked at it  
18 in a long time -- or haven't looked at -- for that particular  
19 item in a while.

20 Q Mr. Sagendorf testified in here, and he also  
21 denies any such conversation with you.

22 A Okay.

23 Q Have you spoken to Melissa Schaefer -- is that  
24 her name? I get them mixed up --

25 A It's still Melissa Schaefer, yeah, she has the

1 same name.

2 Q -- Melissa Schaefer, about this?

3 A About this? No.

4 Q Okay. She does not recollect any such  
5 conversation.

6 A Okay.

7 Q Have you read her grand jury testimony?

8 A Years ago.

9 Q Okay. Could -- you could be mistaken about this  
10 because of the passage of time?

11 A Mistaken about what, specifically?

12 Q This conversation.

13 A That it happened?

14 Q Yes.

15 A I don't believe so.

16 Q Okay. But you don't know who it was with?

17 A I may have the incorrect Vincent, that's  
18 correct.

19 Q And the -- and the conversation was what?

20 A It was a -- just a brief conversation about the  
21 injection practices, about the reuse of propofol, and the  
22 reuse of syringes to access vials, and he said the -- they  
23 were told to reuse the syringes, but he didn't do it.

24 Q Okay. And at -- at that point it seems to me  
25 you know that propofol is being multiused, correct? Treated

1 as a multidose?

2 A In general, yes.

3 Q Okay. Well, in general, it had been stated to  
4 you all, and you all had observed it, correct?

5 A Yes, that was the general practice of the  
6 clinic.

7 Q Okay. And at this time of this conversation  
8 with a Vinnie, there hadn't been any observations of any  
9 syringe reuse, correct?

10 A Not by me, that's correct.

11 Q Not by anyone at that point that you knew about,  
12 correct?

13 A That I knew about at that time?

14 Q Yes.

15 A That's correct.

16 Q Okay. So it seems to me if an employee is  
17 actually saying -- discussing reuse of syringes, that's the  
18 first time you all are hearing it, that would be some  
19 significant seminal event.

20 A I don't know about a seminal event, but it was  
21 significant, yes.

22 Q Okay. But you made no -- no notation, no  
23 report, it's not in your -- what do you call this thing?

24 A The ICS forms?

25 Q Right. Correct?

1 A That's correct.

2 Q When did -- you learned that Gayle Fischer had  
3 observed Mr. Mathahs, CRNA, reusing a syringe to redose a  
4 patient, correct?

5 A Yes.

6 Q You learned about it that afternoon, correct?

7 A Yes.

8 Q And you all then have a meeting about it?

9 A It was in the conference room where we were all  
10 working together, so we were just discussing things in general  
11 throughout the afternoon.

12 Q Okay. And would you -- when you were there  
13 looking for unsafe practices, and/or trying to determine how  
14 this transmission could have occurred, you would bring to the  
15 attention of the clinic, management, anything you saw wrong,  
16 correct?

17 A Yes.

18 Q Okay. Because the whole -- you weren't  
19 conducting, like, a criminal investigation, correct?

20 A That's correct.

21 Q Okay. You were looking to see how -- how in the  
22 world did this happen, and if we can -- how can we correct it  
23 and prevent it so it's not happening again?

24 A Yes, that's correct.

25 Q Okay. And so, like, on that Friday who did you



1 meet with to tell them about propofol multiuse and syringe  
2 reuse?

3 A Friday was Tonya and Dr. Carrol, I believe.

4 Q Okay. And you would share everything with them,  
5 correct?

6 A Yes. We met with them each day and told them  
7 what we found, and any new information, kind of what the next  
8 steps were.

9 Q Okay. And so they would then implement changes  
10 to prevent those things from happening again, correct?

11 A That was our request of them, yes.

12 Q Okay. And to your knowledge, they did that,  
13 correct?

14 A Yes.

15 Q Okay. And so, like, it was -- these are --  
16 don't use propofol for more than one patient, correct?

17 A Yes.

18 Q Okay. And on syringes don't use the same  
19 syringe on the same patient to redose, correct?

20 A Yes.

21 Q Okay. And there was never anything about reuse  
22 of syringes or needles -- I'm calling them as one unit, but  
23 reuse of the needle and syringe multipatient, correct?

24 A That's correct.

25 Q Okay. And by multipatient I'm talking about,

1 like, if a CRNA injected one patient and then used the same  
2 needle and syringe on a different patient?

3 A Yes, that's correct.

4 Q Nothing like that was ever observed, seen,  
5 heard, talked about --

6 A Correct.

7 Q -- correct? And so was it your understanding  
8 that as of Friday the 11th in the meeting going forward, these  
9 changes would take place?

10 A Yes, we met with them late on Friday and they  
11 said they would correct things for when they reopened on  
12 Monday.

13 Q Okay. And the -- did you discuss with Gayle  
14 Fischer what she had observed with CRNA Keith Mathahs?

15 A Yes.

16 Q Okay. And did you understand that the  
17 observation was that he was using a needle and syringe, brand  
18 new, dosing the patient with propofol and/or lidocaine -- I'm  
19 just skipping over that -- but basically dosed the patient,  
20 and then when the patient needed a redose, Mr. Mathahs was  
21 taking out a brand-new needle, removing the dirty needle from  
22 the syringe, placing a clean needle on the syringe, and then  
23 going into propofol and drawing a second dose and then  
24 injecting the patient?

25 A That's correct.

1           Q     Okay. And did you discuss with her the practice  
2 of changing the needle?

3           A     We discussed all of those things, I guess, in --

4           Q     Okay.

5           A     -- throughout the day.

6           Q     And what does that do, changing the needle?

7           A     It doesn't really reduce risk of infection  
8 because the blood can be in the syringe itself, so the needle  
9 itself -- changing the needle really doesn't make a  
10 difference.

11          Q     Okay. And did you have any discussions with --  
12 you -- with Mr. Mathahs about his belief that that was a safe  
13 injection practice by changing the needle?

14          A     No, I did not.

15          Q     Are you aware that Gayle Fischer did?

16          A     I know she talked to him, but I don't know what  
17 the details of the conversation were exactly.

18          Q     Okay. Now, what Keith Mathahs was observed  
19 doing was an unsafe injection practice; is that fair?

20          A     Yes.

21          Q     Okay. And was he observed using propofol as a  
22 multidose vial?

23          A     Yes, I believe he was.

24          Q     Okay. You believe he was?

25          A     Yes.

1           Q     And so if -- if he was, and that was observed,  
2 that was immediately stopped?

3           A     Yes. I know, Gayle said she spoke to him after  
4 that procedure and -- so there wasn't an ongoing risk of  
5 patients that are -- from using a contaminated vial.

6           Q     Okay. And the -- if he was not using propofol  
7 as a multidose vial, and was simply using needle and syringe  
8 to redose a patient, okay, that would not cause any  
9 transmission of hepatitis C?

10          A     That's correct.

11          Q     Okay. And so it was determined by you in your  
12 ultimate conclusion that the likely method of transmission on  
13 the dates in question was a combination of using propofol as a  
14 multidose vial, and at the same time reusing syringes on  
15 individual patients?

16          A     Yes, that's correct.

17          Q     Okay. And if that occurred, there was a chance  
18 that a virus in the source patient could contaminate the vial  
19 of propofol, right?

20          A     Yes.

21          Q     And that that could be -- that vial could then  
22 be used on other -- another patient or patients?

23          A     Yes, that's correct.

24          Q     And, I think you've called that the serial  
25 contamination of vials theory?

1           A     Not just one. You would have to then take it  
2 from a contaminated vial, and then essentially contaminate a  
3 second vial from the --

4           Q     Okay.

5           A     -- first contaminated vial.

6           Q     Okay. And you explained this morning that  
7 theoretically this -- if the transmission occurred in the way  
8 you believe it could have, that it could either have been one  
9 50cc propofol vial was contaminated, correct?

10          A     Yes, theoretically.

11          Q     Right. And that one vial could have  
12 contaminated all of the patients that were contaminated on the  
13 21st of September because there was enough volume in it that  
14 it could have been used on every contaminated patient, if a  
15 little bit was used each time?

16          A     Yes, that's correct.

17          Q     Okay. And that was one -- that's just a single  
18 vial contamination theory?

19          A     Correct.

20          Q     Okay. And then your alternative was the serial  
21 contamin -- S-E-R-I-A-L contamination theory, correct?

22          A     Yes.

23          Q     And for your serial contamination theory, your  
24 conclusion of likely -- this likely serial contamination, this  
25 is the first time anyone has ever come up with such a theory,

1 correct?

2 A I don't know that that's true or not. I haven't  
3 reviewed all the literature to say that nobody else has  
4 thought of that idea.

5 Q Okay. Well, you have looked at the literature  
6 and couldn't find any?

7 A I didn't look at the literature specifically for  
8 that. I didn't do a search for any of those types of things,  
9 so it's possible it's out there, I don't know.

10 Q Okay. Well, to your knowledge no one else has  
11 ever come up with this serial contamination theory, correct?

12 A I guess that's true. I never really looked for  
13 it, so, no -- to my knowledge, no.

14 Q Okay.

15 MR. SANTACROCE: Your Honor, I'm having trouble  
16 hearing him.

17 THE COURT: All right. Well, this actually may be a  
18 good time to take our lunch break, and I think some of the  
19 jurors are hinting they needed a break.

20 Ladies and gentlemen, we're going to go ahead and  
21 take our -- excuse me, our recess. For the lunch break we  
22 will be in recess until 1:40.

23 During the lunch break you are reminded that you're  
24 not to discuss the case or anything relating to the case with  
25 each other or with anyone else. You're not to read, watch,

1 listen to any reports of or commentaries on this case, any  
2 person or subject matter relating to the case. Don't do any  
3 independent research by way of the Internet or any other  
4 medium, and please do not form or express an opinion on the  
5 trial.

6 Notepads in your chairs. Follow the bailiff through  
7 the rear door.

8 (Jury recessed at 12:50 p.m.)

9 THE COURT: And during the break, do not discuss your  
10 testimony with anybody else.

11 THE WITNESS: Can I leave the -- my notebook?

12 THE COURT: Sure.

13 All right. It's lunch.

14 (Court recessed from 12:31 to 1:43 p.m.)

15 (Outside the presence of the jury.)

16 THE COURT: Come on back. Make sure Kenny knows I  
17 meant for him to bring the jury in.

18 (Off-record colloquy.)

19 THE COURT: Bring them in. We're ready.

20 THE MARSHAL: Ladies and gentlemen, please rise for  
21 the presence of the jury.

22 (Jury entering at 1:47 p.m.)

23 THE MARSHAL: Thank you, everybody. You may be  
24 seated.

25 THE COURT: All right. Court is now back in session.

1           And, Mr. Wright, you may resume your  
2 cross-examination.

3           MR. WRIGHT: Thank you.

4 BY MR. WRIGHT:

5           Q     I want to go back to the Friday afternoon,  
6 January 11, 2008, when you report to the clinic that a  
7 propofol issue and a reuse of syringe issue, you all had  
8 determined that you had figured out the method of  
9 transmission, correct?

10          A     At that point it was a concern; I don't know  
11 that we figured out everything about the method of  
12 transmission yet at that point.

13          Q     Okay. Did -- do you recall testifying:

14                Question: My understanding is that you had already  
15 reached your conclusion by January 11, 2008, that the reuse of  
16 syringes on multiple times on one patient, coupled with the  
17 propofol vials being reused on more than one patient, was the  
18 source of contamination of hepatitis C at the clinic; is that  
19 correct?

20                You answered, Yes.

21          A     I don't specifically remember that, but okay.

22          Q     Let me show you -- so you can confirm I read it  
23 right -- the deposition on February 24, 2009. And I'm looking  
24 at page 211.

25          A     (Witness complied.) Okay.



1 Q Is that correct?

2 A That's what it says.

3 Q Having made that determination on Friday,  
4 January 11, I -- I'm now going to jump back to where I was  
5 before we took lunch recess.

6 I was asking you if there were anyone, to your  
7 knowledge -- well, let me put it this way: You're the first  
8 person, to your knowledge, who has ever come up with a serial  
9 contamination theory of -- as the mechanism of spreading a  
10 virus through vials, correct?

11 A To my knowledge, yes.

12 Q And you have looked for any other cases, asked  
13 CDC about other cases, looked in the literature to see if  
14 there was ever any reported case of serial contamination like  
15 you have theorized, correct?

16 A No, I have not reviewed the literature for that  
17 specific item. I haven't done a full study to see if anybody  
18 else has ever published that.

19 Q Okay. Well, you were previously asked in 2009  
20 in your deposition if you were aware of any articles or cases  
21 supporting your theory, correct?

22 A Yes.

23 Q And you said you were not aware, correct?

24 A That's correct.

25 Q And did you then ask the CDC, right after that

1 deposition, to determine if there were any articles or studies  
2 or anything to support your position?

3 A I believe I did.

4 Q Okay. And they couldn't find any, correct?

5 A That seems to be correct.

6 MR. WRIGHT: Can I just have my next in order?

7 BY MR. WRIGHT:

8 Q Look at page 2, 3 of Q1 -- Proposed Q1, tell me  
9 if you recognize that?

10 A (Witness complied.)

11 Q Do you recognize that?

12 A Yes.

13 Q Is that the email from CDC?

14 A Yes.

15 MR. WRIGHT: Move the admission of Q1.

16 THE COURT: Any objection to Q1?

17 MS. WECKERLY: Yes.

18 THE COURT: I'll see Counsel at the bench, and I'll  
19 see the exhibit.

20 (Off-record bench conference.)

21 THE COURT: I mean, isn't that the import of the  
22 email basically?

23 BY MR. WRIGHT:

24 Q Judge -- is that an accurate record from  
25 Southern Nevada Health District emails?

1           A     It looks to be.

2           Q     And that is to you, reporting the results of  
3 their search for publications regarding serial contamination  
4 of vials, correct?

5           A     Yes.

6           MR. WRIGHT: Move its admission.

7           THE COURT: Well --

8           MS. WECKERLY: Same objection.

9           THE COURT: For right now that's overruled, but you  
10 can certainly ask him what they found, how many studies they  
11 found, and whether or not he looked into the study they found,  
12 or publication.

13          MR. WRIGHT: Can we approach?

14          THE COURT: Sure.

15                    (Off-record bench conference.)

16 BY MR. WRIGHT:

17          Q     Did you call Melissa Schaefer on about March 24,  
18 2009, and ask her if the CDC was aware of any articles in the  
19 published literature that document serial contamination of  
20 vials as you presume happened in Las Vegas?

21          A     Yes.

22          Q     Okay. And you stated you want to cite an  
23 article in your report to describe this, correct?

24          A     Yes.

25          Q     Okay. And at the time your report is not

1 completed?

2 A That's correct.

3 Q And then a response came from CDC containing one  
4 article, correct?

5 A Yes.

6 Q And the CDC told you that it seems like there's  
7 enough information --

8 MS. WECKERLY: Objection. Hearsay.

9 THE COURT: Well, go ahead and ask the question.

10 BY MR. WRIGHT:

11 Q The CDC --

12 MS. WECKERLY: Objection, Your Honor. This is the  
13 content of the email.

14 THE COURT: Well, if the point is that's the only  
15 article or why he was directed to that particular article --

16 MS. WECKERLY: That's not the --

17 THE COURT: -- he can answer.

18 MS. WECKERLY: -- content.

19 THE COURT: Go ahead.

20 BY MR. WRIGHT:

21 Q Did the -- did the CDC form you -- tell you,  
22 pardon me. Did the CDC state that the article and -- that  
23 with the article, it seems like there's enough information  
24 here and from your investigation to show that this is clearly  
25 a plausible explanation?

1 A Yes.

2 Q Okay. And the "plausible explanation" they're  
3 talking about, is showing your -- your serial contamination  
4 theory as the mechanism of transmission, correct?

5 A Yes.

6 Q And then the article they sent you involved a  
7 pooling -- P-O-O-L-I-N-G, a pooling outbreak, correct?

8 A Yes.

9 Q Okay. And it really wasn't applicable to your  
10 serial contamination theory, correct?

11 A I'm not sure exactly which article that is, so I  
12 couldn't say.

13 THE COURT: Did you follow up and actually pull the  
14 article and read the article?

15 THE WITNESS: I likely did, yes.

16 THE COURT: Do you -- I mean, don't guess because we  
17 tell everyone don't speculate. If you don't remember, then  
18 don't guess or speculate as to what you did.

19 THE WITNESS: Then I don't remember.

20 THE COURT: All right.

21 BY MR. WRIGHT:

22 Q Now, this is -- this is in February 2009, and  
23 your report is completed in December 2009, correct?

24 A This was actually March, but yes.

25 Q Okay. March, I'm sorry. March 2009, and you

1 completed your report December 2009?

2 A Yes.

3 Q Okay. By -- by then you -- you had already had  
4 published an article about the outbreak, with other authors --

5 A Yes.

6 Q -- correct?

7 A Yes.

8 Q And your theory of contamination?

9 A Yes.

10 Q And you have become a speaker at conferences?

11 A Yes.

12 Q Discussing your theory of contamination?

13 A Among other things, yes.

14 Q Okay. And had you become a celebrity within the  
15 epidemiological group?

16 A No.

17 Q Okay. You were -- you would go to conferences  
18 to discuss the Brian Labus serial contamination theory,  
19 correct?

20 A I think you're the first person that's ever said  
21 that, so I would say no.

22 Q Okay. Ever said what?

23 A The Brian Labus serial contamination theory.  
24 There isn't a conference on that, and it's not a topic of  
25 discussion at the conferences, really.

1 Q Okay. You didn't go put on a PowerPoint and  
2 presentation of this?

3 A Yes, I did. And this was one piece of it, but  
4 it wasn't about just serial contamination. It was the -- the  
5 outbreak, the response, kind of the -- the entire thing from  
6 beginning to end.

7 Q Okay. And so you -- you had published an  
8 article, gone to conferences, plural; how many?

9 A I think I presented on this three or four times  
10 at conferences, maybe.

11 Q Okay. All before you got your report out,  
12 correct?

13 A No, I've presented on it since then as well,  
14 but --

15 Q Pardon?

16 A No, I've presented on it since then as well, but  
17 it -- there were presentations before the report was  
18 completed.

19 Q To this date, 2013, are you aware of any other  
20 cases of serial contamination, or any other articles other  
21 than your own?

22 A No, I'm not.

23 Q Now, having reached the determination by -- by  
24 Friday, January 11, in the evening, as to the method of  
25 transmission, you all started then working with the clinic on

1 a plan for notification; is that correct?

2 A No, the decision to notify came after that,  
3 probably not until February.

4 Q Okay.

5 A We worked with a clinic to remediate the  
6 situations we found that were problems in the clinic.

7 Q Okay. To correct everything?

8 A Yes.

9 Q Okay. And the -- you on -- on your side were  
10 planning a patient notification, correct?

11 A Not at that point.

12 Q Okay. Well, you'd made a determination that  
13 there were unsafe-injection practices?

14 A Yes.

15 Q Okay. And so the -- the question was really the  
16 scope of the notification, not whether you would notify,  
17 correct?

18 A We didn't have discussions about that  
19 notification yet. We needed to complete the investigation  
20 before we moved into that phase, and the investigation on that  
21 date still wasn't completed.

22 Q Okay. You had made your conclusion as to what  
23 it was, correct?

24 A Yeah, we moved that to the top of the list.

25 Q Okay. Well, did I read accurately that you had



1 concluded it by January 11?

2 A Yeah, you did.

3 Q Okay. And your main -- and your -- aside from  
4 correcting what had happened so it stops, your other major  
5 concern as the Health District is to get notification to  
6 anyone who could have potentially been infected by the  
7 practices that preexisted your inspection, right?

8 A At some point, yes, but not at that early date.

9 Q Okay. So your -- your belief is you waited  
10 until February to start determining are we going to notify  
11 patients?

12 A The extent of a notification that was needed,  
13 and how many people, and how to do it, yeah, that -- that  
14 waited a little later.

15 Q So you -- the determination -- ultimately you  
16 decided to notify all patients of what we call Shadow Lane and  
17 Burnham clinics, okay, from -- for the previous four years,  
18 correct?

19 A Yes, it was split up in different phases, but  
20 yes, ultimately that's what we decided.

21 Q Okay. And that determination for notification  
22 was made solely based upon the unsafe-injection practices and  
23 the multiuse -- or the use of propofol as a multiuse vial,  
24 correct?

25 A Well, I wouldn't say "solely," I'd say the fact

1 that there was an outbreak as a result of that showed that  
2 there was a risk to patients, so -- but it was based on those  
3 two items, the two pieces that -- clearly the unsafe-injection  
4 practices.

5 Q Right. And whether there had been a hepatitis  
6 spread or not, you were going to give notification, correct?

7 A Well, that was part of the discussion. And I  
8 can't say what would happen if there wasn't hepatitis because  
9 we didn't have that particular situation. So I can just say  
10 what we did, and that was --

11 Q Okay.

12 A -- to make that --

13 Q But didn't --

14 A -- notification.

15 Q -- didn't you tell Dr. Carrol that in some of  
16 the exchanges with him? You just don't get it, Dr. Carrol,  
17 even if there had been no transmission whatsoever, the  
18 outbreak is what got us into your clinic to observe, and what  
19 we observed is infection -- unsafe-injection practices which  
20 may put patients at risk, and we're going to send out notices  
21 regardless -- regardless of what actually caused the  
22 transmission of hepatitis C, correct?

23 A Yes, that's correct.

24 Q Okay. And so -- and as I recall, right, in  
25 reading one of your depositions, now Dr. Carrol suggested it

1 could have been -- he was baffled about how it had happened,  
2 correct?

3 A Yes.

4 Q Okay. And he even suggested -- you met with him  
5 a couple times?

6 A Yes, we did.

7 Q Right. When he was concerned about whether the  
8 notification was premature, or was broader than necessary?

9 A Yes, that's correct.

10 Q Okay. And he even suggested at one point that  
11 it could have been some person, like, intentionally did this?

12 A Yes, he did.

13 Q Okay. And the -- I -- tell me if I'm wrong, but  
14 I recall your testimony that he would have note -- given  
15 notification even if that was true. If it was, like, caught  
16 on videotape, some person having done -- intentionally caused  
17 the infections, we still would have given notice because of  
18 the unsafe practices we saw?

19 A Yes.

20 Q Okay. Now, that -- and that was the basis of  
21 your notification decision, and the breadth of the -- the  
22 scope of the notification because those practices, as best you  
23 could determine, had existed going back four years --

24 A Yes, that's correct.

25 Q -- right? Because the clinic told you that we

1 have not changed anything over the past four years, our  
2 propofol use, and what we have done hasn't changed day-to-day?

3 A That's correct.

4 Q Okay. Now, when -- when Dr. Cliff Carrol was  
5 talking with you and proposing his -- he was questioning  
6 whether you all were moving too fast --

7 A Yes, that's --

8 Q -- right?

9 A -- correct.

10 Q And the -- he showed you his schematic, or  
11 chart, that raised questions as to how the contamination could  
12 have spread, utilizing your theory, correct?

13 A Well, I'm not sure how he developed the chart,  
14 but yes, he did show me a chart.

15 Q Okay. He showed you a chart, and it had the  
16 rooms separated, correct?

17 A I don't remember if it did or not.

18 Q Okay. Well, the -- do you recall that -- I  
19 don't know if the chart did or not either, but he -- he was  
20 able to tell you what was wrong with the conclusions being  
21 reached because he had patients in separate rooms?

22 A I don't remember that specific --

23 Q Okay.

24 A -- part of the conversation.

25 MR. WRIGHT: I'd like to -- 71.

1 BY MR. WRIGHT:

2 Q It's your interview with Metropolitan Police  
3 Department --

4 A Okay.

5 Q -- in May 2008. Page 71, 72, just read that  
6 to --

7 THE COURT: Is everybody okay?

8 BY MR. WRIGHT:

9 Q -- read that to yourself.

10 THE COURT: Okay.

11 BY MR. WRIGHT:

12 Q See if it refreshes your recollection.

13 A (Witness complied.)

14 Q Does that refresh your recollection?

15 A Yes.

16 Q Okay. And the -- Cliff Carrol had a method of  
17 determining which patient was in which room, correct?

18 A Yes.

19 Q Okay. And this -- this was in February 2008,  
20 correct?

21 A Yes.

22 Q Because it -- the notification was February 27?

23 A Yes.

24 Q Okay. And this conversation with Cliff Carrol  
25 predated the notification?

1 A Yes, it did.

2 Q Okay. And it -- it was during -- and did you  
3 ask him at the time? I mean, because you all hadn't been able  
4 to distinguish rooms, correct?

5 A That's correct.

6 Q Okay. And so Cliff Carrol is showing you a --  
7 or talking to you or showing you problems with your theory or  
8 your conclusion as to the mechanism of transmission by putting  
9 patients in different rooms, right?

10 A Yes, that sounds correct.

11 Q Okay. And so did you ask him how do you do  
12 that?

13 A Yes, I did.

14 Q Okay. What did he say?

15 A From that interview it was that he had some way  
16 of doing it to the computer system.

17 Q Okay.

18 A And we had previously asked them for that a  
19 number of times, and they were never able to previously  
20 provide that to us.

21 Q Okay. But now -- now, he -- he is -- this is in  
22 February and he is telling you it can be done, correct?

23 A Yes.

24 Q Okay. And then you didn't pursue that at all?

25 A To stop the notification? No.

1 Q Right. And/or to try to figure out which --  
2 which person is in which room, correct?

3 A I didn't believe what Cliff Carrol had to say,  
4 so no, I didn't.

5 Q Pardon?

6 A I didn't believe what he had to say, so no, I  
7 didn't --

8 Q You didn't believe --

9 A -- really --

10 Q -- him?

11 A -- no, I didn't.

12 Q Okay. You thought he was just -- what didn't  
13 you believe?

14 A We had asked him for how to split the rooms up a  
15 number of times and he could never tell us, and a week or two  
16 before we were going to make this big announcement, all of a  
17 sudden he knows a way through a computer system that we can't  
18 verify to split the two rooms up. It seemed a little  
19 self-serving at the time.

20 So I -- it wasn't something that was going to change  
21 the notification at that point, and that's really what he  
22 wanted to do. He wasn't arguing about how the outbreak  
23 happened, it was really another attempt to stop the  
24 notification.

25 Q Okay. And so you -- you didn't ask him how he

1 had come up on this date glitch on the computers?

2 A No, I did not.

3 Q Okay. So you just distrusted what he was  
4 telling you at the time?

5 A Yes.

6 Q Okay. And because he -- Cliff Carrol -- Dr.  
7 Carrol just couldn't seem to get it through his mind that this  
8 notification was irrelevant, totally irrelevant to the method  
9 of transmission of contamination, correct?

10 A Yes, that's correct.

11 Q And you had tried to explain that to him that it  
12 doesn't matter anymore how the hep C was spread, this  
13 notification is because of patient risk, based upon practices  
14 that we observed, right?

15 A Yes.

16 Q Okay. Now, having made that determination, and  
17 of course, you all prevailed and it was notification to  
18 patients from 2004, like, March 2004 through January 2008?

19 A Yes, that's correct.

20 Q Okay. And you had made some determination as to  
21 the prevalence of hepatitis C in Clark County, pre -- already  
22 existing hepatitis C, and in the clinic population, correct?

23 A Yes.

24 Q Okay. And you expected a back -- what I call in  
25 a background incidents. In other words, people that walked in



1 the door of the clinic already having hepatitis C would be  
2 some percentage of the population of the patients, correct?

3 A Well, I'd use the term prevalence, not  
4 incidents, it's an Epi term, but yeah, there's --

5 Q Okay.

6 A -- a background rate of disease in the  
7 population coming in.

8 Q Okay. And you made the determination that  
9 because -- that the endo -- the clinics, Burnham, Shadow Lane,  
10 because of the age of the patients, the age of people that get  
11 those type procedures, and the nature of the procedures, that  
12 you expected a prevalence of 6 percent, correct?

13 A I don't think it was that high. I thought it  
14 was 4 percent, but there was a background rate in that range.

15 Q Okay. I'll show you your grand jury testimony.

16 MR. WRIGHT: 116.

17 BY MR. WRIGHT:

18 Q April 15, 2010. Page 116 and going over to 117.  
19 Read that, see if that refreshes your recollection?

20 A (Witness complied.) Yes.

21 Q Okay. And that's 6 percent, correct?

22 A Well, like I said, it was the range, and that's  
23 the high end of the range. So it wasn't a fixed 6 percent.  
24 It was in that range of up to 6 percent.

25 Q Okay. At most a 6 percent background of

1 hepatitis C patients walking in the door infected before they  
2 ever set foot anywhere near the clinic --

3 A Yes.

4 Q -- correct? When you were -- at the clinic, did  
5 you meet Dr. Desai?

6 A Yes, I did.

7 Q Okay. Do you recall how many occasions?

8 A It was twice on Thursday. The first time was  
9 getting out of the elevator, I was introduced to him, and then  
10 our usual Thursday evening meeting or at the end of the day, I  
11 went to Tonya's office and he was there.

12 Q Okay. Now, I have an unrelated question to what  
13 we're talking about, but it has come up throughout the trial.  
14 Should a known hepatitis C patient, one of those 4 to 6  
15 percent walking in the door, assuming they know it -- now, let  
16 me back up.

17 Of that 4 to 6 percent, some of them might not even  
18 know it, right?

19 A Yes, that's correct.

20 Q Okay, but assuming I know it, I've got hepatitis  
21 C, it's chronic, and I'm hepatitis C positive, I'm going into  
22 a clinic for a procedure, are -- are they supposed to treat me  
23 differently?

24 A No, they're not.

25 Q Okay. What are they supposed to do?

1           A     You assume that every person coming in is  
2 basically infected with everything, and so you take  
3 precautions to protect yourself and the other patients.

4           Q     Okay. And you're to treat them equally with  
5 every other patient?

6           A     You know, like I said, you assume everybody has  
7 every disease, so you treat them all equally.

8           Q     Okay. Now, before this event occurred there --  
9 there had been discussions with the Southern Nevada Health  
10 District and other agencies in this state about the lack of  
11 regulation over ambulatory surgical centers, correct?

12          A     There may have been. I wasn't part of them,  
13 though.

14          Q     Pardon?

15          A     I wasn't part of those discussions. I didn't  
16 really become involved with ASCs until this particular  
17 incident. So what predated the regulatory history of this  
18 event, I don't know.

19          Q     Okay. But that NACCHO meeting, do you recall  
20 when this was?

21          A     No, I don't.

22          Q     Patricia Rowley is your boss --

23          A     Yes.

24          Q     -- was?

25          A     Was, yes.

1 Q Office of epidemiology manager here at the  
2 Health District?

3 A Yes.

4 Q Do you recall at that meeting in which you were  
5 present --

6 MR. WRIGHT: Page 41.

7 MS. WECKERLY: I think this is hearsay. My objection  
8 is hearsay to this.

9 THE COURT: I'll see Counsel up here.

10 (Off-record bench conference.)

11 BY MR. WRIGHT:

12 Q Take a look at this. I think you looked at it  
13 before at deposition, and tell me if that's -- if you are Male  
14 No. 1?

15 A Yes, that's me.

16 Q Okay.

17 A Because I identify myself on the first page  
18 here, so yes --

19 Q Okay.

20 A -- that's me.

21 Q And you were present at this meeting. And  
22 Female No. 2 is Patricia Rowley?

23 A That's what it says, yes.

24 Q Okay. And you were -- and this meeting was with  
25 NACCHO representatives discussing the outbreak here in Las

1 Vegas and assisting them in their planning purposes for a  
2 template for future notification issues. Is that what this  
3 was about?

4 A We had several meetings around that same topic.  
5 I'm not sure which meeting it was, but those -- that was a  
6 general topic of all those meetings.

7 THE COURT: How many meetings did you have about that  
8 topic?

9 THE WITNESS: Three, four maybe.

10 THE COURT: Okay.

11 BY MR. WRIGHT:

12 Q So my -- and were you discussing with them there  
13 the various planning that went into it, and the responses of  
14 various government agencies?

15 A Yes.

16 Q Okay. And at that time was it stated  
17 regarding --

18 MS. WECKERLY: Objection. Hearsay.

19 THE COURT: Well, let's let him -- I -- I don't think  
20 it's offered for the truth, just that that was a topic of  
21 discussion and what this witness was aware of. So it can be  
22 considered for that purpose.

23 Go ahead, ask your question.

24 BY MR. WRIGHT:

25 Q Do you recall --

1 Patricia Rowley: We had started discussions about a  
2 year before the outbreak about how there was really no  
3 oversight with infection control in dentist offices, doctor's  
4 offices, ambulatory surgical centers.

5 Is that accurate?

6 A If that's what it says she says. I don't --

7 Q Okay. Well, the -- is --

8 THE COURT: Well, do you remember that that's what  
9 happened, or --

10 BY MR. WRIGHT:

11 Q Do you have any memory of this?

12 A I vaguely remember the meeting. I don't  
13 remember the specific details.

14 Q Do you recall she stating, We were having these  
15 ongoing discussions about the lack of oversight and then this  
16 happened, and then it's, like, oh, my god, here's our worst  
17 nightmare, the thing that we thought might happen because  
18 there really is ineffective oversight and now it's happening.

19 Because the big question that kept coming back to us  
20 was this has been going on --

21 THE COURT: Well, Mr. Wright --

22 MS. WECKERLY: Objection.

23 THE COURT: -- I'm going to sustain because you can't  
24 just read everything that she said. I mean, you can ask him  
25 what he knew, or what his concerns --

1 MR. WRIGHT: Okay.

2 THE COURT: -- were at the time, or what the --

3 MR. WRIGHT: Well, it --

4 THE COURT: -- you know, he was --

5 MR. WRIGHT: -- okay.

6 THE COURT: -- directed to be concerned about or  
7 whatever.

8 MR. WRIGHT: Well, okay.

9 BY MR. WRIGHT:

10 Q Do you recall your boss -- do you recall it was  
11 a big concern because of the lack of regulation of dentist  
12 offices, doctor's offices, ambulatory surgical centers, that  
13 something like this would happen, and then your worst  
14 nightmare, what you thought would happen, happened?

15 A I remember discussions about doctor's offices,  
16 vaguely over time. I didn't know what an ASC really was until  
17 this particular investigation. So any discussions about that  
18 prior to this outbreak --

19 Q Okay.

20 A -- really -- I don't remember any of those.

21 Q The -- after -- after the outbreak -- looking at  
22 2008 now, after the public notification February 27, 2008, did  
23 you then participate in meetings or discussions about how  
24 widespread the practices were in the State of Nevada and what  
25 needed to be done about it?

1 A Yes.

2 Q Okay. And did that result in another Epi-Aid  
3 participation by CDC to come to Nevada to inspect all of the  
4 ambulatory surgical centers?

5 A Yes, it did.

6 Q Okay. And do you recall that there were  
7 widespread practices of multi -- of -- boy, I mix this up  
8 every time -- using single dose vials as multiuse vials?

9 A I remember they identified some of those issues;  
10 I don't know how widespread they were or the full details. I  
11 wasn't involved in that particular Epi-Aid, so I don't know  
12 the details that well on it.

13 Q Okay. Who -- would BLC have been more involved  
14 in that?

15 A Yeah, it was -- it was BLC and the State Health  
16 Division that coordinated statewide. We're only responsible  
17 for Clark County and we don't regulate ASCs, so if it was an  
18 ASC issue it would have been BLC within the State Health  
19 Division that did it.

20 Q Do you recall that the State sent out a  
21 technical bulletin in February 2008 because of the widespread  
22 practices?

23 A I don't know if it was February 2008. I  
24 remember them sending out the technical bulletin in response,  
25 but I don't know the date on it.



1 Q Would you look at Proposed R1, sir?

2 A (Witness complied.)

3 Q Is that -- are you familiar with that?

4 A Yes.

5 Q Is that the notification?

6 A Well, you were referring to the second Epi-Aid.

7 This was based off of the first Epi-Aid, prior to that second  
8 Epi-Aid was ever initiated. This was right after -- if it was  
9 February 2008, it would have been right after our  
10 announcement.

11 Q Okay. And it -- so right at -- and the February  
12 2008 date is on there, correct?

13 A Yes.

14 Q Okay. And so that was essentially sending out a  
15 notice to the State to engage in safe-injection practices and  
16 don't multiuse single-use vials of medication, correct?

17 A Yes, that's correct.

18 Q Okay. And that was -- and, in fact, that was  
19 sent out, correct?

20 A Yes, it was.

21 Q Okay.

22 MR. WRIGHT: I'd move its admission.

23 THE COURT: Any objection?

24 MS. WECKERLY: No objection.

25 THE COURT: All right. That will be admitted. What

1 was that, R1?

2 MR. WRIGHT: Yes.

3 THE COURT: All right.

4 (Defendant's Exhibit R1 admitted.)

5 BY MR. WRIGHT:

6 Q And after what transpired in your investigation,  
7 and after that notice going out to all providers in the State  
8 of Nevada, then the Epi-Aid -- the second Epi-Aid, the  
9 inspection of all the ambulatory surgical centers took place,  
10 correct?

11 A Yes, that's correct.

12 Q Okay. And it -- it's your understanding that  
13 even after that notification and the publicity, there was  
14 still multiuse of vials taking place, discovered during the  
15 second inspection --

16 MS. WECKERLY: Objection. Foundation.

17 BY MR. WRIGHT:

18 Q -- correct?

19 THE COURT: Well, if he -- if he knows.

20 THE WITNESS: Yes, that's correct.

21 BY MR. WRIGHT:

22 Q Did you all at the Health District take a  
23 personal dislike with Dr. Desai?

24 A I can't speak for anybody else at the Health  
25 District. Every time I dealt with him he was pleasant and I

1 had nothing bad to say about the dealings I had with him.

2 Q Do you recall during the NACCHO meeting, people  
3 from the Health District referring to him as Dr. Death, rather  
4 than Dr. Desai?

5 A I don't remember that, and --

6 Q Okay.

7 MR. WRIGHT: On page 46.

8 THE WITNESS: (Witness complied.) Okay.

9 BY MR. WRIGHT:

10 Q Does that refresh your recollection?

11 A I don't remember it, but if it's there, that's  
12 probably the discussion that happened.

13 Q Thank you, sir.

14 THE COURT: Does that conclude your cross?

15 MR. WRIGHT: Yep.

16 THE COURT: All right. Ladies and gentlemen, before  
17 we move into Mr. Santacroce's cross, let's just take a quick,  
18 about 10-minute break until 3:00.

19 During the break you're reminded that you're not to  
20 discuss the case, or anything relating to the case with each  
21 other or with anyone else. You're not to read, watch, listen  
22 to any reports of or commentaries on this case, any person or  
23 subject matter relating to the case, and please don't form or  
24 express an opinion on the trial.

25 Notepads in your chairs. Follow the bailiff through

1 the rear door.

2 (Jury recessed at 2:45 p.m.)

3 THE COURT: I'm sorry?

4 THE WITNESS: The exhibit --

5 THE COURT: Oh, give it to --

6 THE WITNESS: -- do you get that or --

7 THE COURT: -- me.

8 THE WITNESS: -- do I hand it back to him?

9 THE COURT: You can give it to me, so I can hand it  
10 to the clerk. Thank you. And once again, don't discuss your  
11 testimony with anyone during the break.

12 Ms. Weckerly, I'm thinking you'd better line up  
13 witnesses for tomorrow. Line up witnesses for tomorrow.

14 MS. WECKERLY: Okay. We will try to do that.

15 THE COURT: I mean --

16 MR. STAUDAHER: We're -- we're really --

17 MR. WRIGHT: We -- we get to watch a movie --

18 MR. STAUDAHER: -- limited on --

19 MR. WRIGHT: -- tomorrow.

20 THE COURT: Oh, we can watch the --

21 MS. WECKERLY: That's true.

22 THE COURT: -- movie tomorrow. Yeah, that's --

23 MS. WECKERLY: That's 90 minutes.

24 THE COURT: -- a good idea.

25 MS. WECKERLY: And I know Mr. Wright has no objection

1 to it being played.

2 (Court recessed from 2:46 p.m. to 2:58 p.m.)

3 (Outside the presence of the jury.)

4 (Off-record colloquy.)

5 THE COURT: So tell him we're ready. Just so you  
6 know, one of the jurors has an appointment tomorrow morning,  
7 so we'll probably start around 10:30.

8 MR. STAUDAHER: Well --

9 THE COURT: That we told him to move, but he --

10 MR. WRIGHT: Good.

11 MS. WECKERLY: That's fine.

12 MR. STAUDAHER: We're trying to get this worked out.  
13 We've got one confirmed witness for tomorrow right now, and  
14 his flight --

15 MR. SANTACROCE: Can I use your chart?

16 MR. STAUDAHER: -- into town is at about 10 or 10:30.  
17 So we're -- as soon as she gets here, we can do her.

18 THE COURT: Can we stick one of the insurance people  
19 on?

20 MR. STAUDAHER: That's an insurance person --

21 MS. WECKERLY: That's who it is.

22 MR. STAUDAHER: -- but the problem is --

23 THE COURT: Is there any local insurance --

24 MR. STAUDAHER: -- we're trying --

25 THE COURT: -- people?

1 MS. WECKERLY: They don't have their documents ready  
2 yet. We can watch the video.

3 THE COURT: Oh, yeah.

4 MR. STAUDAHER: It's the -- you know, we're in the  
5 process of getting it done --

6 THE COURT: And that's 90 minutes, you said?

7 MS. WECKERLY: Mm-hmm.

8 THE COURT: Okay. Then, so for that reason maybe  
9 we'll go a little bit later today -- Mr. Wright, a little bit  
10 later today, then, since you guys don't have to be back until  
11 10:30?

12 MR. WRIGHT: Yep.

13 THE COURT: Of course, that doesn't help any of us,  
14 but -- because when -- when we start late, then I have to do  
15 my own work. I have to do my own calendar, so it doesn't help  
16 me any.

17 Ready.

18 THE MARSHAL: Ladies and gentlemen, please rise for  
19 the jury.

20 (Jury entering at 3:00 p.m.)

21 THE MARSHAL: Thank you, everybody. You may be  
22 seated.

23 THE COURT: All right. Court is now back in session.  
24 And Mr. Santacroce, you may begin your cross-examination.

25 MR. SANTACROCE: Thank you, Your Honor.

1 CROSS-EXAMINATION

2 BY MR. SANTACROCE:

3 Q Mr. Labus, I represent Mr. Lakeman back here.  
4 I'm going to ask you a few questions about what you testified  
5 at your direct examination. Is it appropriate to call you  
6 Mister and not --

7 A Yes.

8 Q -- Doctor.?

9 A Mister.

10 Q Okay. So you're not an MD?

11 A That is correct.

12 Q When you conducted your investigation of the  
13 hepatitis C outbreak, as I understand it, it was a  
14 multijurisdictional investigation; is that correct?

15 A Yes, it is.

16 Q So it was the Southern Nevada Health District,  
17 the BLC, CDC. Anybody else involved?

18 A Those were the three main groups. CDC was doing  
19 their own investigation, but it was kind of as a technical  
20 consultation of the Health District. They were functioning  
21 under our authority. So the CDC and the Health District are  
22 kind of tied together in some ways.

23 Q Okay. Was the Metropolitan Police Department  
24 involved?

25 A No, they were not.

1 Q District Attorney's Office?

2 A No.

3 Q Okay. You testified in -- in front of the grand  
4 jury and you said it was not like a criminal investigation.  
5 What did you mean by that?

6 A We were conducting a public health  
7 investigation. We wanted to know what happened. We really  
8 don't care who's responsible, who's at fault, if there is  
9 anybody at fault, any of those sort of things. We weren't  
10 trying to establish guilt or innocence of anybody. We wanted  
11 to find out what happened so we could stop it. And the  
12 motivation behind it really didn't matter, as long as we could  
13 find out what it was and prevent any additional cases from  
14 occurring.

15 Q It wasn't your intent or purpose to prove the  
16 mechanism of transmission beyond a reasonable doubt?

17 A That's correct.

18 MS. WECKERLY: Objection. Calls for a legal  
19 conclusion.

20 THE COURT: Well, overruled.

21 BY MR. SANTACROCE:

22 Q Correct?

23 A Yes.

24 THE COURT: He's already answered.

25 BY MR. SANTACROCE:



1 Q So basically you were trying to find out, as the  
2 CDC put it, the likely method of transmission?

3 A Yes, that's correct.

4 Q And when you started your investigation, you  
5 went in there with some sort of a theory or hypothesis that it  
6 was through unsafe-injection practices, correct?

7 A That was the top on the list, but it wasn't the  
8 only thing we considered.

9 Q All right. Well, we're going to talk about some  
10 of the other things you did consider, okay? When you went  
11 into the investigation, I believe you -- the first day you did  
12 some records check -- checking?

13 A The first full day, yes. We met with the  
14 clinic, the first day we met with them on Wednesday.  
15 Thursday, our first full day of investigation, we went through  
16 records.

17 Q And then, the next few days, I guess you did  
18 some observations?

19 A Friday we did observations, and then it was  
20 mostly records the early part of the following week.

21 Q And did you conduct interviews?

22 A Yes, we did.

23 Q Do you know who you interviewed?

24 A We talked to a number of people walking around  
25 the clinics, sometimes -- they weren't really formal

1 interviews, it was kind of, you know, if we saw something we'd  
2 ask whoever was working with it what was going on. We had the  
3 people who were responsible for doing different things show us  
4 what they did.

5 We also did blood draws on all the staff members to  
6 look for hepatitis C, and many of them said different things  
7 because they had an opportunity to talk to the investigators,  
8 but it wasn't a -- a formal interview or anything like that.

9 Q So it wasn't a sit-down interview that was  
10 tape-recorded or -- or written or transcribed?

11 A No.

12 Q And the people you interviewed weren't  
13 necessarily the same people that were working on July 25th of  
14 2007, or September 21st 2007, correct?

15 A That's correct.

16 Q Now, when -- when you go into these  
17 investigations, I guess you're looking for sort of  
18 commonalities, correct?

19 A Generally, yes.

20 Q And you said you looked at certain other things  
21 other than the unsafe-injection practices. What are some of  
22 the other things you looked at?

23 A Well, we wondered if it was a particular staff  
24 member, either directly transmitting the virus to patients, or  
25 the particular actions of a -- of one particular person. So

1 we looked at that. We looked at the cleaning of the scopes.  
2 We evaluated the records to really see if anything kind of  
3 jumped out of procedure-type, or what -- kind of those -- the  
4 common big groupings you could have. Would it be an upper or  
5 lower endoscopy? Did they have the same doctor? same CRNA?  
6 same nurse? Anything like that.

7 Q And as I understand it, you didn't have all the  
8 information you needed, and what I mean by that is, for  
9 example, you didn't know what room these individual patients  
10 were in; is that correct?

11 A Yes, that's correct.

12 Q And you didn't know what time the procedures  
13 that they had actually occurred?

14 A Well, we had a number of times on the charts,  
15 and we had difficulty putting that together into a number that  
16 we could say we were absolutely confident this is the exact  
17 order down to the minute of how things occurred.

18 Q But you did come to some conclusion regarding  
19 the times, did you not?

20 A In general, yes, but it was very specific to do  
21 a -- a minute-by-minute analysis because that data just wasn't  
22 reliable.

23 Q And I -- I think what you testified to in the  
24 grand jury was that you finally came to the conclusion that  
25 the nurse's notes were accurate as far as the times went?

1           A     We decided there were a couple things we were  
2 going to use. They had a computerized system, so at the  
3 beginning of the procedure, I believe, we used the time the  
4 nurse wrote down that said, it's now, you know, 3:15 p.m., and  
5 wrote that down as when it started. There's some fuzziness to  
6 that because it could have been the clock on the wall, they  
7 could have looked at the computer, they could have looked at a  
8 watch.

9           So, you know, the -- all the times aren't exactly  
10 synched up. For the ending time we had that time as well as a  
11 timestamp that was basically when the doctor finished, they  
12 kind of signed the chart, and that was a timestamp on there  
13 that we would use as the completion of the procedure,  
14 basically when the doctor was done. Even if there was 20  
15 minutes of cleaning up and all those things, it didn't matter  
16 because we knew the procedure itself was basically done at  
17 that time.

18           Q     And I believe you testified that you actually  
19 observed the nurses looking at a clock and writing times down,  
20 correct?

21           A     Yes.

22           Q     Okay. And you sort of take -- you took that  
23 time as -- as being as accurate as you possibly could be?

24           A     That's correct.

25           Q     I want to talk about some of the things that you

1 investigated, and I'm going to show you this chart -- Exhibit  
2 228 by the State. And these were some of the things that --  
3 who prepared this? You did?

4 A I did.

5 Q Okay. The staff, the patient, you ruled that  
6 out. You didn't see any -- you tested everybody, all the  
7 staff for hep C, they didn't have it, so you ruled that out,  
8 correct?

9 A Yes, and we also had the names of former staff  
10 members, and we cross-referenced those against a list of  
11 people we knew to be hep C positive in Southern Nevada and  
12 didn't find any matches.

13 Q And the next one, what did that mean, physician?

14 A Was there one physician. The actions of one  
15 physician make it more likely. So, for example, Dr. A or Dr.  
16 B was more responsible for the cases than another one.

17 Q And then CRNA?

18 A The same sort of thing. Was one CRNA  
19 responsible for the -- the cases, or was it a general issue?

20 Q Okay. And the next one, technician?

21 A The same thing.

22 Q Okay. But who -- which technicians are we  
23 referring to?

24 A The technician that was listed on the chart as  
25 assisting the provider. The one who basically helped handle

1 the scope, handed equipment to the -- the doctor. So there  
2 was a -- a technician posted right next to the -- the  
3 equipment, and that technician's name was on the chart.

4 Q And you obtained the name of those GI  
5 technicians through the patient charts?

6 A Yes, we did.

7 Q Did you interview any of those people?

8 A We talked to some of the technicians, just in  
9 the course of our investigation, but it wasn't a formal  
10 interview. The techs that were doing the scope reprocessing,  
11 we had them show us the process; so we spent a little more  
12 time with them, but we didn't sit down and do a formal  
13 interview with any of them.

14 Q Did you interview or talk to any of the GI techs  
15 that were reprocessing scopes on the two infection dates?

16 A We didn't have a list of who was doing that on  
17 those dates, so we may have, but I don't know.

18 Q Well, you said you reviewed the patient charts  
19 for those dates, didn't you?

20 A The techs that are listed on there were the  
21 techs directly assisting with the procedure. The one that was  
22 reprocessing isn't listed in the chart.

23 Q Okay. And what is the issue with the scopes?  
24 Or what was the issue?

25 A When the process was presented to us, they'd use

1 an enzyme detergent, and it goes in a basin and they -- it's  
2 kind of like soapy water in your sink with an enzyme  
3 detergent. They use that to clean the scopes. They use  
4 brushes and -- that detergent is supposed to be used for one  
5 scope, and they were doing two scopes at a time. The two  
6 scopes were basically done together and then went into the  
7 automated reprocessor. So they were using the detergent on  
8 more than one scope.

9 Q And what's the danger with not cleaning the  
10 scopes properly?

11 A There could be a potential transmission of  
12 infection if the scopes aren't cleaned properly.

13 Q Okay. And did you note how long it took them to  
14 clean the scopes?

15 A Yes, we did.

16 Q How long was that?

17 A The automated process was about 17 minutes, the  
18 overall process was 30 to 35 minutes or so. It took about  
19 a -- a half-hour a scope is a safe estimate. They had to do  
20 a -- a manual part first, and then it went into one of two  
21 reprocessing machines where they passed a high-level  
22 disinfectant through the machine and basically sanitized it.  
23 And then -- that was -- and then they just -- I think, air  
24 dried it or blew some air through it to dry it out there, then  
25 hung it for the next person. So it took roughly a half-hour

1 or so.

2 Q So if we had testimony from an expert on Friday  
3 that says it takes 55 minutes to clean the scopes, they  
4 weren't -- they weren't taking 55 minutes, were they?

5 MS. WECKERLY: I'm going to object. There's no  
6 evidence that it's the same machine, same manufacturer,  
7 nothing.

8 THE COURT: All right. That's sustained. You can  
9 say that --

10 BY MR. SANTACROCE:

11 Q What --

12 THE COURT: -- there's no -- and then --

13 MR. SANTACROCE: I'll ask it a different way.

14 THE COURT: -- anything else is argumentative to the  
15 --

16 BY MR. SANTACROCE:

17 Q Did you review any of the  
18 manufactured-recommended cleaning instructions for the scopes?

19 A Yes, we did.

20 Q And how long did the recommended manufacturers  
21 guidelines tell you it would take to clean the scopes?

22 A It was an automated process, and so it wasn't --  
23 I don't believe they set a time on it or it had a time. It  
24 was basically press the button and go kind of thing.

25 Q Were you aware that some -- at some points the



1 Medivators that clean the scopes were broken?

2 A Yes, we had heard reports of that.

3 Q And, in fact, you testified in front of the  
4 grand jury as to that, correct?

5 A I may have.

6 Q And what did you tell the grand jury that the GI  
7 techs would do when the Medivators were broke?

8 A When the Medivators were broken there were two  
9 things. They could get replacement equipment if needed, but  
10 there was a manual process where they would basically soak the  
11 scopes in the high-level disinfectant, rather than use the  
12 machine.

13 Q And you noted that there was an issue as to the  
14 otoscopes they were cleaning before changing the enzymatic  
15 fluids, correct?

16 A Yes.

17 Q I'm going to show you State's Exhibit 150. Did  
18 you ever view this room -- the room where the scopes were hung  
19 up to dry?

20 A Yes.

21 Q There was testimony in this case that some GI  
22 techs, or some nurses observed fecal matter on these chux here  
23 after scopes were allegedly cleaned. Did you note any of  
24 that?

25 A We didn't see any of that.

1 Q Did you talk to anybody that told you that?

2 A No.

3 Q If that was, in fact, true, would that be a  
4 problem for you?

5 A It would have been a concern, yes.

6 Q Now, the BLC -- were you aware that the BLC did  
7 a summary statement of deficiencies for the clinic?

8 A Yes.

9 Q Had you seen that?

10 A Yes.

11 Q Showing you State's Exhibit ADE-3. This is  
12 allegedly an observation by the BLC on 1/16/08. The GI tech  
13 was asked to describe the measured amount of M power with what  
14 amount of water. The GI tech stated, Add two to three pumps.  
15 Not sure the capacity of the basin. And then it says, I don't  
16 have an answer for that.

17 Were you -- were you aware of that? Did you observe  
18 that?

19 A Yes.

20 Q Okay. And the recommendation by the BLC -- are  
21 you aware what that recommendation was?

22 A I remember reading them, but I don't remember  
23 what their specific recommendations were.

24 Q Here it notes -- can you read this? Do I have  
25 it down far enough for you? The GI techs cleaned two

1 endoscopes before discarding the enzymatic detergent solution  
2 in a water rinse. Did you observe that too?

3 A Yes.

4 Q Did any of the GI techs tell you that they had  
5 actually cleaned more than two scopes, possibly six, seven,  
6 eight, nine scopes before changing the enzymatic fluid?

7 A No, they did not.

8 Q Would that have been a concern to you?

9 A Yes, it would have.

10 Q Now, going down your chart here, you talk about  
11 biopsy equipment. What was the concern regarding the biopsy  
12 equipment?

13 A If a particular piece of biopsy equipment could  
14 have been the source of transmission was something that we  
15 ruled out, as not all patients had a biopsy and those with a  
16 biopsy were no more likely to be infected than those who  
17 didn't have a biopsy.

18 Q The biopsy equipment was reused?

19 A That was reported later on. During the initial  
20 investigation it was just -- for this particular one, was  
21 there an increased risk due to having a biopsy or not?

22 Q And you ruled that out because of what?

23 A Not all patients had a biopsy and the --  
24 basically the patients with a biopsy weren't at a higher  
25 statistical risk than those who did have a biopsy.

1           Q     I'm showing you Exhibit 157. This purports to  
2 be a chart of -- have you seen this before, so I don't have to  
3 explain it?

4           A     Could I see the actual chart itself?

5           Q     Sure.

6           A     That may make it a little easier than --

7           Q     Have you seen that?

8           A     Yes.

9           Q     Okay. So you know what it is?

10          A     Yes.

11          Q     Were you aware that on July 25th that the source  
12 patient Ziyad Sharrieff and Michael Washington both had  
13 biopsies?

14          A     Is that what it says on the chart? I'd have to  
15 look and see. I -- it's not on the column up there, but --

16          Q     Okay. I'm asking you if you were aware of that  
17 when you ruled out that biopsy equipment was the source of  
18 transmission?

19          A     Well, that's not related to that table. That  
20 table was about September 21. So we ruled it out for  
21 September 21.

22          Q     So this table only applies to September 21?

23          A     That's what the title says at the top.

24          Q     So the biopsy equipment could be the source of  
25 transmission for the 25th?

1           A     I didn't do a statistical calculation on the  
2 biopsy equipment for that particular day.

3           Q     So, I guess my question is, you can't rule it  
4 out for that date?

5           A     Statistically, no, we couldn't do any  
6 calculations for that day because there was only one infected  
7 person.

8           Q     Now, what's the next thing? The endoscopes,  
9 which I believe we already talked about, correct?

10          A     Yes.

11          Q     And the next -- next one?

12          A     Procedure type where patients with a colonoscopy  
13 are more likely to be infected than those with an upper  
14 endoscopy or vice versa. There was no statistical finding  
15 that either one was a higher risk.

16          Q     And bite blocks?

17          A     The same. Same thing. It's very closely tied  
18 to the procedure type. Only upper endoscopies had bite  
19 blocks.

20          Q     Now, were you aware that they were reusing bite  
21 blocks?

22          A     Yes.

23          Q     And the next issue?

24          A     That would be the IV placement.

25          Q     And why did you rule that out?

1           A     In order to contaminate a common saline bag  
2 you'd have to have a reentry into that saline bag. It was a  
3 single flush on September 21. In addition, on July 25, the  
4 source patient didn't go into the IV room, his IV was done in  
5 the procedure room. So the -- the IV placement room wouldn't  
6 have been a factor if the source patient never went into that  
7 IV placement room.

8           Q     Were you aware that there was a mistake on the  
9 CDC's report as to who gave the -- who started the IVs on July  
10 25?

11          A     Yes, I believe they had an incorrect name or  
12 something on there of -- of who did it.

13          Q     Okay. So the fact that you ruled it out because  
14 you believed that the same person started the IV heparins was  
15 incorrect?

16          MS. WECKERLY: I'm going to object. I think that  
17 misstates the testimony.

18          MR. SANTACROCE: Well, he can state what he testified  
19 to.

20          THE COURT: I'm not -- you can answer the question.

21          THE WITNESS: From the chart it appeared that the IV  
22 was placed in the procedure room, and not in the -- the IV  
23 prep room.

24          Q     But that was incorrect that you came to find out  
25 later?

1           A     In the CDC report --

2           MS. WECKERLY:  Objection.  No -- they're talking  
3 about --

4           THE COURT:  Okay.  When you say the --

5           MS. WECKERLY:  -- that misstates the testimony.

6           THE COURT:  -- IV placement here, what are you  
7 talking about?

8           THE WITNESS:  The -- the patient -- they put a  
9 heplock in the arm they could inject into.

10          THE COURT:  Okay.

11          THE WITNESS:  On July 25, the patient didn't go into  
12 the IV prep room to get the heplock placed, it was placed in  
13 the surgical room itself.  And that was based on observations  
14 of the patient charts.

15          THE COURT:  Okay.

16          BY MR. SANTACROCE:

17               Q     Okay.  And my point is that the CDC erroneously  
18 reported that both patients -- that is, the source patient and  
19 the infected patient Michael Washington -- their IVs were not  
20 both started in the procedure room.

21               A     I never said that Michael Washington's was.  It  
22 was the source patient that was starting the procedure.  On  
23 the subsequent ones for the day would have been done in the --  
24 the IV placement.  They basically had their IVs placed in two  
25 different places.

1 Q How about on September 21?

2 A I believe those were all placed in the IV  
3 placement room.

4 Q Okay. Did you find any commonalities with  
5 regard to that?

6 A No, we did not.

7 Q I'm going to show you this chart for September  
8 21. The top line is all the patients that were in Room 1.  
9 And the bottom line are the patients in Room 2, and those are  
10 the patients that were tested and reported having hep C. You  
11 see Kenneth Rubino, the source patient, up here?

12 A Yes.

13 Q Started by Lynette Campbell in the preop area.  
14 Did you interview Lynette Campbell?

15 A I don't believe that she was one of the people I  
16 talked to.

17 Q Do you see Rodolfo Meana?

18 A Yes.

19 Q Started by Lynette Campbell.

20 A Yes.

21 Q Sonia Orellana? Lynette Campbell. Gwendolyn  
22 Martin? Lynette Campbell. Nguyen Huyhn? Lynette Campbell.  
23 Patty Aspinwall? Lynette Campbell. Carole Grueskin? Lynette  
24 Campbell. The other two patients were started by Jeff Krueger  
25 in the same preop area. Did you note that?



1           A     I'd have to look at the table, but I -- I see  
2 what you're saying, yes.

3           Q     Okay. And Jeff Krueger testified that they  
4 shared saline in the preop area.

5           A     Okay.

6           Q     Knowing this commonality and knowing the fact  
7 that they shared saline, does that give you any cause for  
8 concern?

9           A     No, based on the -- the CDC observations of the  
10 IV prep room, it was known that it was a shared saline. We --  
11 that's not a surprise. It is a multidose vial, and it  
12 appeared to be used appropriately from the CDC observations.

13          Q     Is multidose vials of saline acceptable  
14 practice?

15          A     Yes, if the saline is labeled for multidose, and  
16 in that case I believe that it was.

17          Q     Going back to the BLC statement of deficiencies,  
18 that's Exhibit ADE-3. Calling your attention to this area  
19 here, do you see that? What was the BLC's recommendation  
20 regarding the intravenous fluids?

21          A     Do not use bags or bottles of IV solutions, a  
22 common source of supply for multiple patients.

23          Q     So the fact that they were using it was not  
24 appropriate practice, at least according to this; wouldn't you  
25 agree?

1           A     Well, according to that, yes, that's what they  
2 said.

3           Q     Now, we're going to talk about propofol. And  
4 you talked about your theory that the mechanism of  
5 transmission was unsafe injection practices contaminating  
6 propofol bottles, correct?

7           A     Yes.

8           Q     And you testified that you didn't actually know  
9 what room the patients were in, when you came to this  
10 conclusion?

11          A     Yes, that's correct.

12          Q     In fact, the CDC issued a preliminary finding  
13 before they left Las Vegas in mid-January that the -- that's  
14 what they believed the cause was?

15          A     Yes.

16          Q     Okay. We had both of the doctors from CDC  
17 testify here, and Dr. Gayle Langley Fischer testified that in  
18 order for the transmission to have occurred through  
19 contaminated propofol, there would have to be a showing that  
20 the bottle traveled from room to room. Do you concur with  
21 that?

22          A     I would agree that propofol had to travel from  
23 room to room; not necessarily a bottle, but yes.

24          Q     A contaminated bottle?

25          A     Or a syringe that was drawn with contaminated

1 propofol.

2 Q Well, her opinion was that the contaminated  
3 bottle would have to travel from room to room. Do you  
4 disagree with that?

5 A Yes, I do.

6 Q Again, I -- I'm going to show you State's  
7 Exhibit 156. And I guess it's your belief from the last  
8 answer that -- you believe that the contaminated bottle  
9 wouldn't necessarily have to go from room to room, but an  
10 infected syringe would?

11 A A syringe that had been drawn with contaminated  
12 propofol.

13 Q You didn't have any evidence that a -- first of  
14 all, that CRNAs went from room to room except during lunch  
15 periods and brief periods of breaks, correct?

16 A And on the table here you can see that -- if  
17 it's set up by room you see people in both.

18 Q And we'll get to that. I want to know what you  
19 testified to in front of the grand jury. You told the grand  
20 jury that you had no evidence, or didn't observe any CRNAs  
21 moving from room to room except at lunch breaks or a bathroom  
22 break, correct?

23 A Yes.

24 Q And you didn't see any syringes go from room to  
25 room either?

1 A That's correct.

2 Q But it's your theory that on this particular  
3 date, September 21, somehow a contaminated syringe went from  
4 room to room?

5 A Or a vial. Well, it had to be one of the two.  
6 I wasn't saying it was --

7 Q Had to be one of the two?

8 A -- I wasn't saying it was exclusively a syringe,  
9 but it -- one --

10 Q Let's look --

11 A -- one of those.

12 Q -- at the chart. Room 1 is on the top of your  
13 screen there, okay?

14 A Okay.

15 Q You see Kenneth Rubino. That's the source  
16 patient, correct?

17 A Yes.

18 Q And his procedure started at 9:45, correct?

19 A What's the column header on that one?

20 Q Let's take a look.

21 A I just want to see what's on the top of that --

22 Q Let's -- actually --

23 A -- that table.

24 Q -- let's use the nurses' time because that's  
25 what you said, I believe, you relied on; is that correct?

1 A Well, I don't know what column that is, so...

2 Q Can you see the nurses' times there? The  
3 nurses' log notes?

4 A Yes.

5 Q Right here?

6 A Yes.

7 Q Okay. And what time does it say Kenneth Rubino  
8 started?

9 A 9 --

10 Q He's the orange one.

11 A -- 9:49.

12 Q Okay. And what time did he end?

13 A 10.

14 Q And what time did Stacy Hutchinson -- she's  
15 right here, Stacy in Room 2.

16 A I can't see that on the screen. Okay. There it  
17 is.

18 Q See that?

19 A Yes.

20 Q Stacy, Room 2? Then sliding over to the nurses'  
21 notes, what time did she start her procedure?

22 A 9:55.

23 Q So Kenneth Rubino didn't finish his procedure  
24 until 10:00. Stacy Hutchinson began before Rubino finished.

25 So presumably Mr. Rubino was already still under anesthesia at

1 the time that Ms. Hutchinson was undergoing her procedure,  
2 right?

3 A Yes, that's correct.

4 Q So somehow the bottle from Room 1, from Rubino,  
5 would have had to have been transferred to Stacy Hutchinson,  
6 or an infected syringe, correct?

7 A Yes.

8 Q Even though both of them were undergoing a  
9 procedure at the same time in different rooms?

10 A Yes.

11 Q Now, what is the next item here? These are what  
12 we just talked about, the sedation and injection practices?

13 A Yes.

14 Q Okay. You were a co-author on the CDC's -- on  
15 this report here, correct?

16 A Yes.

17 Q And let me give this back to you before I  
18 forget. Thank you. This is Exhibit 105. What contributions  
19 did you make to this article?

20 A Review and comments on it. The main authors  
21 were Gayle and Melissa.

22 Q Okay. So you reviewed it, commented, signed off  
23 on it?

24 A Yes.

25 Q And you're aware that their conclusions were

1 drawn prior to any of the information we discussed regarding  
2 the assignment of the rooms, the times, all of that, correct?

3 A Yes.

4 Q And you'll notice on the last page, there was a  
5 caveat to the report. Do you recall what that caveat was?

6 A No, not off the top of my head.

7 Q The investigation and conclusions reached are  
8 subject to unavoidable limitations. Do you know what those  
9 limitations were?

10 A Yes, and they're described in the rest of that  
11 paragraph.

12 Q Okay. And that is that it -- the investigation  
13 was done over a 10-day period, five months after the outbreak,  
14 was subject to recall bias?

15 A Yes.

16 Q And in fact, you didn't interview the GI techs  
17 that were involved on the days of the infections. You didn't  
18 interview Lynette Campbell, who was involved on the infection  
19 date, did you?

20 A That's correct.

21 Q I have nothing further. Thank you.

22 THE COURT: All right. Redirect?

23 MS. WECKERLY: Mr. Santacroce, may I just have that  
24 for one second? Thank you.

25 REDIRECT EXAMINATION

1 days were you there?

2 A Five or six days.

3 Q And during those five or six days, were all  
4 the -- the charts reviewed from July the 25th and September  
5 the 21st?

6 A Yes, they were.

7 Q And based on your -- your interviews that you  
8 personally did, as well as the CDC interviews and your review  
9 of the charts and your own observations, did you eventually  
10 personally reach a conclusion about how you believe the  
11 hepatitis outbreak occurred in this particular case?

12 A Yes.

13 Q And -- I mean, did I leave any -- well, let me  
14 ask you this: What was that conclusion?

15 A That the reuse of propofol vials for multiple  
16 patients and the reuse of syringes to access those vials for  
17 an individual patient provided the greatest risk of  
18 transmission of blood-borne pathogens between patients.

19 Q And you, I think, talked about earlier that you  
20 -- or you considered other possible means of transmission; is  
21 that fair?

22 A Yes.

23 MS. WECKERLY: May I approach?

24 THE COURT: Mm-hmm.

25 BY MS. WECKERLY:



1           Q     Sir, I'm showing you what's been marked as  
2 State's Proposed Exhibit 228. Is this a chart that you  
3 prepared in association with this investigation?

4           A     Yes, it is.

5           Q     In order to prepare this chart, did you rely on  
6 your -- the investigation you conducted with the CDC?

7           A     Yes.

8           Q     And your observations at the clinic on the days  
9 you were there?

10          A     Yes.

11          Q     Any -- like, the records or anything else that  
12 you may have relied on?

13          A     The clinic propofol records as well, and the --  
14 some of the purchasing records the clinic had as well.

15          Q     Okay. And the patient files, is that --

16          A     Yes.

17          Q     Okay.

18          MS. WECKERLY: State moves to admit 228.

19          MR. WRIGHT: Objection.

20          MR. SANTACROCE: Objection.

21          THE COURT: Yeah, let me see it.

22          MR. WRIGHT: May we approach --

23          THE COURT: Sure.

24          MR. WRIGHT: -- after you look at it?

25                   (Off-record bench conference.)

1 BY MS. WECKERLY:

2 Q Now, let's talk about State's Proposed 228. Was  
3 this a chart that -- that you personally prepared?

4 A Yes, it is.

5 Q And in terms of -- without reading what the  
6 content is, with regard to the top of the chart and the  
7 conclusion that you drew, on the first box there, was that  
8 based on personal observations or the collective investigation  
9 or -- can you let us know what that was based on?

10 A It was based on laboratory results that I  
11 reviewed, and -- I guess both of them would be lab results  
12 that I reviewed.

13 THE COURT: Can you speak up? I didn't hear that  
14 last --

15 THE WITNESS: Both were laboratory results that I  
16 reviewed.

17 THE COURT: Okay. Laboratory results from where?  
18 The Health District, or the --

19 THE WITNESS: It was a combination. The first one  
20 was done -- the lab results -- the specimens were collected by  
21 the Health District. The second one, the specimens were  
22 collected by the Health District or their commercial labs and  
23 tested at the CDC.

24 THE COURT: Okay. And then when you say "reviewed,"  
25 is that you sitting there and looking at the -- at the results

1     yourself?

2                 THE WITNESS:   Yes.

3                 THE COURT:    Okay.

4     BY MS. WECKERLY:

5                 Q     And then the --

6                 THE COURT:   And just, sir, so you know, just sort of  
7     generally, so I don't have to keep interrupting, if it's not  
8     something that you did, let's say, you know, it's somebody  
9     else at the Health District who did that, just, you know, say  
10    who that person was as opposed to "we" did that because that  
11    doesn't really mean anything to us, you know?

12                THE WITNESS:   Okay.

13                THE COURT:    Okay.

14    BY MS. WECKERLY:

15                Q     And the -- the second conclusion, can you tell  
16    us what that was based on, or -- or how you formulated that  
17    opinion?

18                A     I analyzed the data that was collected by the  
19    team, extracted from the charts, and did the calculations to  
20    see if that was a risk.

21                Q     Okay.   So that was your own calculation and your  
22    own analysis of the data, but the data might have been  
23    gathered by others, is --

24                A     That's correct.

25                Q     In addition to yourself, though, probably too?

1           A     Yes, that's correct.

2           Q     Okay. And then the -- sorry, the third box?

3           A     Same thing. The data was collected by the  
4 group; I did the analysis myself.

5           Q     Okay. So that's your own conclusion?

6           A     Yes.

7           THE COURT: I have a question, I'm sorry. How was  
8 the data recorded by the group, meaning, did they just have  
9 their notes and you all sat and discussed it, or did they all,  
10 then, prepare their own written report of what the -- their  
11 data was; or how was that, I guess, conveyed to you? Was it  
12 conveyed through conversation or a meeting or what?

13          THE WITNESS: We had standard forms that we used to  
14 --

15          THE COURT: Okay.

16          THE WITNESS: -- extract the data from the chart.  
17 Once it was on the forms, the data was entered to a -- into an  
18 Excel spreadsheet, and that -- I went back and recollected  
19 some of the data and updated and corrected things, so at the  
20 end we had one Excel spreadsheet that we could use to do the  
21 data analysis.

22          THE COURT: Okay. And that was a compilation of all  
23 of the chart -- the charts?

24          THE WITNESS: Yes, that's correct.

25          THE COURT: All right.

1 BY MS. WECKERLY:

2 Q Okay. And the fourth box?

3 A The fourth box, the same thing. It was a data  
4 analysis that I performed on data collected by the group.

5 Q Okay. And the next one?

6 A Same thing. It was a data analysis that I did  
7 on data collected by the group.

8 Q Okay. The -- is this the sixth box are we on  
9 here?

10 A Yes.

11 Q Okay.

12 A That was a review of the data collected by the  
13 group that I performed.

14 Q Okay. And that particular data was collected  
15 from patient charts; is that fair?

16 A It would have been the procedure charts from --

17 Q The procedure charts.

18 A -- the endoscopy center. There were two sets of  
19 charts. The patient charts were the -- kind of the medical  
20 chart of all the -- all the things that patient had; then  
21 there was a chart specific to the procedure that was in the  
22 endoscopy center, not the gastroenterology center.

23 Q Okay. The next one?

24 A Again, that was an analysis I did of the group  
25 data.

1 Q Okay. This is the third box up from the bottom.

2 A That was also an analysis I did of the data  
3 collected by the group.

4 Q And the second-to-the-last one?

5 A The first part was an observation by the CDC --  
6 actually, the whole thing was the -- the observations by the  
7 CDC.

8 Q Okay. And the last one?

9 A Let's see. The first one was my observation --  
10 it was a CDC observation, my observation, my conversation --

11 Q Okay.

12 A -- and then my review of the data collected by  
13 the group.

14 Q Okay.

15 MS. WECKERLY: With that, Your Honor, the State moves  
16 to admit 228.

17 THE COURT: All right. That is admitted.

18 (State's Exhibit 228 admitted.)

19 BY MS. WECKERLY:

20 Q Can you see that on your screen up there, sir?

21 A My -- I don't think my screen is on.

22 Q Oh. Thank you.

23 A It's on now. Yes.

24 Q Can you see it now? Okay.

25 A Yes, I can.

1           Q     Looking at the top of what's been admitted as  
2 State's 228, it looks like the chart goes through possible  
3 modes of transmission from September the 21st of 2007 --

4           A     Yes --

5           Q     -- correct?

6           A     -- that's correct.

7           Q     Okay. Now, the first one is -- the first column  
8 appears to be possible modes of transmission, the middle  
9 column appears to be your conclusion regarding it, and the  
10 third column on the right appears to be the -- the rationale  
11 or your thought process for the conclusion that you drew?

12          A     Yes, that's correct.

13          Q     Okay. So let's talk about a possible  
14 transmission source of staff to patient. What were your  
15 conclusions regarding that as a possible source of  
16 transmission?

17          A     We ruled it out because none of the staff  
18 members were positive for hep C. We reviewed the records we  
19 had in the database to see if any of the former staff, those  
20 were names that we couldn't test, were in there as previously  
21 being positive for hepatitis C. And so that was -- initially  
22 we ruled it out, and then we had the genetic testing later and  
23 could identify the source patient, and that definitely ruled  
24 out the staff as a source of hepatitis C.

25          Q     Okay. And you -- not to pick on you, you said

1 we ruled it "out," but did you personally rule it out?

2 A I guess I'm speaking as the leader on behalf of  
3 the team, but I ruled it out personally --

4 Q Okay.

5 A -- yes.

6 Q So if -- I just want you to be clear if these  
7 are your actual conclusions as we go through the --

8 A It's a little difficult because we work as a  
9 team all the time, but yes --

10 Q -- yeah.

11 A -- I was the leader of that team; these are my  
12 conclusions.

13 Q Okay. Thank you. And the next possible -- next  
14 possibility was, I guess, like, a physician transmitting the  
15 hepatitis C, that was considered?

16 A Yes.

17 Q And ruled out. Why was that?

18 A We identified multiple physicians that treated  
19 the patients that were infected. We did -- I did a  
20 statistical analysis and evaluated if any one of those  
21 physicians put the patient at higher risk of being infected,  
22 and none was found.

23 Q Okay. And what -- when you say you did a  
24 statistical analysis, saying -- I guess, looking at whether  
25 one physician put someone more at risk of -- risk of



1 contracting the disease, what do you mean by that? Because I  
2 know Margaret is going to want to know the math here.

3 A Okay. This is a calculation called relative  
4 risk.

5 Q Okay.

6 A And so you look at the -- the risk of disease in  
7 the exposed people, and you compare that to the risk of  
8 disease in the nonexposed people. So you'd say, the risk of  
9 being infected for Physician A, versus the risk of being  
10 infected -- or not being infected from everybody else. It's a  
11 comparison of the different risks there. So it's -- you do a  
12 calculation, then, where it's -- the infection rate in one  
13 divided by the infection rate in the other, and you can get a  
14 statistical significance on it if you set the -- the P, the  
15 probability that it happened by chance at 0.05, the -- kind of  
16 the accepted standard, it has to be less than 0.05 to be  
17 considered statistically significant.

18 Q Now, is that -- is that something that  
19 epidemiologists do all the -- all the time to kind of assess  
20 risks or possible factors that caused transmission, or -- or  
21 how do -- I mean, how does that fit in the --

22 A We use that all the time. When you see on the  
23 news that -- whatever the newest thing that's going to kill  
24 you is 10 times more likely to kill you than whatever, those  
25 are the kind of calculations they're talking about. So it's

1 the risk of disease, giving it exposure, compared to the risk  
2 of disease not having that exposure.

3 Q Okay. And in my head I -- I would say that that  
4 -- does the genetic link that we learned later from the CDC  
5 affect that at all as well, or --

6 A Well, in this case we're talking about a  
7 physician -- something that was specific to a physician's  
8 procedure. So not --

9 Q I see.

10 A -- not the physician -- their blood going to the  
11 patient, that would fall under staff to patient. So is it  
12 some particular practice of one doctor --

13 Q Okay.

14 A -- that made it more likely to transmit hep C  
15 because of something that doctor did.

16 Q All right. Thank you. The next was provider,  
17 meaning, the CRNA?

18 A And this was the same sort of evaluation. We  
19 ruled out any one particular CRNA. The patients that had a  
20 CRNA were at no greater risk for any of the CRNAs compared to  
21 the other CRNAs.

22 Q Okay. Technician?

23 A The same is true for that. There was no one  
24 technician that created a greater risk for the patient than  
25 others.

1 Q Okay. And what about biopsy equipment?

2 A Not all infected patients had a biopsy, so that  
3 would make it very difficult to transmit it by biopsy  
4 equipment, though there's always the potential for  
5 cross-contamination. So we -- we did look at the  
6 statistics -- or I did look at the statistics as well, and  
7 there was no increased risk of disease based on having a  
8 biopsy or not.

9 Q Okay. And when you look at those type of  
10 statistics, is there a point in the statistics where it  
11 becomes, like, statistically significant, or -- or how do  
12 you -- how do you measure that?

13 A Yeah, there's a probability value that you can  
14 calculate, and so it's -- they call it a P value and it's  
15 between 0 and 1. So it's the probability that something  
16 happened by chance alone.

17 Q Okay.

18 A If it's a -- if it's unlikely to have happened  
19 just by chance alone, the P value is smaller and smaller and  
20 smaller. Anything over 0.05, so 5 percent, is considered not  
21 significant.

22 Q Okay. And that was the statistical outcome of  
23 the biopsy equipment, essentially?

24 A Yes.

25 Q How about the endoscope?

1           A     This one the -- there were a number of different  
2 scopes that were used. Because of the large number of scopes,  
3 there weren't enough to really do any meaningful calculations,  
4 but the patients all had scopes that appeared to be different  
5 from the source patient. We had some problems with the  
6 records and some duplicates and things like that. So it's  
7 difficult to say for certain, but it didn't appear that there  
8 was one scope used on all the infected patients.

9           Q     Okay. How about procedure type?

10          A     There was no increased risk based on an upper or  
11 lower endoscopy. The same statistical calculations I  
12 performed.

13          Q     And reuse of -- sorry. Reuse of bite blocks?

14          A     This is basically the same as a procedure type.  
15 The bite blocks are used only in one of those two procedures.  
16 There was no risk from the -- the upper endoscopy procedure,  
17 so there can't be the same risk from the bite blocks.

18          Q     Okay. That one seems like you could do without  
19 math, but I don't know. No?

20          A     It's the same thing. We still do the  
21 calculations just to make sure.

22          Q     Okay. And IV placement?

23          A     In this case, it was the observations on how the  
24 IVs were set up by the -- the clinic staff.

25          Q     Okay. And sedation-injection practices?

1           A     So in this case this is the one we did not rule  
2 out. We observed the staff reusing propofol vials. The  
3 clinic records clearly indicated that they used fewer vials  
4 each day than they would have needed for one per patient. So  
5 there was vial reuse. And then there was also the observation  
6 that the syringe was used to re-access the vial by the CDC.

7           Q     And that was the observation made of Ms. Langley  
8 by -- of Keith Mathahs? Is that the observation you're  
9 referring to?

10          A     Yes.

11          Q     Okay.

12          A     As well as the conversations with Vincent Mione  
13 that said he was told to reuse the syringes but didn't. So it  
14 was the idea that that was going on at the clinic at some  
15 point.

16          Q     Okay. Now, you talked about the -- the propofol  
17 records, I -- you made an allusion to that or you made  
18 reference to the propofol records versus the number of  
19 patients. Was that something that you personally looked into?

20          A     Yes, it is.

21          Q     And -- and what were your -- what was your  
22 assessment or what were your findings regarding that?

23          A     For each day that we looked at we looked at the  
24 number of vials that were checked out, the number of vials  
25 that were returned, so we could determine how many vials were

1 used on a typical day in the clinic. For each day that we  
2 looked at there were roughly 60 patients a day, and there were  
3 fewer than 60 vials being used. It varied day-by-day  
4 depending what was going on, and the size of the vials as  
5 well.

6 But from that it was clear that they weren't using  
7 the same number of vials, at least, as patients.

8 Q So there had to be some propofol reuse on  
9 multiple patients?

10 A Yes.

11 Q Now, when you -- you and the CDC were there,  
12 were you able to determine which patients were in which one of  
13 the procedure rooms?

14 A No, we were not.

15 Q And was that ever something that -- that you, I  
16 guess, incorporated in your conclusions as you sit here today,  
17 or how does that fit in with your conclusions?

18 A Several months later something came to our  
19 attention that allowed us to try and split it up. The board  
20 of medical examiners told us about in their investigation they  
21 had a comment from one of the staff members that there was  
22 a -- a date error on the bottom of some of the charts, and  
23 that could be used to split it out.

24 So we went back and looked at the date-error issue,  
25 and found that that date error did exist at the time of the

1 procedure. I was able to contact the provider of one of the  
2 patients on September 21 and get a copy of the chart that was  
3 faxed over right after their procedure.

4 The date error was obvious at that time. So we know  
5 that it happened at that point in time when the procedure was  
6 performed, not later. And from that some charts had the date  
7 error, some didn't, and that came from a computer system. So  
8 we were able to -- if that showed that one room had the error  
9 and the other didn't, it allowed us to split up the two rooms.

10 Q Now, the -- the fact of that date error, did  
11 that at all affect your conclusions at all?

12 A No, it did not.

13 Q And were you able to reach your -- were you able  
14 to reach a conclusion regardless of -- of knowing that piece  
15 of information?

16 A Yes, we were.

17 Q In -- in your knowledge of -- of hepatitis C and  
18 hepatitis C transmission, are people exposed -- that are  
19 exposed to hepatitis C, do they necessarily contract the  
20 disease even with the direct exposure?

21 A No. With just about any pathogen, when you  
22 expose somebody to a virus or bacteria, some people will  
23 become sick; others didn't get sick for whatever reason, or  
24 didn't develop an infection for whatever reason.

25 Q Okay. And are there some people who are exposed

1 to hepatitis C -- and I think you said this at the beginning  
2 of your testimony, that -- that don't even know they have it,  
3 and don't experience any symptoms at all, even though they may  
4 be positive?

5 A That's actually the vast majority of patients,  
6 85 to 90 percent of people never have symptoms of it and they  
7 wouldn't know unless they were tested.

8 Q Okay. Now, in this particular case, with the  
9 conclusions that -- that you drew, is -- are your conclusions  
10 premised on the idea that there was just one infected vial of  
11 propofol that was responsible for this on the 21st?

12 A No.

13 Q Can you explain how the transmission -- or the  
14 -- the ways that you see the transmission occurring on that  
15 day?

16 A Well, there's multiple ways that it could have  
17 occurred. Because we didn't observe what happened on the  
18 21st, we can't say exactly what happened. It's possible that  
19 it could have come from one vial. There was -- looking at the  
20 -- the dose that was recorded for each patient, there would  
21 have been enough propofol in one vial to give a little bit to  
22 each one, but that wasn't really a realistic scenario.

23 You would have a -- there were 50cc vials, so that  
24 would potentially be used for multiple patients, much more  
25 than a 20cc vial, obviously.



1 Q Sure.

2 A So that vial could have moved back and forth and  
3 it could have been one vial. Or you could have had fresh  
4 propofol drawn from that vial, and basically contaminated a  
5 second vial when they went in to draw the rest of it, or  
6 through, basically using it on a patient, then going into a  
7 second vial.

8 So they could basically recontaminate a second or  
9 third vial, as many as needed for that to happen.

10 Q Okay. And in -- is there any way -- would there  
11 be any way for you to determine in that type of scenario if  
12 the -- if the virus or there's -- if the virus dilutes it all,  
13 or the virus, you know, somehow gets less and less in each  
14 vial, or is -- is that impossible?

15 A It's likely that some dilution would occur,  
16 especially if you're talking about going from one vial to a  
17 second. But we didn't know how much blood was introduced. We  
18 didn't know the patient's viral load. And we didn't know what  
19 happened from vial to vial exactly. So there's no way we can  
20 say step by step exactly what happened.

21 Q What was the -- the year that you issued your  
22 conclusion regarding the -- the outbreak in this case, and how  
23 it was your conclusion regarding the mode of transmission?

24 A The final report was released in 2009.

25 Q Okay. And that was the -- the conclusion was

1 the -- sort of the combination of reusing propofol vials and  
2 the reuse of syringes on single patients?

3 A Yes, that's correct.

4 Q It's several years later; have your conclusions  
5 changed at all since you issued your report?

6 A No.

7 Q Has anything come to your attention that makes  
8 you question your conclusion that you made back in 2009?

9 A No.

10 Q Thank you.

11 MS. WECKERLY: I'll pass the witness.

12 THE COURT: All right. Ladies and gentlemen, before  
13 we move into cross-examination, let's go ahead and take our  
14 morning recess. We'll be in recess until about 11:15.

15 During the recess you're reminded that you're not to  
16 discuss the case or anything relating to the case with each  
17 other or with anyone else. You're not to read, watch, listen  
18 to any reports of or commentaries on the case, any person or  
19 subject matter relating to the case, and please don't form or  
20 express an opinion on the trial.

21 Notepads in your chairs, and follow the bailiff  
22 through the rear door.

23 And, Mr. Labus, during the break please don't  
24 discuss your testimony.

25 THE WITNESS: Okay.

1 (Jury recessed at 11:01 a.m.)

2 THE COURT: I'm just waiting for them to get out of  
3 the hallway. And, sir, if you want to take a break, you're  
4 free to go out that door.

5 THE WITNESS: Thank you.

6 (Court recessed from 11:02 a.m. to 11:15 a.m.)

7 (Outside the presence of the jury.)

8 THE COURT: Are you going to be first, Mr. Wright?

9 MR. WRIGHT: Yep, I think.

10 THE COURT: And you -- this is going to take two  
11 days?

12 MR. WRIGHT: I don't think --

13 THE COURT: Ms. Weckerly took an hour.

14 MR. WRIGHT: -- I don't think so.

15 THE COURT: Almost exactly an -- a little less than  
16 an hour.

17 MS. STANISH: That's not long.

18 THE COURT: It was, like -- it was, like, no, that's  
19 what I'm saying --

20 MS. WECKERLY: I'm the quickest.

21 THE COURT: -- it was 50 minutes. I mean, so --

22 MR. WRIGHT: No, I don't --

23 THE COURT: -- how do you turn --

24 MR. WRIGHT: -- think so.

25 THE COURT: -- Ms. Weckerly's 50 minutes into 2 days?

1 MR. WRIGHT: I didn't know what it was going to be.  
2 THE COURT: Right.  
3 MR. WRIGHT: So I don't think it --  
4 THE COURT: I mean, it was almost --  
5 MS. WECKERLY: Got more narrowed, admittedly, this  
6 morning, but --  
7 THE COURT: -- so.  
8 MR. WRIGHT: So, no, I don't see it being as long as  
9 I had forecast.  
10 THE COURT: All right. In other words, Ms. Weckerly,  
11 be prepared to have another witness for tomorrow.  
12 MS. WECKERLY: We will -- yes, try to get someone  
13 together. It will -- it will in all likelihood be an  
14 insurance person.  
15 THE MARSHAL: Ready, Judge?  
16 THE COURT: Yeah. Mr. Labus, come on back up to the  
17 witness stand. The bailiff is going to bring in the jury.  
18 MS. WECKERLY: Also, I did the email, everybody --  
19 draft instructions.  
20 THE COURT: Oh, great.  
21 MS. WECKERLY: So everybody can...  
22 (Off-record colloquy.)  
23 THE COURT: Bring them in.  
24 THE MARSHAL: Ladies and gentlemen, please rise for  
25 the jury.

1 (Jury entering at 11:17 a.m.)

2 THE MARSHAL: Thank you, everybody. You may be  
3 seated.

4 THE COURT: All right. Court is now back in session.

5 And, Mr. Wright, you may begin your  
6 cross-examination.

7 MR. WRIGHT: Thank you.

8 CROSS-EXAMINATION

9 BY MR. WRIGHT:

10 Q Good morning, Mr. Labus. I'm Richard Wright. I  
11 represent Dr. Desai.

12 A Good morning.

13 Q In preparation for your testimony here, what  
14 have you reviewed?

15 A I went through my report, I went through some of  
16 the notes I had from -- that I had taken in the clinic, as  
17 well as an -- a number of research articles.

18 Q Okay. Did you read any of your testimony?

19 A My grand jury testimony.

20 Q Okay. Anything else?

21 A No, that's all that comes to mind.

22 Q Okay. And are you a hepatitis expert?

23 A No.

24 Q The -- your -- the definition you utilized for  
25 acute hepatitis C -- well, strike that.

1           We've had experts in here testify regarding the  
2 distinction between acute hepatitis C and chronic hepatitis C,  
3 and symptomatic hepatitis and nonsymptomatic hepatitis C, and  
4 they have talked about the acute/chronic distinction as being  
5 one of duration. In other words, acute hepatitis C is short  
6 term, and chronic long term. Do you agree with that?

7           A     Yes.

8           Q     Okay. And they talk about acute hepatitis C as  
9 -- all hep -- let me put it this way, all -- when I contract  
10 hepatitis C, whether I know I have it or not, I have acute  
11 hepatitis C for the first, say, six months, and I will either  
12 be symptomatic or not symptomatic; does that make sense?

13          A     Yes.

14          Q     Okay. And I had understood your definition of  
15 acute hepatitis C, it seems like you were viewing acute  
16 hepatitis C as newly acquired hepatitis with symptoms --  
17 symptomatic?

18          A     Yes, that's correct.

19          Q     Okay. So that's -- that's your definition of  
20 it, correct?

21          A     No, that's the -- the national case definition  
22 that we use for public health surveillance. The Council of  
23 State and Territorial Epidemiologists comes with -- comes up  
24 with definitions, so there's one for acute hepatitis C, and  
25 then there's another one they call past or present. And it's

1 because of that challenge in determining is it a newly  
2 acquired nonsymptomatic case, or is it something the person  
3 had for decades.

4 So for surveillance purposes and for outbreaks we  
5 use the -- the acute disease with symptoms as the definition  
6 for acute disease.

7 Q Okay. The -- so that when we're talking about  
8 -- because some -- some of those other experts said the acute  
9 hepatitis C has nothing to do with the severity of the  
10 disease. But for your purposes, when we say, like, in Clark  
11 County there are two to four reported cases a year; is that  
12 about accurate?

13 A Yes.

14 Q Of acute hepatitis C, we're talking about  
15 someone newly acquired hepatitis and they are symptomatic,  
16 jaundiced, sick, everything that happens in those first six  
17 months, if -- if it's symptomatic, correct?

18 A Yes, the cases I'm talking about, it's the  
19 public health case definition. They're taking the medical  
20 approach which they need for treatment. So it's kind of two  
21 views of the same thing.

22 Q I got it. And so the -- how many -- and you --  
23 you testified that acute hepatitis C with symptomatic, okay?  
24 I'm -- I just got it and I'm sick.

25 A Yes.

1 Q That's reportable by physicians by law?

2 A Yes, it is.

3 Q Okay. And the first two cases that are  
4 November, December were reported by physicians?

5 A Yes, that's correct.

6 Q Okay. And how many -- aside from physicians  
7 reporting acute hepatitis C, the Health District also gets  
8 reports from all the labs around here of positive hepatitis  
9 results, my -- my terminology.

10 A Yes, that's correct.

11 Q Okay. And so every -- every one that gets a  
12 blood test at any time, for whatever reason medically in Clark  
13 County, if it -- if they test positive for hepatitis, that's  
14 reported to the Health District?

15 A Yes, it is.

16 Q Okay. And then the Health District keeps a  
17 record of all of that?

18 A Yes, we do.

19 Q Okay. A registry of hepatitis C?

20 A More of a list of just positive lab results, but  
21 that kind of idea, yes.

22 Q Okay. And how many -- how many hepatitis --  
23 when you get -- how many do you get a day from a lab, average?

24 A I can't say for -- per day. I'd say for -- per  
25 month we get 2 to 3,000 probably. We get thousands of results



1 a month; it's a very large number.

2 Q Okay. I didn't hear you. Say that again?

3 A I said we get probably 2 to 3,000 a month, a  
4 very large number.

5 Q Okay. So 2 to 3,000 a month reports come in of  
6 positive blood tests for hepatitis C?

7 A Yes.

8 Q Okay. In Clark County?

9 A Yes.

10 Q I mean, is that -- that's your jurisdiction --  
11 Southern Nevada Health District is co-terminus with Clark  
12 County, correct?

13 A Yes, it is.

14 Q Okay. And are -- are those new reports or  
15 duplicates because someone keeps getting blood tests?

16 A It would be both of those.

17 Q Okay. Both of those? Because you get -- say  
18 you get 3,000 this month, some of them you may already have in  
19 your database?

20 A Yes, that's correct.

21 Q Okay. When I say "you," I'm talking about the  
22 Health District, obviously.

23 A Yes, that's correct.

24 Q And so it's -- of those -- say it's -- it's  
25 3,000, so we're, like, talking about -- say 100 are reported

1 tomorrow, come it -- does -- does anyone contact those people  
2 or do anything with that?

3 A No, we don't.

4 Q Okay. And do -- you don't know if it's newly  
5 acquired -- well, you -- you would know if it's newly  
6 reported, correct?

7 A Yes.

8 Q Okay. But you wouldn't know if the person just  
9 got hepatitis C, and you wouldn't know if they have symptoms?

10 A Without a physician report on just the lab  
11 tests, no, we wouldn't.

12 Q Okay. So when -- when this -- these first two  
13 reports came in, and then we're back to January 2008 now,  
14 okay? And that -- that was your initial involvement?

15 A Yes, that's correct.

16 Q Okay. And it was passed up to you because  
17 you're an epidemiological investigator; is that right?

18 A Yes.

19 Q Okay. And already the two reports that had come  
20 in had been investigated in the sense of your office -- or the  
21 health -- someone in the Health District contacting the two  
22 people, correct?

23 A Yes, that's correct.

24 Q Okay. And talking to them either by phone or in  
25 person to determine risk factors?

1 A Yes, that's correct.

2 Q Okay. And do you -- you also independently test  
3 them?

4 A Generally, we won't, unless there's some  
5 additional reason to do so. If we have a lab test from a  
6 commercial diagnostic lab, there's no reason to do additional  
7 testing.

8 Q Okay. And that's -- that's reliable  
9 information? I mean, you -- you have the -- it's reported by  
10 a physician, and then the -- the lab tests are there showing  
11 that it's positive for hepatitis C?

12 A Yes.

13 Q And then the -- the person is contacted and they  
14 are symptomatic, and they're interviewed for the common risk  
15 factors you all have developed, correct?

16 A Yes, but I'd say we also determine if they're  
17 symptomatic. Just because a physician reports it as an acute  
18 case, it may not meet our definition. It may be a  
19 misdiagnosis. It may be he only had partial information. So  
20 that's part of it as well.

21 Q Okay. And so someone else did that in the  
22 Health District?

23 A Yes.

24 Q Okay. And they confirmed that the people are --  
25 were sick, had been hospitalized or whatever and they were

1 symptomatic with acute hepatitis C?

2 A Yes, that's correct.

3 Q And then the -- the background -- the interview  
4 of them for risk factors, that takes place, correct?

5 A Yes.

6 Q And as I understand it from testimony we've had  
7 here, the -- the risk factors for newly acquired acute  
8 hepatitis C, but symptomatic, is not as thorough an analysis;  
9 is that fair?

10 A That's correct, we can't consider every  
11 possibility.

12 Q Right. I mean, it's newly acquired, so just by  
13 definition we know, like, within the last six months they got  
14 the hep C?

15 A Right. When we do the interviews we ask about  
16 those risk factors and the six months prior to the onset of  
17 their symptoms, so we limit it to the -- the incubation period  
18 of the disease.

19 Q Okay. As opposed to other people, if I just  
20 test positive hep C, and I -- I just found out; I took a blood  
21 test and just learned I had hep C and didn't even know it, an  
22 interview on me on risk factors goes all the way back,  
23 correct?

24 A Yes, that's correct.

25 Q The -- to -- and the most common risk factors

1 are the -- I'm not sure I'm saying it right. The most --  
2 what's the most dangerous conduct? How do you rank the risk  
3 factors?

4 A For newly acquired disease, the majority of  
5 cases it winds up being IV drug use, so that's the big  
6 question. When you look at the older cases, a lot of it was  
7 blood transfusion, so before they started screening the blood  
8 supply for it accurately in 1992 there was a risk of hep C,  
9 and especially going back into the '70s the way they -- they  
10 got blood donors. At one point they had paid blood donors and  
11 it tended to attract people that were more likely to have  
12 hepatitis.

13 And so there were risks from mostly blood or medical  
14 procedures back then. More recently, though, it's more IV  
15 drug use, and a lot of them are undetermined still.

16 Q And so now it's confirmed by your -- by the  
17 Southern Nevada Health District, we have two reported cases,  
18 and at that time you had the common link which was a same  
19 clinic, correct?

20 A Yes.

21 Q And the -- that -- that's what caused it to come  
22 to your desk to start looking into it?

23 A Yes, that's correct.

24 Q Okay. And just -- I guess, just those two isn't  
25 the correct word, but, I mean, with -- with only two reported,

1 that in and of itself sends up big red flags when they are  
2 connected to a common facility?

3 A Yes, for an uncommon disease like hep C.

4 Q Right. And so with -- with those two, who do  
5 you reach out to first?

6 A I'll talk to my boss, I'll talk to other  
7 epidemiologists or the lab, as necessary. In this case it was  
8 mostly talking to my boss, and then contacting the CDC.

9 Q Okay. And your boss is?

10 A Patricia Rowley.

11 Q Okay.

12 A Or was my boss; not anymore, but she was at the  
13 time.

14 Q Okay. And what is her position?

15 A She was the manager of the epidemiology office.

16 Q Okay. And how many of you epidemiologists are  
17 in there?

18 A There's around a half-dozen over that time  
19 period. There's a couple that do infectious disease and the  
20 other ones do chronic disease, injury, all sorts of things  
21 that are totally unrelated to any outbreak investigations.

22 Q Okay. 'Cause you guys go in and look at the  
23 restaurants and all that stuff that we see on T.V.?

24 A That's the environmental health inspectors, but  
25 if there's an outbreak there we do the restaurant outbreaks as

1 well.

2 Q Okay. And you were -- when this -- how did this  
3 end up on your desk or your computer -- what would -- end up  
4 on your computer?

5 A Yes, I got an email from my boss that just had  
6 the details, so the -- the supervisor over the disease  
7 investigators that did the interviews notified the office  
8 manager, who told me about it.

9 Q Okay. And you -- were you selected -- do you  
10 specialize in this type of investigation?

11 A We only had two infectious disease  
12 epidemiologists and I was the senior person. So I -- I tend  
13 to find out about most things, or at least at the time I did.

14 Q Okay. And had -- had you previously done a --  
15 and is an investigation the correct word in your --

16 A Yes.

17 Q -- okay.

18 A Yes, it is.

19 Q The -- had you previously done an investigation  
20 involving hepatitis C transmission?

21 A No.

22 Q Had you previously investigated an ambulatory  
23 surgical center for a viral outbreak?

24 A No.

25 Q Okay. And by "viral outbreak", I'm talking

1 about a virus as opposed to, like, bacterial infection, right?

2 A That's correct. I haven't -- I haven't done any  
3 ASC investigations before this one.

4 Q Okay. And the -- and had -- had you  
5 investigated any hepatitis cases?

6 A Yes.

7 Q Okay. What type?

8 A I've done hepatitis A and hepatitis B.

9 Q Okay. And hepatitis A is generally transmitted  
10 how?

11 A Hepatitis A is typically food borne, and  
12 hepatitis B is the same sort of transmission generally as  
13 hepatitis C.

14 Q Okay. And were those in clinics, hospitals, or  
15 what?

16 A No.

17 Q They were not?

18 A That's correct.

19 Q Okay. So when -- when this initially came and  
20 it -- it -- you guys deal -- that relative risk, the  
21 statistics you all were talking about, that -- that had to be  
22 up there high, the two within a couple of months same --  
23 precisely same clinic, correct?

24 A Well, I would say a red flag was there, but I  
25 wouldn't say relative risk. We use that in a different



1 context, basically.

2 Q Okay. The -- and so you -- did you talk to your  
3 boss, and then initially contact CDC that very day?

4 A Yes.

5 Q Okay. And so this is January 2nd, if I recall  
6 correctly?

7 A Yes, that's correct.

8 Q And so you get in touch with CDC and you tell  
9 them what you have, correct?

10 A Correct.

11 Q Okay. And are you at that point requesting this  
12 epi -- what they called an Epi-Aid?

13 A Not at that point. Not initially.

14 Q Okay. You are contacting them looking for  
15 guidance and expertise?

16 A Yes, that's correct.

17 Q Okay. And so -- and that -- that first day  
18 while you were contacting them, a third case gets reported?

19 A Yes.

20 Q Okay. And once again, that was  
21 physician-reported?

22 A Yes, it was.

23 Q And it was vetted -- I mean, it was confirmed  
24 it's hepatitis, it's acute, and no risk factors, and lo and  
25 behold same clinic and same date as one of the others?

1           A     I believe one or two of the cases also had a  
2 dental procedure in the six-month window as well, but all  
3 three of them had that -- that same endoscopy center link.

4           Q     Okay. And so you reported that to CDC?

5           A     Yes.

6           Q     Okay. And then the -- the plans -- how -- what  
7 happened between the 2nd and the 9th?

8           A     We started discussing with CDC, was an Epi-Aid  
9 appropriate? Did they have people available to come out and  
10 assist us, and -- and then it was a question of which branches  
11 at CDC. So we spoke with the hepatitis branch and the branch  
12 that does healthcare-acquired infections, DHQP is their  
13 acronym, it's Division of Healthcare Quality and Promotion.

14                So we were having discussions with them, trying to  
15 figure out what the next steps were going to be. We made our  
16 official Epi-Aid request, probably the -- the third, probably  
17 that next day. They got their team together and said they'd  
18 be able to arrive the following Wednesday.

19           Q     Okay. And the Epi-Aid request, I mean, that's  
20 part of the bureaucracy of government, you have to officially  
21 have someone ask them?

22           A     Our state epidemiologist has to make an official  
23 letter of request to the CDC; and then the CDC comes up with  
24 kind of a plan of why are they coming out, what are they  
25 looking for, and what's the reason for the trip. Then that

1 gets approved and they find hotels and flights and all that  
2 sort of stuff. But it's a pretty standard process that's used  
3 all over the country, and we've had Epi-Aids before; it's not  
4 a first time we've used it.

5 Q Okay. And so the -- the state epidemiologist --  
6 is that?

7 A Yes.

8 Q Who is that?

9 A That's Dr. Ihsan Azzam.

10 Q Okay. And so he -- he was in the loop and  
11 forwarded the request?

12 A Yes, that's correct.

13 Q Okay. And so they -- they come out and they --  
14 they, from the CDC was Melissa --

15 A Dr. Schaefer --

16 Q -- Schaefer --

17 A -- and Dr. Fischer.

18 Q -- okay. And they arrive on the Wednesday the  
19 9th?

20 A Yes.

21 Q And you all have a meeting with them, before  
22 going over to the clinic?

23 A Yes, that's correct.

24 Q And at that meeting, yourself, Dr. Fischer, and  
25 Dr. Schaefer from CDC, and people from BLC?

1           A     As well as a number of other Health District  
2 people.

3           Q     Okay. It -- so they're -- your -- your agency?

4           A     Yes.

5           Q     Okay. And at that time had you been -- had you  
6 made any initial determinations in your own mind as to what  
7 you thought the probable cause was --

8           A     No.

9           Q     -- going in?

10          A     No, I didn't.

11          Q     Okay. Do you recall that your initial belief  
12 was that it was scope-related because it was a clinic and  
13 that's what you all, meaning the Health District, thought was  
14 the most likely cause?

15          A     I believe my boss sent an email that it was  
16 concerned about the scopes because it was an endoscopy  
17 clinic --

18          Q     Okay.

19          A     -- and that was just the initial thought, based  
20 on the type of the clinic.

21          Q     And it -- and it was the CDC that said, no, we  
22 think that injection practices is the most likely cause, based  
23 upon our past outbreak investigations?

24          A     I don't think they said it was the most likely  
25 cause, they said it was more likely that it was an injection

1 safety issue than the scopes, but it really could be anything  
2 going into there.

3 Q Okay. But they said the first thing we want to  
4 look at is injection practices?

5 A I don't know if it was the first thing they  
6 said, it was something they wanted to look at, though.

7 Q Okay. The -- I read a conversation you had with  
8 somebody called Nachos?

9 A It's NACCHO. It's the National Association --

10 Q NACCHO.

11 A -- of County and City Health Officials.

12 Q Okay.

13 A Yes, they get that --

14 Q Well, it's --

15 A -- all the time. It's a running joke with them.

16 Q -- N-A-A-C-H-O [sic], NACCHO?

17 A N-A-C-C-H-O, NACCHO.

18 Q And it -- and -- do you recall the conversation?

19 A I remember talking to them a number of times  
20 over the years.

21 Q Okay. But the -- do you recall a conversation  
22 with yourself, Dr. Sands, the -- everyone involved in this  
23 with the NACCHO representatives after this outbreak and  
24 investigation had occurred in which you were sharing with  
25 them, your -- your -- what had occurred?

1           A     Vaguely.

2           Q     Okay. Do you recall -- because I recall reading  
3 in there that you stated that your all's initial presumption  
4 or assumption was that it was scope related, but that's why we  
5 call in the experts because they said the first thing we want  
6 to look at is injection practices. And I -- I'm summarizing  
7 it, but --

8           A     It doesn't sound incorrect. I don't  
9 specifically remember the conversation, though.

10          Q     Okay. And it -- it does not sound incorrect.  
11 That sounds like that's accurate about the mindset on going in  
12 the door.

13          A     In a general sense, yeah. The scopes were on  
14 the list, and I would say the injection safety was probably  
15 the top of the list of things that we were looking at.

16          Q     Okay. And so you all had waited for CDC to  
17 arrive, and that was one week, correct?

18          A     I think they officially approved the request on  
19 Friday, so it was several days, yes.

20          Q     Okay. The -- oh, I mean, from -- from the 2nd  
21 to the 9th you all made the determination to wait, get CDC,  
22 BLC involved, and don't notify the clinic until everything is  
23 in place?

24          A     Yes.

25          Q     Okay. And that's just part of the way

1 investigations are properly done, correct?

2 A Yes.

3 Q Okay. Because the -- you want to -- to your  
4 knowledge, no one at the clinic had any idea of this outbreak  
5 until you called on the -- on Wednesday the 9th?

6 A As far as I know, that's correct.

7 Q Okay. And you called that afternoon, and told  
8 them -- did you tell them on the phone?

9 A I think we gave them a brief overview that we  
10 had a number of hepatitis C cases that were potentially linked  
11 to the clinic, and we were initiating an investigation, and we  
12 wanted to come over and meet with them right away.

13 Q Okay. And do you remember who you spoke with on  
14 the phone?

15 A I got passed around to a couple of different  
16 people, and I think the final person I really spoke to was  
17 Tonya Rushing.

18 Q Okay. And so -- and then you all, within a  
19 half-hour, walked across the street and --

20 A Yes.

21 Q -- into the clinic. Had you ever been there  
22 before?

23 A No.

24 Q Okay. And you ultimately met with Tonya  
25 Rushing, correct?

1 A Yes.

2 Q Okay. Dr. Cliff Carrol?

3 A Yes.

4 Q Okay. And Jeff Krueger or Katie Maley may have  
5 been present at the first meeting?

6 A Jeff was present for most of it; Katie was kind  
7 of in and out.

8 Q Okay. So most likely Jeff Krueger first  
9 meeting?

10 A Yes.

11 Q And at -- at that meeting you had the two -- two  
12 BLC people, two CDC people, and yourself?

13 A Yes.

14 Q Okay. And did you tell them of the three cases?

15 A Yes, we did.

16 Q Okay. And it's hepatitis C, acute,  
17 symptomatic --

18 A Yes.

19 Q -- positive? And what -- what was the response  
20 or reaction?

21 A They were surprised and offered whatever  
22 assistance we needed in the investigation. They were very  
23 accommodating when we talked to them.

24 Q Okay. And what -- you had set up with CDC a  
25 game plan for the investigation, correct?



1 A Yes.

2 Q Okay. And so you told them, here's what we will  
3 need when we come back tomorrow?

4 A We started to because we didn't know what  
5 documents existed. So the first question is what do they  
6 have, and then we can decide what sort of things we wanted to  
7 look at. We -- I think we had some general categories, but  
8 without visiting the clinic we didn't know exactly what to ask  
9 for.

10 Q Okay. And so in visiting it -- and you actually  
11 did a walk-around, correct?

12 A A brief one, yes.

13 Q Okay. And you were aware that there was a --  
14 what we've called the -- the gastro side, which was medical  
15 offices, and then there was actually the procedure clinic,  
16 I -- endoscopy side?

17 A Yes.

18 Q Okay. And you learned that they had a patient  
19 log -- patient list for both days, correct?

20 A Yes.

21 Q And patient charts, that would be, like, the  
22 patient's file for those days?

23 A Well, there were two patient charts. So there  
24 was the procedure chart on the endoscopy side, and then there  
25 was the general medical chart of the patient on the -- the

1 gastro side.

2 Q Okay. And essentially -- and whether it was all  
3 learned right at that very first afternoon -- Wednesday  
4 afternoon, you became aware of all of those charts, the doctor  
5 side and the procedure side, and those were presented for all  
6 of the patients for July 25th and September 21st, correct?

7 A As well as a couple additional days. I think --  
8 I think July 25th was a Monday, so I don't think we got any  
9 charts from prior to that, but we got the -- the two or three  
10 days prior to September 21st as well.

11 Q Okay. And to get -- so going -- so a number of  
12 days, three or four, before the September 21st?

13 A Yes.

14 Q Okay. Now, at that first meeting Wednesday  
15 afternoon, they -- they give you an overview verbally of their  
16 operation?

17 A Yes.

18 Q Okay. Like, number of procedures, types of  
19 procedures, types of scopes, types of processing, types of  
20 medication?

21 A They talked about the number of patients and the  
22 general setup. I know we talked about the medications. I  
23 don't know that we went into the types of scopes and how those  
24 were processed. That was maybe a little more detailed than  
25 the first meeting.

1           Q     Okay. And at that first meeting they -- they  
2 talked about medications that they used, administered, on the  
3 patients, correct?

4           A     Yes.

5           Q     Okay. And they talked about anesthesia?

6           A     Yes.

7           Q     And that they used several narcotics?

8           A     Yes.

9           Q     And used propofol?

10          A     Yes.

11          Q     And used lidocaine with propofol?

12          A     Yes.

13          Q     Okay. And they explained at that first meeting  
14 that the lidocaine and propofol came from multidose vials?

15          A     I know they explained the lidocaine did, I don't  
16 know that they said it was a propofol multidose vial. I don't  
17 remember specifically what they said. But I believe the  
18 conversation they said they used one vial per patient, that  
19 they weren't using multidose propofol vials.

20          Q     Okay. You think they said they were not  
21 multidosing propofol?

22          A     From what I remember with the conversation,  
23 Tonya said if -- if you check the Sharps container there'll  
24 be, you know, vials in there with a bunch of propofol left in  
25 them from the procedures.

1           Q     Did you do a -- what do you call this report I'm  
2 going to show --

3           A     I can't see it. I don't know. Those look like  
4 the incident command forms from --

5           Q     Okay.

6           A     -- each day.

7           Q     And incident command forms. Did you prepare  
8 incident command forms for this investigation?

9           A     Yes.

10          Q     I'm going to show you --

11          MR. WRIGHT: Can I approach, Your Honor?

12          THE COURT: Sure.

13          BY MR. WRIGHT:

14          Q     -- page 9 and 10, which I think is January 9,  
15 2008. Look at those, tell me if that refreshes your  
16 recollection regarding that they told you that they used  
17 lidocaine and propofol from multidose vials.

18          A     (Witness complies.) That's what I have in the  
19 note here. It still doesn't sound like exactly what happened.  
20 The lidocaine was from multidose vials. The propofol, as far  
21 as I knew, was not. It's not clear from the way this is  
22 written, but that was the -- the conversation.

23          Q     Okay. When you say, "was not," I understand  
24 that the vials say -- I mean, ultimately, when you  
25 investigate, the vials say single dose; but what I'm asking

1 is, did they tell you that they used propofol multi --  
2 multipatient?

3 A I don't believe that they did.

4 Q Okay. What -- do you read that differently than  
5 I do?

6 A Yes, it was a -- quick notes that I jotted all  
7 this down at the end of the day to kind of log everything.  
8 And I should have been clearer on what I wrote there, but I --  
9 I wrote it as, Propofol with lidocaine is the primary  
10 anesthesia used, and comes from multidose vials. The  
11 lidocaine came from multidose vials, but the propofol, as far  
12 as I knew, did not.

13 Q Okay. Have you looked at the BLC -- when you  
14 ultimately prepared a report, did you look at their report?

15 A I've read their report, yes.

16 Q Okay. Did you look at their notes of this first  
17 meeting?

18 A When I read the entire report, but it's been  
19 five or six years since I read it, so --

20 Q Okay.

21 A -- that's not something I recall.

22 Q Are you aware that -- do you know who Dorothy  
23 Simms is?

24 A Yes.

25 Q Okay. Was she present at this first meeting?

1 A Yes.

2 Q Okay. And she states that Jeff Krueger said  
3 that they use multidose vials of propofol?

4 A Okay. If that's in the report, I can't disagree  
5 with it.

6 Q Okay. Well, does that explain why you would put  
7 in your January 9th incident status summary that, Propofol  
8 with lidocaine is the primary anesthesia used, and comes from  
9 multidose vials?

10 A It could be.

11 Q Is there any -- strike that.

12 After this first meeting on Wednesday, in the  
13 afternoon, you all make plans to come back the next morning?

14 A Yes.

15 Q Okay. And you return the next morning, and  
16 that's all of -- all of the same people, plus several more  
17 from your office?

18 A I believe so. I think it was the same two BLC  
19 investigators, plus one additional BLC person as well. I  
20 think they had three people on the first day that -- that BLC  
21 came back.

22 Q Okay. And that -- that first full day would  
23 have been Thursday the 10th?

24 A Yes.

25 Q And that was almost exclusively devoted to

1 records review?

2 A Yes.

3 Q And you all set up in a conference room, and  
4 they brought in the patient's logs -- patient lists for the  
5 relevant days, and started bringing in all of the charts,  
6 hospital -- or the -- ASC, the procedure records and the  
7 doctor records?

8 A Yes, that's correct.

9 Q Okay. And you all started going through those  
10 to put together your -- your chart, looking for commonalities?

11 A Yes.

12 Q And that -- that took place most of Thursday?

13 A Yes.

14 Q Okay. And anything else on Thursday that was  
15 relevant?

16 A Well, there was a staff meeting we attended,  
17 where we told them what was going on, and that we'd be  
18 observing in the clinic because we planned to do observations  
19 the next day, so we wanted them to know --

20 Q Okay.

21 A -- why we were there.

22 Q Okay.

23 A We also caught the end of a procedure, and then  
24 saw the scope reprocessing that day, I believe.

25 Q Okay. And so the -- the staff meeting, we're

1 talking about the clinic staff, correct?

2 A It was the endoscopy center staff.

3 Q Okay. Right. Procedure -- the procedure  
4 clinic's staff, and it was explained to them who you all were,  
5 and why you would be lurking in the background --

6 A Yes.

7 Q -- watching?

8 A Right.

9 Q Okay. And so then you all came back on Friday,  
10 and started your observations, correct?

11 A Yes.

12 Q And you were doing observations of procedures  
13 that morning?

14 A Yes, that's correct.

15 Q And you were watching Linda Hubbard --

16 A Yes, I was.

17 Q -- CRNA? And what doctor; do you recall?

18 A The -- Dr. Clifford Carrol.

19 Q Okay. And did you watch a number of procedures?

20 A Yeah, a half-dozen or so.

21 Q Okay. Were they uppers or lowers or do you  
22 know?

23 A I think it was a mix of the two. I remember the  
24 colonoscopies. It was just a -- is a longer procedure, and so  
25 there was a little more to observe. But it was just kind of a



1 mix of whatever was scheduled in whatever order. We didn't  
2 choose any certain type. We just, you know, whatever they  
3 brought in is what we observed.

4 Q Okay. And you are observing with whom?

5 A I was in the room with Melissa Schaefer, and BLC  
6 people were kind of in and out.

7 Q Okay. And so as you're watching -- you're  
8 watching Linda Hubbard's injection practices?

9 A Yes.

10 Q Okay. And she knows -- you're there, Melissa is  
11 there?

12 A Yes.

13 Q And possibly another BLC or two?

14 A Yes.

15 Q Okay. And so with you all watching her, she is  
16 drawing propofol and doing patient injections?

17 A Yes, that's correct.

18 Q Okay. Did you see any -- we'll get to the  
19 number of propofol vials, but just on her injection practices,  
20 did you see anything unsafe?

21 A Specifically, on hers, I think on one of them it  
22 was the way -- or she didn't wipe the top of the vial with  
23 alcohol or something like that, but nothing -- nothing major,  
24 just the kind of minor, typical things that you expect to see  
25 if there's, you know, slight problems here or there.

**IN THE SUPREME COURT OF THE STATE OF NEVADA**

Electronically Filed  
SEP 02 2014 09:16 a.m.  
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Clerk of Supreme Court

DIPAK KANTILAL DESAI,	)	CASE NO. 64591
	)	
Appellant,	)	
	)	
vs.	)	
	)	
THE STATE OF NEVADA,	)	
	)	
Respondent.	)	
_____	)	

**APPELLANT'S APPENDIX VOLUME 33**

FRANNY A. FORSMAN, ESQ.  
Nevada Bar No. 000014  
P.O. Box 43401  
Las Vegas, Nevada 89116  
(702) 501-8728

RICHARD A. WRIGHT, ESQ.  
Nevada Bar No. 000886  
WRIGHT, STANISH & WINCKLER  
300 S. Fourth Street, Suite 701  
Las Vegas, Nevada 89101

Attorneys for Appellant

STEVEN S. OWENS  
Chief Deputy District Attorney  
Nevada Bar No. 004352  
200 Lewis Avenue  
Las Vegas, Nevada 89155  
(702) 671-2750  
Attorney for Respondent

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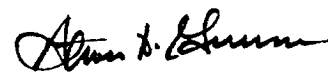
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TRAN



CLERK OF THE COURT

DISTRICT COURT  
CLARK COUNTY, NEVADA  
\* \* \* \* \*

THE STATE OF NEVADA,	)	
	)	
Plaintiff,	)	CASE NO. C265107-1,2
	)	CASE NO. C283381-1,2
vs.	)	DEPT NO. XXI
	)	
DIPAK KANTILAL DESAI, RONALD	)	
E. LAKEMAN,	)	
	)	
Defendants.	)	<b>TRANSCRIPT OF</b>
	)	<b>PROCEEDING</b>

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

**JURY TRIAL - DAY 37**

MONDAY, JUNE 17, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ.
	MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER  
TRANSCRIBED BY: KARR Reporting, Inc.

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## **I N D E X**

### **WITNESSES FOR THE STATE:**

BRIAN LABUS

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1           **LAS VEGAS, NEVADA, MONDAY, JUNE 17, 2013, 9:13 A.M.**

2                           **\* \* \* \* \***

3                           (Outside the presence of the jury.)

4           THE MARSHAL: Judge Valerie Adair presiding. Thank  
5 you. Everybody may be seated.

6           THE COURT: Our last juror just arrived, so -- but  
7 then I just heard you had something out of the presence?

8           MR. WRIGHT: Yeah. Introduction of the report.

9           THE COURT: Okay. Shut the door. All right. Yes?

10          MR. WRIGHT: The Health District report.

11          THE COURT: I'm sorry?

12          MR. WRIGHT: Admissibility of the --

13          THE COURT: Right. We have to have a ruling on that  
14 because Mr. Labus is -- I've consulted the cases, and while  
15 Health District-type reports are admissible in some cases, you  
16 know, reading everything, this is not a routine cataloging of  
17 information. That's one of the things talked about in the  
18 case of United States versus Barry.

19                 One of the things we look at is whether or not the  
20 report is prepared, it's likely there's going to be litigation  
21 or a criminal proceeding. I think this was a very unique  
22 case, and I think that this report is much more akin to an  
23 investigative police-type report than it is to an  
24 epidemiological report or a public record, which is, you know,  
25 as cited by the United States Supreme Court, the routine

1 cataloging of information. And so for that reason I don't  
2 think that the report is admissible in this case.

3 Now, the next issue are the hepatitis-infected  
4 people, the 109 or so people. Are you -- and I haven't fully  
5 decided that issue -- will that be something that you're going  
6 to be getting to in the -- this morning, Ms. Weckerly?

7 MS. WECKERLY: Your Honor, I wasn't planning to  
8 actually go into that --

9 THE COURT: Okay. Here's --

10 MS. WECKERLY: -- on direct.

11 THE COURT: -- that's -- okay. You and I are on the  
12 same page, then.

13 MS. WECKERLY: Okay.

14 THE COURT: Here's my sort of preliminary ruling, if  
15 you will. The State is precluded from going into it on direct  
16 examination. If, however, on cross-examination the defense  
17 opens the door by, kind of like what I said with the CDC  
18 investigators by, you know, pointing to, oh, it's only these  
19 seven people or it's only these eight or nine or however many  
20 it was, people, then I think the door can be opened for  
21 questioning. You know, there were other people who could not  
22 be determined to have been infected by another source, nor  
23 could they, you know, scientifically or genetically be linked  
24 to the center. So I think it could be opened.

25 Is that what you're going to say, Ms. Weckerly?

1 MS. WECKERLY: I was going to say that. There's just  
2 a couple of things -- just so it -- on the actual infection  
3 days that we have charged, there were ten people on each day  
4 that were lost to follow-up.

5 THE COURT: Okay.

6 MS. WECKERLY: I was planning on eliciting that on  
7 direct examination.

8 THE COURT: And I think that's fine, that doesn't  
9 implicate the confrontation clause --

10 MS. WECKERLY: Right.

11 THE COURT: -- because they were lost to follow-up.

12 MS. WECKERLY: Right. We don't know their outcome,  
13 right.

14 THE COURT: Right.

15 MS. WECKERLY: I think if there's questions, though,  
16 about, you know, the exclusion, you know, maybe it was Lynette  
17 Campbell and the saline flush or maybe it was scopes, I think  
18 certainly the fact that there were numerous other infections  
19 that are at least related or linked, I mean, that -- Mr. Labus  
20 uses -- he categorizes it by whether or not there's a risk  
21 factor, but there were 105 people that didn't have a risk  
22 factor, and I think that lends itself to it not being scopes  
23 and it not being a particular employee.

24 THE COURT: It still could be scopes, though, because  
25 didn't you say of the people who are on the case, not all had

1 colonoscopies? So you've got that same argument whether it's  
2 the 100 and -- is that basically what you're saying? Because  
3 if they all had the same thing, whether it's 100 people or  
4 10,000 people, if the -- let's just say the scopes were the  
5 means of transmission, they could still be infecting that many  
6 people.

7 Do you see what I'm saying? If they're not  
8 sterilizing the scopes or the forceps --

9 MS. WECKERLY: Yeah.

10 THE COURT: -- or whatever --

11 MS. WECKERLY: I mean, I think that it's not  
12 conclusive, but I think it certainly --

13 THE COURT: Well, I'm not sure it is -- I mean, I  
14 think it could be suggestive if you looked at, okay, well,  
15 Lynette Campbell wasn't working these other days, or I think  
16 you pointed out already previously in the trial, you know, you  
17 can't say it's the colonoscopy instruments when some people  
18 had endoscopies.

19 MS. WECKERLY: Right.

20 THE COURT: I mean, I think that kind of --

21 MS. WECKERLY: Right.

22 THE COURT: -- thing, but just a number alone doesn't  
23 tell me anything. Do you see what I'm saying?

24 MS. WECKERLY: Yes.

25 THE COURT: And so I think, yes, different procedures

1 than that would -- or some people had polyps removed so that  
2 could implicate the forceps, but some people didn't have  
3 polyps removed so that couldn't implicate the forceps.

4 MS. WECKERLY: Yeah.

5 THE COURT: Or some people had endoscopies so -- with  
6 nothing removed at all, no tissue sampling, so that wouldn't  
7 be the same. Do you see what I'm saying? A comparison like  
8 that, I think, is meaningful because you're comparing the use  
9 of different instruments.

10 Numbers alone, I don't find particularly meaningful  
11 in a vacuum because, like I said, let's just say it's the  
12 forceps and you're treating 60,000 people and you tell me,  
13 well, it was 100 people. Well, it still could be dirty  
14 forceps if all of those people were having polyps removed or  
15 biopsies done or something like that. Do you see what I mean?

16 MS. WECKERLY: I do. There was -- there was, though,  
17 at least one case at the other center --

18 THE COURT: Okay.

19 MS. WECKERLY: -- and, I mean, that would -- I doubt  
20 --

21 THE COURT: Well --

22 MS. WECKERLY: -- there's the same scope there or  
23 whatever. I guess there could be the same cleaning issues or  
24 whatever, but in -- I -- whatever the ruling is, I'll  
25 certainly --

1 THE COURT: I mean --

2 MS. WECKERLY: -- abide by it.

3 THE COURT: -- like I said, I can see them opening  
4 the door.

5 MS. WECKERLY: Okay.

6 THE COURT: If you feel that they have opened the  
7 door in some way, then obviously the remedy is to approach the  
8 bench --

9 MS. WECKERLY: Sure.

10 THE COURT: -- and we may have to -- I may -- we may  
11 have to do some questioning of Mr. Labus out of the presence  
12 of the jury to establish, you know, what he knows and how he  
13 knows it and possibly argument to say -- to link up whether or  
14 not, in fact, it is contrary to what has been suggested by a  
15 question on cross. Do you see what I mean?

16 MS. WECKERLY: There is one table from the report  
17 that -- I understand the ruling on the report itself, but it  
18 goes through what was eliminated as a source of transmission  
19 on the 21st that I will seek to admit because it's just  
20 narrowed to that infection date.

21 THE COURT: Any objection to the table --

22 MR. WRIGHT: Yes.

23 THE COURT: -- being separately marked as an exhibit?

24 MR. WRIGHT: Yes, I object to it.

25 MR. SANTACROCE: Can I see it?



1 MS. WECKERLY: Sure.

2 THE COURT: Basis?

3 MR. WRIGHT: The basis is -- and it's a bigger basis  
4 than just the table, and so -- I understand the report is not  
5 admissible, and the State is not going to elicit -- I just  
6 want to make sure I understand --

7 THE COURT: Elicit on --

8 MR. WRIGHT: -- the rules, right?

9 THE COURT: -- direct examination the infection.  
10 That's what Ms. Weckerly said, she does not --

11 MR. WRIGHT: Right.

12 THE COURT: -- have the intent to elicit on direct  
13 examination the 100-plus other infected patients. But she  
14 does intend to elicit that how many people were -- couldn't be  
15 contacted, we just don't know.

16 MS. WECKERLY: Ten on each day -- on each infection  
17 day didn't respond. So they were lost. There's no follow-up  
18 on them.

19 THE COURT: I'm fine with that because I don't think  
20 that implicates the confrontation clause because --

21 MR. WRIGHT: Well, the --

22 THE COURT: -- it is what it is. They were contacted  
23 and we just don't know.

24 MR. WRIGHT: They were subpoenaed?

25 MS. WECKERLY: Well, we didn't --

1 THE COURT: They didn't. That was what the whole  
2 issue was.

3 MS. WECKERLY: We don't know who they are.

4 THE COURT: That was the whole issue with the Health  
5 District --

6 MR. WRIGHT: Certainly, we know who they --

7 THE COURT: -- Mr. Coffing, who I see is sitting here  
8 --

9 MR. WRIGHT: Certainly.

10 THE COURT: -- opposed the release of that  
11 information. I ruled in the Health District's favor. That  
12 was one of the issues, as I recollect.

13 MR. WRIGHT: There's only 120 patients. We know the  
14 names of every one of them. This isn't rocket science. Of  
15 course they know who it is, and they can subpoena them. And  
16 because they opted not to, I'm supposed to -- if I examine the  
17 expert on the information he used to reach his conclusions,  
18 I'm opening the door to waiving my confrontation rights?

19 THE COURT: I don't think that's what anyone is  
20 suggesting here. I think -- what I'm ruling, anyway, is kind  
21 of what happened with the CDC people, where you sought to  
22 suggest that, oh, well, you are basing it on this limited  
23 number or something like that, and I said -- I don't remember  
24 exactly what the question was -- I don't remember exactly what  
25 the answer was, but I said, Look, you can't create a false

1 impression without opening the door to then the State, you  
2 know, addressing that false impression. That's what I said.  
3 I think it's the same with Mr. Labus.

4           So, you know, if you open the door, then the State  
5 may be able to get into that. Again, limited to this: By  
6 their own self-reporting we did not identify other risk  
7 factors, but they could not be scientifically or genetically  
8 linked to the center. I mean, that's it. That's what I  
9 understand that the evidence would be.

10           So they can't say that -- in argument -- that  
11 they're linked because they never were linked. They can't say  
12 definitively they didn't have other risk factors. By their  
13 own self-reporting they didn't identify other risk factors. I  
14 mean, I think that's what it would open the door to.

15           Again, you know, I think my ruling is consistent  
16 here, that, you know, you can't create a false impression, and  
17 if you do, then that may open the door to what really occurred  
18 with the testing and interviewing of all of the infected  
19 people.

20           MR. WRIGHT: Okay. So if I open the door, then I get  
21 the identity --

22           THE COURT: Well --

23           MR. WRIGHT: -- of all of those people and I get the  
24 information I need? The State has created this riddle, Judge,  
25 and I want to -- I'm not making myself clear. They opted

1 to --

2 THE COURT: No, I think you --

3 MR. WRIGHT: -- put an --

4 THE COURT: -- are making yourself clear.

5 MR. WRIGHT: -- no, they opted to put an expert on  
6 the stand who has looked at materials and reached his  
7 conclusions. And part -- part of his thought process had to  
8 have been, oh, I think it's this or that because we sent out  
9 letters and we got this many back, and that corroborates it to  
10 me this or that happened. And so that's off limits. I can't  
11 go to the area that he relies upon because I'm not going to  
12 get it, if -- because of the law that says that's --

13 THE COURT: Well, what if you asked him of his  
14 thought process and his thought process was, well, there were  
15 100-and-something other infected patients? I'm not going to  
16 tell him, Well, you can't testify about your true thought  
17 process.

18 It's exactly the same situation that was created  
19 with the CDC. I'm not going to tell him, well, if Mr. Wright  
20 asks you what your thought process was or why you focused on  
21 this to the exclusion of something else and that involved 109  
22 other patients, then I'm not going to tell him that he can't  
23 answer that question truthfully.

24 I mean, I guess we are in a bit of a --

25 MR. WRIGHT: That's good. So I'm -- I'm waiving --

1 THE COURT: -- conundrum here, but --  
2 MR. WRIGHT: -- I'm waiving my confrontation rights  
3 --  
4 THE COURT: No, you're not --  
5 MR. WRIGHT: -- he --  
6 THE COURT: -- waiving your confrontation rights.  
7 MR. WRIGHT: -- certainly I am.  
8 THE COURT: You have your full confrontation rights.  
9 MR. WRIGHT: Of those 106 patients? Get something  
10 straight, I dispute that they even have hepatitis. I dispute  
11 that they got it at the clinic. I admit nothing. He's  
12 relying upon hearsay to make the determination, No. 1, that  
13 they are infected. No. 2, that they're clinic-associated  
14 because they have no risk factors. And No. 3, he won't  
15 disclose who they are. That's the evidence. He won't tell us  
16 who they are.  
17 They're putting an expert on the stand who knows  
18 something, has it down -- I can't look at what he's looked at,  
19 and the State opted to use him as the expert. In any ordinary  
20 case like this, you get an expert, you have him read all the  
21 transcripts of the evidence that came in, or you have him sit  
22 here the whole day so that they have heard the same thing  
23 everyone has heard, and then they get up there and opine.  
24 But Mr. Labus has, by law -- by your ruling -- the  
25 right to have information that he has relied upon, that he

1 cannot share with me. And so how do I have the right to  
2 confront him on that issue?

3 MS. WECKERLY: As to --

4 THE COURT: Ms. Weckerly?

5 MS. WECKERLY: -- as to the charge days, everybody  
6 has access to -- to all of that information, and I don't --  
7 the fact that they sent out letters and didn't get a response  
8 from 10 people on each day -- there isn't -- there's nothing  
9 there. There's nothing to confront because they didn't get  
10 information back from --

11 THE COURT: He's not talking about that. I am  
12 assuming --

13 MS. WECKERLY: But as --

14 THE COURT: -- you're talking about the 100-and-some  
15 --

16 MR. WRIGHT: Correct.

17 MS. WECKERLY: Okay. The other 100 -- the other 105,  
18 he can -- I mean, he's certainly, when I've read his  
19 depositions, he's very qualified when he talks about that  
20 because he says, This is their self-reporting, I can't link  
21 them conclusively to the clinic; they may, you know, there's  
22 instances where people falsely report. I don't think he  
23 relies on those opinions to form his opinion or conclusion  
24 about how the transmission occurred on our actual days, but he  
25 does rely on the transmission to, I guess, to make the

1 decision as to how far -- how far back to send out  
2 safe-injection practices.

3           So he -- he saw unsafe-injection practices back in  
4 2005 --

5           THE COURT: But -- and that doesn't really matter --

6           MS. WECKERLY: -- but -- but I'm not asking --

7           THE COURT: -- what --

8           MS. WECKERLY: -- him about that, so --

9           THE COURT: -- whether he sent out 30,000 letters --

10          MS. WECKERLY: Right.

11          THE COURT: -- or 90,000 letters or 60,000 letters or  
12 whatever. I mean, to me that has nothing to do with, you  
13 know, whether your defendants, in this case, you know, are  
14 guilty or not guilty --

15          MS. WECKERLY: Right.

16          THE COURT: -- how many letters he wound up sending.

17          MS. WECKERLY: Right. But I don't think that he  
18 relies on that aspect of the Health District action to reach  
19 the conclusion as to the source of transmission. But if he's  
20 going to be asked about, you know, why did you send all those  
21 out, or boy, you only got seven people out of sending out 47  
22 letters, you know, that's not true. So I think that's where  
23 the --

24          THE COURT: I --

25          MS. WECKERLY: -- the false impression is.

1 THE COURT: -- and that's -- that's exactly what I  
2 was -- was saying too. Everything else you can -- I mean, I  
3 don't see a problem with fully confronting him on the bases of  
4 his conclusions, and how, you know, he determined it had to  
5 have been the propofol and the CRNAs, and --

6 MR. WRIGHT: Because they elect to choose him as the  
7 witness who has information that he cannot share with me.  
8 They -- they didn't have to use him, and so because of that if  
9 I cross-examine him fully with my confrontation rights I'm  
10 waiving -- I'm opening the door and then in can come evidence  
11 that is hearsay, and that I don't have a right of  
12 confrontation to --

13 THE COURT: Well, let's be clear here --

14 MR. WRIGHT: -- all because the State didn't do it.

15 THE COURT: Let's be clear here. First of all, they  
16 didn't go out and choose Mr. Labus as their expert. Mr. Labus  
17 was the employee of the Health District that went out and did  
18 the investigation which far preceded any involvement by the  
19 District Attorney's Office. Just -- so to me I think it's  
20 unfair to somehow suggest that Mr. Labus is in the same exact  
21 position of a retained expert and they could have chosen  
22 anyone is inaccurate.

23 I mean, they're -- they're calling Mr. Labus because  
24 Mr. Labus was on the front lines of this thing. He was on the  
25 ground there doing this investigation, and the District



1 Attorney's Office had no part in that choice.

2 Ms. Weckerly?

3 MS. WECKERLY: Well, I mean, that's true. He's a  
4 percipient witness too. He has conversations with people that  
5 we intend to bring in because their statements in court, you  
6 know, these are prior inconsistent statements. He's a regular  
7 witness and he also has expertise, and based on his  
8 observations on the day they were there, his collaborative,  
9 you know, I guess discussions with the CDC representatives, he  
10 reaches a conclusion about how the transmission occurred. And  
11 when he rules out the other sources it's based on information  
12 he observed or got from the records from those two infection  
13 days.

14 Now, why the notification was as broad as it was is  
15 a different decision, so, I mean --

16 THE COURT: I don't think that's really what Mr.  
17 Wright is focusing on, the --

18 MR. WRIGHT: Right.

19 THE COURT: -- notification.

20 MR. WRIGHT: I'm not. I just have the -- and I have  
21 a problem with the -- for the two dates in issue, July and  
22 September. The -- they're -- they are going to elicit that 10  
23 patients on each day we don't know whether they have  
24 hepatitis, is that what I understand?

25 MS. WECKERLY: Right. Yeah, there's no follow up on

1 -- they didn't --

2 MR. WRIGHT: Okay. But --

3 MS. WECKERLY: -- respond.

4 MR. WRIGHT: -- okay.

5 THE COURT: I think what you can't argue -- I mean, I  
6 think the evidence will be they didn't respond, that's it.

7 MR. WRIGHT: To what? The subpoenas?

8 THE COURT: To the letters.

9 MR. WRIGHT: The compulsory process? What -- why  
10 wasn't the case investigated? So I -- I open the door if I go  
11 into these 10? I want to know who they are. I want to know  
12 who didn't respond, and that's what I'm going to ask him.

13 THE COURT: I don't think you open the door to  
14 anything --

15 MR. WRIGHT: Okay. Well, then --

16 THE COURT: -- there.

17 MR. WRIGHT: -- I'm going to ask him for those 10 on  
18 each day --

19 THE COURT: And then he can say, well, it was our  
20 belief that -- or we were -- or we were told we didn't have  
21 to -- or whatever the case may be. I mean, those were the  
22 part of the ones that, as I recollect, were litigated. The  
23 State subpoenaed the information, as you recall, the Health  
24 District filed -- I think they filed that they objected to the  
25 service of a subpoena, I believe, so they filed it, I think,

1 as a motion to quash, if I recall, and they argued that  
2 pursuant -- as you -- as you'll remember, pursuant to state  
3 statute. They didn't have to disclose that information.

4 The Court ruled in the Health District's favor, that  
5 they didn't have to disclose that information. And so -- now,  
6 could the --

7 MR. WRIGHT: So that --

8 THE COURT: -- state have done more?

9 MR. WRIGHT: Yeah, could --

10 THE COURT: Yes.

11 MR. WRIGHT: -- is that hard to figure out with 126  
12 patients? They sit on their hands and do nothing to  
13 investigate the case.

14 MS. WECKERLY: But, I mean, even if -- even if we got  
15 the people, we still don't know how the Health District  
16 classified them. I mean, that's -- you know, yes, we could,  
17 but we wouldn't know what the internal classification of the  
18 Health District --

19 THE COURT: Right. But you would -- I mean,  
20 hypothetically, had you done the -- I mean, to be fair, had  
21 you done the investigation and had you found the people and  
22 had you contacted them and had some of them been willing to  
23 speak with your investigator, at least some of them may or may  
24 not have been tested and some of them may have disclosed the  
25 results of those tests.

1 MS. WECKERLY: Right. I mean, that's how we got --

2 THE COURT: That's what Mr. Wright --

3 MS. WECKERLY: -- looked --

4 THE COURT: -- is talking about. So then you would  
5 know, okay, these ten -- of the ten you found five and five  
6 were infected with hepatitis -- or two of the five were and  
7 the other three weren't, or whatever the case may be. Is that  
8 basically what you're saying?

9 MR. WRIGHT: Correct. And I am viewing it that there  
10 are six total -- well, one -- one viral -- not connected, I  
11 mean, the one for the two days -- or two.

12 MS. WECKERLY: Two.

13 MR. WRIGHT: But I'm viewing that that the state of  
14 the evidence is there were seven for the two days combined,  
15 seven out of 126 or whatever the number is. And if the State  
16 is going to argue that there's seven, or there may be 27 --

17 THE COURT: Yeah, I don't think that would be --

18 MR. WRIGHT: -- that -- that --

19 THE COURT: -- fair. They can't argue that. That  
20 would be --

21 MS. WECKERLY: No, we're going to argue that --

22 THE COURT: -- totally --

23 MR. WRIGHT: Well, then why are they --

24 THE COURT: -- unfair.

25 MR. WRIGHT: -- bringing it out at all?

1 MS. WECKERLY: We're -- we're going to argue there's  
2 nine because we're -- we count --  
3 THE COURT: Yeah, the --  
4 MS. WECKERLY: -- Lakota Quannah and --  
5 THE COURT: -- Lakota Quannah --  
6 MR. WRIGHT: Oh, that -- that's --  
7 THE COURT: -- that's fine.  
8 MR. WRIGHT: -- what I meant.  
9 THE COURT: You can argue that there's nine. I mean  
10 --  
11 MR. WRIGHT: But they're --  
12 THE COURT: -- I don't --  
13 MR. WRIGHT: -- they're going to argue there's --  
14 MR. COFFING: Hold on, one --  
15 THE COURT: -- think you can say --  
16 MR. COFFING: -- at a time.  
17 MR. WRIGHT: -- 29.  
18 MR. COFFING: One at a time.  
19 THE COURT: -- well, we didn't hear from these  
20 people, so they, you know, it -- the inference is that they  
21 were infected. I mean, it's just as likely they didn't  
22 respond to the Health District because they weren't infected,  
23 and they thought --  
24 MR. WRIGHT: Well --  
25 THE COURT: -- I'm not infected, why -- why am I

1 going to bother with this whole thing?

2 MR. WRIGHT: Right. But the --

3 THE COURT: I mean, I think that's just --

4 MR. WRIGHT: -- what --

5 THE COURT: -- as reasonable an inference --

6 MR. WRIGHT: -- why -- why is it --

7 THE COURT: -- as to why.

8 MR. WRIGHT: -- coming out, other than to draw the

9 inference that there may be others?

10 THE COURT: I think they can bring it out to explain

11 the blanks on the sheet that -- that we don't know, that

12 the -- is that -- I mean, if that's what they're doing --

13 MS. WECKERLY: That's -- right, we don't --

14 THE COURT: -- on the schedule --

15 MS. WECKERLY: -- know.

16 THE COURT: -- is to say, look, these were people,

17 the Health District, that we don't know.

18 MR. WRIGHT: The Health District does, but we don't?

19 THE COURT: Yeah. I mean --

20 MR. WRIGHT: And so in a --

21 THE COURT: -- the truth is the truth --

22 MR. WRIGHT: -- criminal case we're not --

23 THE COURT: -- Mr. --

24 MR. WRIGHT: -- allowed to know. I --

25 THE COURT: Mr. Wright, there are -- I've said this

1 over and over again. You know, you didn't weigh in on the  
2 issue with the Health District and the State. I'm not saying  
3 you had to, but here's the deal, and I've said this over and  
4 over again: There are two, you know, just -- this is a, you  
5 know, the Health District preventing the spread of disease and  
6 studying how disease is, you know, spread and things like  
7 that, that's a very strong State-ish interest, and I ruled  
8 that that State interest is equal to the State interest in  
9 going forward in criminal proceedings.

10 And so in this case I ruled they didn't have to  
11 disclose --

12 MR. WRIGHT: Okay.

13 THE COURT: -- that name because you --

14 MR. WRIGHT: I -- I'd --

15 THE COURT: -- have to protect the open flow of  
16 information with the Health District because their function is  
17 to, you know, identify communicable diseases and to try to, I  
18 guess, ascertain how those are spread and to prevent the  
19 further spread. And so, you know, they have a strong and  
20 compelling, in my view, legitimate interest --

21 MR. WRIGHT: Okay. As --

22 THE COURT: -- in keeping the -- that information  
23 confidential.

24 MR. WRIGHT: And stronger than my client's right to a  
25 fair trial and his compulsory process rights and his rights of

1 confrontation? I make the demand right now for a Court order.  
2 You say the State's balance doesn't tip; I want it -- under  
3 compulsory process, my right to confront witnesses and the  
4 evidence that is available. I want the information that won't  
5 be turned over to the State by the Health District.

6 MS. WECKERLY: Well, yeah, I don't have it, so...

7 MR. WRIGHT: No, I'm -- I'm subpoenaing it, I'm  
8 demanding it, he's testifying, I am requesting that the  
9 witness produce it.

10 THE COURT: Mr. Coffing, I'm assuming you're here for  
11 the Health District?

12 MR. COFFING: Your Honor, I was here to just be with  
13 the witness, Your Honor. I wasn't --

14 THE COURT: Right. I mean, here's --

15 MR. COFFING: -- anticipating --

16 THE COURT: -- the thing. You want to subpoena the  
17 information, I guess, subpoena the information. As I recall,  
18 the --

19 MR. WRIGHT: No, I'm requesting --

20 THE COURT: -- statute, it was pretty much no  
21 exceptions. You know, to me the remedy if, you know, you  
22 can't get a fair trial with the information is a separate  
23 remedy than forcing the Health District to turn over the  
24 information. Now, everyone keeps saying that, well, you could  
25 have figured out the information other ways. So if that's the



1 case, then I don't see how the interest of the Health District  
2 somehow is minimized when there are alternate routes to find  
3 that information.

4 MR. WRIGHT: I don't have to do any of that.

5 THE COURT: Well, all I'm saying is, first of all,  
6 the State cannot create a false inference to their benefit by  
7 virtue of the fact ten people didn't respond. They can  
8 explain what the missing people mean on the chart, but they  
9 can in no way argue, well, maybe these people would have had  
10 hepatitis, we just don't know. That would be improper  
11 argument in my view, and you can't do it. So does that  
12 alleviate some of your concerns?

13 MR. WRIGHT: No. I still want the information.  
14 I'm -- I don't want to -- I don't want to -- I don't want this  
15 on an idea that, okay, if you want it, go subpoena it. The  
16 witness is here, and so I am going to request that he produce  
17 it. And so I -- I just want a ruling so that --

18 THE COURT: Do you have the 126 names?

19 MR. STAUDAHER: They're -- they're on the chart.

20 MS. WECKERLY: They're on the charts, but we --

21 THE COURT: On the day?

22 MS. WECKERLY: -- you know, we redacted them. But I  
23 don't --

24 MR. STAUDAHER: Counsel --

25 MS. WECKERLY: -- I don't --

1 MR. STAUDAHER: -- Counsel had the --  
2 MS. WECKERLY: -- know who --  
3 MR. STAUDAHER: -- originals, so they've --  
4 MS. WECKERLY: -- didn't follow up.  
5 MR. STAUDAHER: -- got all that.  
6 MS. WECKERLY: I don't know that. I know who the  
7 people are, but I don't know who was lost to follow up because  
8 that would only be known to the Health District.  
9 MR. WRIGHT: Oh, so you're -- you're talking about  
10 -- I mean, there are -- there are 20 people who didn't respond  
11 for the two --  
12 MS. WECKERLY: Right.  
13 MR. WRIGHT: -- days, correct?  
14 MS. WECKERLY: Correct.  
15 MR. WRIGHT: The identity of those 20?  
16 MS. WECKERLY: I don't know that. Only the Health  
17 District knows that.  
18 THE COURT: Then how do you know --  
19 MR. WRIGHT: We have patient lists.  
20 THE COURT: -- okay, well, wait. I'm missing  
21 something here because if you have -- let's make this easy for  
22 us, 100 people, okay? And let's say of the 100 people 8 -- 8  
23 that day were infected, okay? So now you've got 92 people.  
24 And of those 92 people, are you saying -- and then, of the 92  
25 people, I understand you knew X, you know, A, B, and C, and D,

1 weren't infected; is that true?

2 MR. STAUDAHER: No.

3 MS. WECKERLY: No.

4 MR. STAUDAHER: What we have is 126 -- the -- and  
5 Counsel had the original, the unredacted information, so both  
6 sides have had all the names of the patients that -- those two  
7 days, who had procedures done on those two days. Of those 126  
8 people, or whatever, we -- we -- there are apparently a total  
9 of 20, 10 for each day, that were lost to follow up by the  
10 Health District. So of the --

11 THE COURT: Right. But you know who was not lost to  
12 follow up.

13 MR. STAUDAHER: No.

14 MS. WECKERLY: No.

15 MR. STAUDAHER: If we knew who was not lost to follow  
16 up, we would know --

17 THE COURT: Then you would know who --

18 MR. STAUDAHER: -- was --

19 THE COURT: -- right.

20 MS. WECKERLY: Right.

21 MR. STAUDAHER: -- and that was all -- that was the  
22 information that we were requesting. That was what the Court  
23 ruled we could not get. So we don't know which ones the  
24 Health District contacted and didn't contact --

25 THE COURT: So all you know is, okay, of the other,

1 say 90 people that weren't lost to follow up --

2 MR. STAUDAHER: We don't know who those people are --  
3 which ones were not lost.

4 THE COURT: -- right. That -- that none of them  
5 tested positive for hepatitis, and that 10 people you don't  
6 know and nine people did test positive; that's what you know?

7 MS. WECKERLY: Right.

8 THE COURT: And you know the identity of the people  
9 who do -- did test positive?

10 MR. STAUDAHER: That we have linked --

11 THE COURT: Right.

12 MR. STAUDAHER: -- and --

13 THE COURT: Right. And --

14 MS. WECKERLY: Of the ones that followed up --

15 THE COURT: -- that's all you know?

16 MS. WECKERLY: -- we know who they are. We know that  
17 the -- we know the ones that are positive.

18 THE COURT: Right. Which are the ones -- you know  
19 that. So the other people, you know that they weren't  
20 positive, but you don't know their identities.

21 MR. STAUDAHER: No, we don't know that they weren't  
22 positive. We don't --

23 THE COURT: I'm not talking about --

24 MR. STAUDAHER: -- know if they were ever tested --

25 THE COURT: -- the people who didn't follow up, I'm

1 talking about --

2 MR. STAUDAHER: Oh.

3 THE COURT: -- the people who did follow up.

4 MR. STAUDAHER: It's our understanding that those  
5 people were tested --

6 THE COURT: And they're negative?

7 MR. STAUDAHER: -- at some point and they were  
8 negative, yes.

9 THE COURT: Okay. And what Mr. Wright is saying is  
10 okay, you know there were 126 patients on that day. You can  
11 eliminate the people we already know their identities because  
12 they're in this case and they tested positive. Of those other  
13 people, what you could do is try to subpoena and contact all  
14 of those, and then find out from those who contacted you back,  
15 Did you follow up with the Health District or not follow up  
16 with the Health District?

17 Is that essentially what you're saying, Mr. Wright?

18 MR. WRIGHT: Yes. And it -- it affects on the chart  
19 when we have skipped -- the whole skipping and room to room,  
20 and presumptions that this -- this person that followed didn't  
21 get hep C, now it's going to be left -- well, we -- we don't  
22 know if they did or didn't.

23 THE COURT: How is this different from --

24 MR. WRIGHT: And --

25 THE COURT: -- any other case where the defense's

1 argument is, Look at how poorly investigated this case was.  
2 Let's just take a run-of-the-mill robbery case and, you know,  
3 somebody says, oh, you know, it was an African-American person  
4 that was 5 feet, and then they stop an African-American person  
5 on the street and he's 5'7 and they arrest him, and then they  
6 shut the whole thing down and they don't bother with  
7 fingerprints or DNA or anything else that they could have done  
8 that would have potentially exonerated the person that they  
9 picked.

10 And that's what the defense argues, and I know,  
11 though, you don't tend to handle those kinds of cases, but  
12 trust me on this, that's probably the majority of what we see.  
13 You know, how is this any different when the argument is,  
14 look, the State didn't do a good job? They didn't do a  
15 thorough investigation. They could have done more. You know,  
16 where -- where are these other things that they could have  
17 done?

18 MR. WRIGHT: The --

19 THE COURT: Tell me how this is different.

20 MR. WRIGHT: The difference is the State of Nevada  
21 has the information. They -- the State of Nevada has it.  
22 You're saying the District Attorney doesn't. The State has  
23 evidence that may be exculpatory. That may help the -- and I  
24 can't have it. And you're putting this privacy right of the  
25 Health District --

1 THE COURT: Well, first of all, let's be --

2 MR. WRIGHT: -- above --

3 THE COURT: -- clear here, Mr. Wright. You weren't  
4 heard on -- you were all here, as I recall, but none of the  
5 defense wanted to be heard on the issue with the Health  
6 District. So what the Court considered was what the State had  
7 presented and what the Health District had presented.

8 And basically, the issue that was litigated at that  
9 time was, well, the State said, well, we, you know, feel like  
10 we need to find these things and blah, blah, blah, and, you  
11 know, the Health District, as I recall, said there's other  
12 ways for them to get it.

13 And our interests in protecting full and complete  
14 disclosure to fulfill the duties of the Health District, you  
15 know, are tantamount to -- to their, you know, interests in  
16 finding this information. The statute, I thought, was pretty  
17 clear -- the State statute -- and so that was the issue before  
18 the Court at that time.

19 The Defense, you know, was here, they, you know,  
20 didn't -- didn't choose to weigh in at that point. And so I  
21 don't think in some way it's fair to penalize the District  
22 Attorneys who are here because they did seek out that  
23 information --

24 MR. WRIGHT: Well, they --

25 THE COURT: -- from the Health District. I'm not

1 saying you were obligated to do it.

2 MR. WRIGHT: Of course, I'm not --

3 THE COURT: All I'm --

4 MR. WRIGHT: -- I'm not obligated --

5 THE COURT: -- no, and I'm not -- and well, just  
6 before -- I'm not suggesting that you were, but let me just  
7 say that the consideration that, you know, what was -- what  
8 was considered by the Court was the arguments from the State,  
9 the DA's office, and the Health District at that time, you  
10 know, not, you know, some of the arguments that you're making  
11 today. So that's all I'm saying.

12 In any event --

13 MR. WRIGHT: Because today I'm saying it under  
14 compulsory -- compulsory process, and the right of  
15 confrontation, I want the evidence that the State of Nevada  
16 has and will not give me.

17 And I don't buy their higher investigative privilege  
18 that trumps my client's right to the evidence. There -- these  
19 cases come up all the time. The State, if they don't want to  
20 turn it over, has the option. They do this in secrecy cases,  
21 top secret, don't want to turn over CIA information. The  
22 remedy is the case gets dismissed.

23 You don't just say, oh, sorry, you got to go to  
24 trial without it. That's what I am requesting and want, and  
25 the State has it. And the Health District, they're



1 willy-nilly on their obligations. They'll promise  
2 confidentiality. I mean, it's right in their -- in Labus's  
3 note, they tell someone this is an off-the-record statement,  
4 and then turn right around and hand it to the police.

5 So I don't buy this investigative --

6 THE COURT: Well, just --

7 MR. WRIGHT: -- privilege and the public interest.

8 THE COURT: -- just to be clear, it's not an  
9 investigative privilege under the --

10 MR. WRIGHT: Public health privilege.

11 THE COURT: -- statute -- it's a patient privilege.  
12 It's to get people to disclose these diseases to the Health  
13 District, as I -- as I recall it, so that they're not afraid  
14 that their identities will be made known, in this case,  
15 publicly.

16 And so, that's what it's for, so that people feel  
17 like they can go to the Health District if they've contracted  
18 a disease and they don't have to worry about their name being  
19 disclosed down the road.

20 And the -- the State interest is pretty obvious. We  
21 need people who are willing to go and disclose these things  
22 for the Health District so that the Health District can  
23 determine outbreaks and put an end to them. And the idea  
24 being, if people know, well, hey, if I go to the Health  
25 District, then some criminal defense attorney may get my name

1 and, you know, the reporter sitting in the back row now is  
2 going to know who I am and that I've got hepatitis, or, you  
3 know, maybe I went even, you know -- you know, some people may  
4 not want it -- want it known they went to the gastro center  
5 because maybe they have, you know, Crohn's disease or cancer  
6 or some other disease that they don't want known publicly.  
7 They don't want their employers to know about it.

8 And so these are all interests. What if one of  
9 those people tested positive for AIDS, HIV, totally unrelated  
10 to this case? That's something that's clearly protected. And  
11 so there are abundant reasons why that's an important statute  
12 that had nothing to do with the proceeding.

13 But, you know, right now as I'm sitting here I can  
14 think, well, gosh, if people know, wow, if I go in and I  
15 disclose these things and I'm tested and I have a disease that  
16 I don't want people know -- knowing about because it's  
17 stigmatized, and it could even be a problem with my employer,  
18 you know, what if you're -- then that's going to put a --  
19 put a stop to the flow of information to the Health District.

20 And I think this right here what we're -- what we're  
21 seeing is exactly what they're concerned about. And so, you  
22 know, I -- I stand by the ruling in that regard.

23 So here's what I would suggest going forward. Let's  
24 get started. We'll go through the direct of Mr. Labus. If  
25 you have a question regarding cross, if that will open the

1 door, then certainly approach the bench. If we need to take a  
2 break or something like that, we'll excuse the jury and take a  
3 break.

4 With respect to this issue with the nondisclosure.  
5 This was an issue that's been known for a long time, and so to  
6 me, to spring it on, you know, on the Court and ask for an  
7 order compelling the Health District to turn over these  
8 records in, you know, contravention of the previous order  
9 or -- I'm not going to do that.

10 So, you know, you certainly have the right to raise  
11 this issue at a later date, and you can do that, you know, to  
12 brief it fully and say that your client's rights were  
13 denied --

14 MR. WRIGHT: Okay.

15 THE COURT: -- because of the failure of the Health  
16 District upon the Court's order to disclose the information,  
17 and then the failure of the District Attorney's Office to take  
18 alternate steps to try to learn or ascertain the information.  
19 You certainly can do that, as, you know --

20 MR. WRIGHT: Okay. So is it --

21 THE COURT: -- post-trial remedy, but at this point  
22 in time I don't think it's fair to make the motion while the  
23 jury is all waiting around to start, when this is an issue  
24 that's been known, not for days, not for weeks, but for  
25 months. I made that ruling months ago.

1           So, Mr. Santacroce?

2           MR. SANTACROCE: Yes, I just needed to make my  
3 record, Your Honor. I want to join Mr. Wright's motion  
4 objection regarding these 104 patients. In addition, I want  
5 to object to State's Proposed 228, which is the chart. This  
6 chart lists a bunch of things that the Health District  
7 apparently considered and ruled out, and it says, results  
8 ruled out.

9           They go through the IV placements. They go through  
10 the scopes. They go through the biopsy equipment. And they  
11 say, we've ruled these out for various reasons. And now, the  
12 Court's telling me if I go into, for example, Lynette Campbell  
13 and the IV placements which they ruled out, then I'm opening  
14 the door to these 104 patients? I mean, how -- if you're  
15 going to allow this in, and the jury is going to take it back  
16 to the jury room --

17          THE COURT: I didn't say I was -- okay. Go on.

18          MR. SANTACROCE: -- no, I'm just saying I object to  
19 it coming in, unless I can cross-examine on each one of these  
20 things that were ruled out without opening the door to the  
21 bigger issue. So that's the dilemma I have, and that's why  
22 I'm objecting to allowing this to come in.

23          THE COURT: All right.

24          MR. SANTACROCE: Or at least give me some direction  
25 as to what I can go into without opening the door.

1           THE COURT: One of the problems the Court's having  
2 right now is I don't know what Mr. Labus's answers would be to  
3 those questions. And I don't know if Ms. Weckerly knows what  
4 Mr. Labus's answers would be to those questions. I mean, I  
5 think it's fair, you know, Mr. Santacroce's theory is that  
6 it's more likely that the -- that it was transmitted through  
7 contaminated saline than it was through, you know, the  
8 propofol, which makes sense in -- you know, I think he's --  
9 he's got a good theory he's working with because you got to  
10 put the virus in numerous bottles of propofol as opposed to a  
11 single bottle of saline.

12           So, you know, it's -- that's where he is, and he has  
13 a right to flesh that theory out, certainly. So, you know, if  
14 Mr. Santacroce gets into, you know, why was Lynette Campbell  
15 and the saline solution excluded, you know, do you know what  
16 Mr. Labus is going to say because I certainly don't?

17           MS. WECKERLY: I mean, I think he's going to say  
18 it's, you know, it's based on their observations at the clinic  
19 and their review of the charts. I don't think he -- I mean, I  
20 don't think he's going to make reference to the other 105  
21 cases. But he's going to base it on what they observed at  
22 their investigation.

23           THE COURT: Okay. So pretty --

24           MS. WECKERLY: And all of these conclusions are based  
25 on their observations or chart reviews from the --

1 THE COURT: -- just from those two days.

2 MS. WECKERLY: -- two infection days.

3 THE COURT: As long as that's it, then I don't see  
4 that opening the door. You can fully cross-examine.

5 MR. SANTACROCE: Okay.

6 THE COURT: You know, Ms. Weckerly, I guess what --

7 MS. WECKERLY: Well, I can get him and ask him.

8 THE COURT: -- well, you can ask him or, you know,  
9 just tell him, look, if some answer is going to call for going  
10 into the -- why don't you just, you know, ask him. If that's  
11 all he based everything on, then I don't see the door being  
12 opened, and we're -- okay?

13 MS. WECKERLY: Okay.

14 THE COURT: So if anyone needs -- yes, Mr. Wright?

15 MR. WRIGHT: Right. I just want it clear. I don't  
16 want to ask him in front of the jury. I mean, the state of  
17 the record is I have requested the production of the patients  
18 that -- the 105, identity of them, and the 20 for the two  
19 dates in question.

20 THE COURT: Right.

21 MR. WRIGHT: And the -- the privilege precludes the  
22 production; is that correct?

23 THE COURT: I mean, I don't know --

24 MR. WRIGHT: I mean, I just want the record --

25 THE COURT: -- I don't know why it --

1 MR. WRIGHT: -- straight.

2 THE COURT: -- would be different from you requesting  
3 it than it was from the State requesting it.

4 MR. WRIGHT: Because I have compulsory process --

5 THE COURT: Well, that wasn't --

6 MR. WRIGHT: -- and right of confrontation --

7 THE COURT: -- okay --

8 MR. WRIGHT: -- and they don't. And I -- and you act  
9 like I knew this the entire time. I'm telling you, until we  
10 were at a sidebar up there talking about the 105, I did not  
11 know they didn't know who those 105 were. We were up there --

12 THE COURT: Well, the 105, and the 10 are different  
13 --

14 MR. STAUDAHER: Yes, they're completely different.

15 MR. WRIGHT: Correct.

16 MS. WECKERLY: They're different.

17 THE COURT: -- different issues.

18 MR. WRIGHT: Correct. I understand they're different  
19 issues, but I -- I'm telling you, I didn't know they hadn't  
20 conducted -- because that's when I was up there squawking  
21 about --

22 THE COURT: Okay.

23 MR. WRIGHT: -- why didn't they do a criminal  
24 investigation. Why did they just take -- handed to them this,  
25 and then they turned it into a criminal case? And then I

1 learned, up there for the first time, that they didn't do  
2 anything. That they just --

3 MR. STAUDAHER: No, that's --

4 MR. WRIGHT: -- well --

5 MR. STAUDAHER: -- that's another time, now --

6 MR. WRIGHT: -- that's a misstatement. I'm -- I  
7 don't meant hey didn't -- they accepted the report of the  
8 Southern Nevada Health District, and accepted what would be  
9 turned over to them, and did nothing further to try to get  
10 more information than what was in there. And so, I didn't  
11 know all of that from preparation towards the case.

12 So all I'm saying is now my compulsory process right  
13 under the Constitution, I just want it clear that they -- that  
14 the privilege, and I -- you articulated it well, and I  
15 understand the reasons and the basis for it, and I don't --  
16 and I'm not arguing about your judgment on the call, I'm just  
17 saying I want the record clear that it not only trumps the  
18 State's demand for it, but it trumps my demand for it for Dr.  
19 Desai.

20 THE COURT: All right. Off -- that issue was not  
21 considered at the time I made the ruling.

22 MR. WRIGHT: Right.

23 THE COURT: All right. So having said that, you  
24 know, I read this months ago. My belief, from memory, would  
25 be that there were no exceptions to that. Now, you know, if



1 you would like -- again, I think it's a little bit unfair to  
2 ask for a ruling, you know, right now. My recollection of  
3 reading everything and studying it and -- was that there are  
4 no exceptions. And again, I'm, you know, I think it's to  
5 protect people from, you know, being hauled into court in  
6 unrelated matters, and having their private health information  
7 disclosed.

8 And so, you know, I think that the -- the ruling  
9 would be the same. And I'll certainly say, this morning I'm  
10 not going to order Mr. Labus or the Health District to turn  
11 over the information to you.

12 MR. WRIGHT: Okay. And I wasn't -- I wasn't  
13 suggesting there was a statutory exception in there for the --

14 THE COURT: No. No, I know you --

15 MR. WRIGHT: -- okay. I'm saying --

16 THE COURT: -- you're not -- I'm saying, I didn't  
17 consider it -- the statutory rule and weighing that, doing any  
18 kind of weighing analysis with Dr. Desai's Constitutional  
19 rights. And I think you're right, you know, generally if he  
20 can't get a fair trial and there's no way to turn over the  
21 information or get the information, then the remedy is  
22 dismissal. I don't see that as being the case here. I don't  
23 see that he's being denied his right to a fair trial because  
24 of the absence of the information.

25 MR. WRIGHT: Okay. But I'm not talking due process

1 for a trial. I'm talking compulsory process aside from right  
2 of confrontation in me cross-examining him. My independent  
3 right. I can't even remember the cases on compulsory process,  
4 but it's -- there's one Supreme Court case, Oklahoma versus  
5 somebody, and there was a statute that precluded turning over  
6 certain information, and it was found that compulsory process  
7 trumped --

8 THE COURT: And I'm happy to read that case, and I  
9 would have read it had anyone given me a heads-up that we  
10 would be arguing this this morning, which is why I'm saying, I  
11 don't think it's fair of you, really, to spring this this  
12 morning on the State. Ms. Weckerly, did you read that case in  
13 anticipation for --

14 MS. WECKERLY: Not on --

15 MR. WRIGHT: I didn't either.

16 THE COURT: -- today's argument? I certainly didn't.

17 MS. WECKERLY: Not on compulsory process.

18 THE COURT: So, you know, I'm happy to read it at the  
19 lunch break, if someone wants to get me a cite for that case,  
20 and consider it; but again, that wasn't what was considered  
21 last time, you know, no exceptions to the statute.

22 I'll reiterate it, the State interests and the  
23 public health interests in the statute, I think, are obvious.  
24 And as we sit here fighting over these people, and, you know,  
25 media being present, I think the reason for the statute,

1 really, has hit home. And it's quite obvious to the Court.

2 And so, you know, if these people were hauled into  
3 court, I think it would have a chilling effect on future  
4 people going to the Health District if they think, gee, I  
5 don't, you know, want to be -- I don't want my name being out  
6 there in the -- in the public eye. I'm happy to read the  
7 case.

8 MR. WRIGHT: Okay.

9 THE COURT: Like I said, you know, this is just  
10 sprung on me this morning. I didn't read the case. You know,  
11 I haven't been reading up on compulsory process and -- and  
12 statutes that preclude, you know, dissemination of  
13 information. So --

14 MR. WRIGHT: I haven't read up on it either, Your  
15 Honor. It just seems so fundamental to me that a witness  
16 can't get on the stand that knows more than I do, and then the  
17 State has the information and can't share it with me. I mean,  
18 I don't even need cases for that -- to say that proposition  
19 doesn't work.

20 But I understand -- understand the ruling --

21 THE COURT: Well, he is a percipient witness to this,  
22 and frankly --

23 MR. WRIGHT: I have no problem with his percipient  
24 witness -- I want to be clear on that -- I didn't say he  
25 couldn't testify. I mean, whatever his percipient thing is, I

1 got it. I know the issue.

2 THE COURT: Here's the problem, though, the whole --  
3 I mean, part -- what I'm -- I've heard from the Defense is,  
4 you know, this was sort of the whole -- I mean, my words not  
5 yours -- this whole sort of rush to judgment and, you know,  
6 that they didn't consider everything. Brian Labus was, you  
7 know, and the CDC -- the gals from the CDC, it was them. So I  
8 don't know how this case could be put on without Brian Labus  
9 or someone from the Health District to explain, well, Why did  
10 we get to this theory?

11 Because that's what I'm hearing in the opening  
12 statement, it was a rush to judgment, it wasn't a thorough  
13 investigation. Then you get the plaintiff's bar involved and  
14 it's really, oh, go after the propofol and -- to the exclusion  
15 of these other cheaper things, like the saline -- the multiuse  
16 saline. And so I don't know how the case could go forward  
17 without bringing all of that out.

18 So let's take a couple-of-minute break, and then I  
19 want to get started with the jury.

20 MR. STAUDAHER: Your Honor, I'm not going to argue  
21 anything. I just want to put something on the record, if I  
22 may, and it will just take one second.

23 I know that the Court -- and I'm not quibbling with  
24 the order regarding the admission or not of the actual report  
25 of the Health District, but I do want to put in that the State

1 did submit four cases for the Court's review: United States  
2 v. Berry, 683 F 3d --

3 THE COURT: And I think that was the one --

4 MR. STAUDAHER: -- 1015 --

5 THE COURT: -- I was quoting from this morning.

6 MR. STAUDAHER: -- a 2012 case, that was a criminal  
7 matter. And then also, Ellis v. International Playtex, 745 F  
8 2d 292. Drayton v. Pilgrim's Pride, which was 472 F 2d 638.  
9 And also, the Beechcraft -- or Aircraft Corporation v. Beech  
10 Aerospace Services v. Rainey, which was 488 US 153, a U.S.  
11 Supreme Court decision.

12 I didn't indicate -- have any indication that the  
13 Defense had ever submitted any cases --

14 THE COURT: They did not.

15 MR. STAUDAHER: -- and I don't know what else the  
16 Court reviewed, but I did want to have on the record that that  
17 was submitted, and --

18 THE COURT: And I did consider all of them, and --

19 MR. STAUDAHER: -- at least --

20 THE COURT: -- and the case I was quoting from this  
21 morning was U.S. v. Berry, which was the sole criminal case,  
22 and that was the one where the documents that the Court upheld  
23 were routine administrative documents, that there was no  
24 anticipation of a criminal proceeding.

25 Other cases have talked about litigation, and, you

1 know, I don't know the exact timing of all of these events,  
2 but, you know, I think it was pretty clear early on, certainly  
3 by what was going on in the media, that there could be  
4 criminal charges, certainly that there would be civil  
5 litigation involved in all of this.

6 And so I think the record is complete there. Can we  
7 get started with the jury?

8 MR. STAUDAHER: Yes, Your Honor.

9 THE COURT: Okay.

10 (Pause in the proceedings.)

11 THE COURT: Go ahead and bring in the jury, Kenny.  
12 Thanks.

13 Do you have the full name of that Oklahoma case?

14 MR. WRIGHT: No, but I'll get it.

15 THE COURT: Doesn't give me a lot -- doesn't give my  
16 poor law clerk a lot to work with there.

17 MS. STANISH: Oklahoma and compulsory process --

18 MR. WRIGHT: Right.

19 MS. STANISH: -- U.S. Supreme Court, you'll find it.

20 MR. WRIGHT: Compulsory process.

21 MS. STANISH: Westlaw search will work with that.

22 MR. WRIGHT: It seems like to me it was a statute  
23 that preclude -- if you can believe this --

24 THE COURT: Well, I mean, if it's --

25 MR. WRIGHT: -- a statute precluded the defendant

1 from calling a charged accomplice as a witness or something.

2 It was a statute that precluded testimony.

3 THE COURT: What was the, like, basis for the  
4 statute? Like, the public policy behind the statute?

5 MR. WRIGHT: I don't even -- it wasn't very good. It  
6 wasn't as big as the --

7 THE COURT: Unlike this public --

8 MR. WRIGHT: -- interest here.

9 THE COURT: -- policy behind the statute, which is,  
10 you know, pretty compelling.

11 MR. WRIGHT: Correct.

12 THE MARSHAL: Ladies and gentlemen, please rise for  
13 the presence of the jury.

14 (Jury entering at 10:11 a.m.)

15 THE MARSHAL: Thanks, everybody. You may be seated.

16 THE COURT: All right. Court is now back in session.  
17 The record should reflect the presence of the State through  
18 the Deputy District Attorneys, the defendants and their  
19 counsel, the officers of the court, and the ladies and  
20 gentlemen of the jury.

21 And the State may call its next witness.

22 MS. WECKERLY: Brian Labus.

23 THE COURT: Mr. Labus, just right up here, please,  
24 sir, next to me, up those couple of stairs. And then remain  
25 standing, facing this lady right there, who will administer

1 the oath to you.

2 BRIAN LABUS, STATE'S WITNESS, SWORN

3 THE CLERK: Thank you. Please be seated. And please  
4 state and spell your name.

5 THE WITNESS: Brian Labus, B-R-I-A-N, L-A, B as in  
6 boy, U-S, as in Sam.

7 THE COURT: All right. Thank you.

8 Ms. Weckerly?

9 DIRECT EXAMINATION

10 BY MS. WECKERLY:

11 Q Sir, how are you employed?

12 A I'm the senior epidemiologist for the Southern  
13 Nevada Health District.

14 Q And how long have you been the senior  
15 epidemiologist for the Health District?

16 A I've been the senior epi for about 11 years;  
17 I've been employed there for 12.

18 Q Okay. And what's your educational background  
19 that allowed you to work in that capacity?

20 A I have a bachelor's degree in biology from  
21 Purdue and I have a master's of public health and infectious  
22 diseases from UC Berkeley.

23 Q Prior to having the position you have as the  
24 senior epidemiologist, did you hold other positions within the  
25 Health District?



1 A Yes, I was an epidemiologist.

2 Q An epidemiologist. Were you assigned to  
3 investigate the hepatitis outbreak at the Endoscopy Center of  
4 Southern Nevada in 2007?

5 A Yes, I was.

6 Q Can you explain to the members of the jury how  
7 it was that the -- the outbreak itself came to your attention?

8 A Hepatitis C, when acute cases occur, is  
9 reportable to the health authority, and by law we're  
10 responsible for investigating those.

11 Q And what -- what is -- how does the Health  
12 District and the CDC define an acute case of hepatitis C?

13 A An acute case of hepatitis C is defined by a  
14 number of lab tests that show the person has hepatitis C, as  
15 well as some current liver problems, so an elevated liver  
16 enzyme which shows damage to the liver, or bilirubin, which is  
17 why you turn yellow and get the symptoms from hepatitis. You  
18 have to have a discrete onset of symptoms. So the combination  
19 of the lab test and the symptoms are what defines it as an  
20 acute case of hepatitis C.

21 Q And is there a time period where cases are  
22 defined as acute, like, from the time of exposure, like, what  
23 would be the outer range of what could be considered acute?

24 A If a person is infected, they'll develop acute  
25 disease within six months.

1 Q And the other cases, I assume, are called  
2 chronic?

3 A That winds up being a little bit of a tricky  
4 term. Chronic usually refers to a long-term infection with  
5 hepatitis C. So you have a new infection. A small percentage  
6 of those people get symptoms, they get sick with the disease.  
7 The rest have a subclinical disease. So the virus is in them,  
8 it's doing damage, but they don't have any outward symptoms.  
9 Some people clear the infection, but most go on to have a  
10 long-term infection, which is the chronic hepatitis C.

11 Q And are chronic cases reported to the Health  
12 District?

13 A All lab reports are reported to us, but chronic  
14 hepatitis C is not legally reportable to us.

15 Q Okay. And typically how many acute cases would  
16 be reported to the Health District in a normal year?

17 A Usually between two and four cases in Clark  
18 County.

19 Q Okay. In Clark County? Now, when you -- when  
20 was it that you first learned of this outbreak?

21 A I learned about it on January 2, 2008.

22 Q And when you -- did you learn about it, like,  
23 because you were assigned to investigate it, or how was it  
24 that it came to your attention?

25 A We had the two cases reported, one was in late

1 November, one was in December. They were investigated by our  
2 investigation staff at the office. And when they identified  
3 the common link between the cases it was passed up the chain,  
4 and that's when I became aware of it.

5 Q Okay. So initially you were just aware of two  
6 cases that were possibly associated with the clinic?

7 A That's correct.

8 Q And based on that, what steps did you take in  
9 order to kind of get a plan together to start investigating?

10 A This was sort of uncommon for us. We don't  
11 normally see hepatitis C tied to a medical facility; and when  
12 the two cases were identified, they had procedures on  
13 different dates. So we had two cases, sort of associated with  
14 the same place, and sort of in the same time range, but not on  
15 the same date. So we contacted the CDC to talk to them about  
16 where should we go with this investigation? What would be the  
17 appropriate next steps?

18 Q So initially, one of the cases you had reported  
19 was -- went from July 25?

20 A That's correct.

21 Q And then you had another one from September the  
22 21st?

23 A That's correct.

24 Q And then based on that they -- they had an  
25 association with the clinic, but not much else of a

1 connection; is that fair, initially?

2 A Yes. Colonoscopies are a common procedure, and  
3 so the fact that both people had them, it was uncommon, but it  
4 really -- didn't really make it certain that it was any one  
5 particular clinic. It could have just been a coincidence.

6 Q Okay. And what was -- what was behind the  
7 decision to contact the CDC?

8 A The fact that we had some connection between  
9 these two cases, but not a really strong connection, and we  
10 wanted to talk to the experts on hepatitis and  
11 healthcare-acquired infections to see if this warranted a full  
12 investigation.

13 Q And when -- had you -- have you in previous  
14 investigations contacted the CDC for, I guess it's advice  
15 or -- or their thoughts on an investigation or an outbreak?

16 A Yes.

17 Q And is that something that's frequently done by  
18 the Health District?

19 A Yes, and there's a process in place to do that.  
20 There's kind of informal request and formal request, but  
21 they're kind of the -- the experts on those diseases. So when  
22 we don't know what to do -- if the State doesn't know, then we  
23 go up to the CDC.

24 Q Now, do the -- does the CDC always send an  
25 investigative team out, or sometime do they just offer advice

1 or -- or maybe information, and then the investigation is just  
2 done with local officials?

3 A Most of the time it's more of an informal  
4 discussion with CDC where we're just asking for their  
5 expertise and they kind of give us their thoughts just as  
6 scientists. We occasionally will request a formal  
7 investigation from the CDC. There is a document that's  
8 requested by our state epidemiologist that goes to the CDC,  
9 and there's an official process for having them send somebody  
10 out.

11 Part of it is deciding, is it worth sending somebody  
12 out? Is it something where they need to come into the field?  
13 Or is it something they can do just by assisting from Atlanta?

14 Q Okay. In this particular case two people were  
15 sent out from the CDC, correct?

16 A Yes, that's correct.

17 Q And that's Dr. Melissa Schaefer and Dr. Gayle  
18 Fischer, now, Langley?

19 A Yes, that's correct.

20 Q Okay. When was it that those two doctors came  
21 out?

22 A They arrived on January 9.

23 Q And prior to them coming on January 9, what --  
24 what did you do in terms of the investigation?

25 A Well, on the 2nd we were discussing things with

1 CDC, and we identified a third case. And the third case with  
2 acute disease also had a procedure on September 21. So now we  
3 had two cases that were on the same day, a third case on a  
4 different day. Clearly there was something going on with that  
5 clinic because that's more than we'd expect in a typical year,  
6 basically.

7 Q Sure.

8 A So we began just to -- to get whatever documents  
9 we had on -- on the clinic; we talked to the Bureau of  
10 Licensure and Certification because they are the group  
11 responsible for regulating that facility. So the first  
12 question was, are they responsible; we contacted them, they  
13 said that they were responsible, and then we coordinated our  
14 response with them.

15 We both decided to wait until CDC arrived to launch  
16 our field investigation.

17 Q Okay. And then the CDC obviously gets there?

18 A Yes.

19 Q And do you -- are you the one that actually  
20 makes the call over to the clinic on the 9th to inform them  
21 that you're coming over?

22 A Yes.

23 Q And how -- how much in advance of your arrival  
24 at the clinic did you make that phone call?

25 A It was about 30 minutes.

1           Q     Okay. And when -- when you all went over on the  
2 9th, do you recall if it was in the morning, afternoon?

3           A     It was in the afternoon.

4           Q     And it was yourself, Dr. Schaefer, and Fischer,  
5 and who else?

6           A     And we had two people from the Bureau of  
7 Licensure and Certification.

8           Q     Was the -- was the investigation of the Bureau  
9 of Licensure coordinated with your investigation at all, or  
10 was it a separate one, or how would you describe it?

11          A     I would say it's a parallel investigation. They  
12 had their own investigative process. There were things that  
13 they had to look into when they were out there. They were  
14 doing basically a complaint response, essentially, and they  
15 had certain things they had to do that -- that we didn't and  
16 vice versa.

17                So CDC was there to assist us, and the BLC was doing  
18 a parallel investigation at the same time.

19          Q     Okay. So it's fair to say you worked pretty  
20 closely with the CDC and less so with the -- the Bureau of  
21 Licensure?

22          A     We were all in the same room, but a lot of it --  
23 they were looking at some other things that we weren't  
24 particularly interested in, and they looked at a lot of the  
25 paperwork; do -- do the employees all have licenses, do they

1 have up-to-date TB tests, a lot of just the normal things they  
2 do as part of the -- the regulation of the clinic. Things  
3 that didn't matter to us as part of the outbreak, really.

4 Q Okay. And so it's pretty close by, right -- the  
5 -- where the Health District was at that time versus the  
6 location of the clinic?

7 A Yes, the clinic was right across from the Health  
8 District; my office was another block up the street.

9 Q Okay. So you -- did you just walk over there --

10 A Yes.

11 Q -- on the 9th, all of you?

12 A Yes.

13 Q And who do you meet up with when you get to the  
14 clinic on the afternoon of the 9th?

15 A We met with Tonya Rushing. We met with Dr.  
16 Carrol. And then they had a few other people join us. Jeff  
17 Krueger was in and out, and Katie Maley.

18 Q And who was it of your group that explained to  
19 the clinic staff why you were there?

20 A I did.

21 Q And what did you tell them?

22 A Basically what I've told you. We identified  
23 three cases of hepatitis C, we had this common connection,  
24 they were acute cases, we, you know, we don't know what's  
25 causing it, but we're here to do an investigation, figure out



1 why this occurred, and what steps, if any, are needed to  
2 prevent additional cases in the future.

3 Q Did you make any requests of the clinic in terms  
4 of your next steps in the investigation?

5 A Yes, we started to ask for documents and those  
6 sort of things. They took us down and gave us a quick kind of  
7 walk through the clinic just to give us an overview, and we  
8 started talking about what kind of documents they had so that  
9 the next day we could start to get the -- the paperwork we  
10 needed to go through.

11 Q And what was the -- the paperwork that you were  
12 looking for?

13 A We wanted the -- the logs that had a list of  
14 every person that was seen on those days, and then we wanted  
15 the charts from all the people that had procedures on those  
16 days, as well as the -- I believe the three or four days prior  
17 to the -- their procedures as well.

18 Q Okay. You didn't get -- you didn't review those  
19 charts on the first day you were there, though; is that fair?

20 A No, we were at the clinic maybe an hour, hour  
21 and a half. We had a meeting with them, they gave us the  
22 overview, and that was -- we got there at the end of the day,  
23 4:00 or so, so it was already late in the day. We planned to  
24 come back the next morning at 8:00 and start our -- our  
25 document review at that time.

1 Q Did you observe any procedures at all that first  
2 day on the 9th, or was it just sort of a walk-through?

3 A We didn't really observe procedures. We could  
4 see what was going on; I think it was the last patient of the  
5 day, or they were just finishing up. So there really wasn't  
6 much to see at that point. It wasn't a -- an observation of  
7 their procedures, more just kind of a looking around and  
8 getting a feel for how the clinic worked.

9 Q Okay. Obviously you go back on the 9th?

10 A The 9th was the Wednesday, we went --

11 Q I mean, the 10th, sorry.

12 A Yes, that's correct.

13 Q And did you go in the morning at this -- at that  
14 point?

15 A Yes, we did.

16 Q And is it the same group of people that you  
17 described, the BLC, the two doctors from the CDC, and  
18 yourself?

19 A Yes, as well as a couple additional  
20 investigators from my office. We had a lot of documents to go  
21 through, so I -- we had different people at different times  
22 assisting us go through and abstract the information.

23 Q Okay. And what were the -- what did you first  
24 do when you -- when you got there on that second day?

25 A We were requesting documents on that day, and so

1 they started to bring us those documents. They showed us to a  
2 conference room and let us get set up in there so we could  
3 start to review things. Then we started going through all the  
4 -- the paperwork that they had, the patient logs, the charts;  
5 we started requesting things, like their policies and  
6 procedures. BLC was doing the same thing at the same time, so  
7 we made a lot of requests of them for paperwork, basically.

8 Q Between yourself and other representatives from  
9 the Health District and the CDC, did you all develop sort of  
10 information you were looking to extract from each patient file  
11 on those days, or how did you go about categorizing that  
12 information?

13 A The CDC came up with a questionnaire that we  
14 could use to extract the information on the document, so  
15 collect the patient names, demographic information, then all  
16 the -- the details of the procedure: What time did it start?  
17 What time did it end? Which people were involved. Basically  
18 so we got consistent information out of the charts and could  
19 put a big table together of everything we collected.

20 Q And was that to do sort of a comparison to see  
21 if you could see any, I guess, commonalities?

22 A Right. We were looking for whatever common  
23 links we could identify between the cases.

24 Q Now, at the time you were there and extracting  
25 information from the charts, did you have at that time, in

1 your head, an idea of how you thought the hepatitis C could  
2 have been transmitted in this case that early on?

3 A We had a number of possibilities going in, just  
4 knowing what had happened in previous outbreaks, but we didn't  
5 know what happened in this particular clinic.

6 Q And when you say you had a number of ideas, are  
7 part of those or were part of those ideas based on just the  
8 nature of the disease itself?

9 A No, they were based more on the nature of  
10 previous outbreaks that had happened over the last 10 or 15  
11 years that CDC investigated and had been published in the  
12 literature. So we knew what sort of things others had found  
13 doing these types of investigations, so those were kind of the  
14 main things that we expected to look at in our investigation.

15 Q Okay. And those were -- I mean, I think you  
16 just said it, those were things you were going to look at, but  
17 not to the exclusion of other options or other possibilities;  
18 is that fair?

19 A That's correct.

20 Q So as -- as you're reviewing the charts on the  
21 second day, did you or any members of your team or the CDC  
22 start to observe procedures at all?

23 A At the end of the day we went in and we did a  
24 meeting with the staff, and explained why we were there. We  
25 saw part of one procedure, and I believe they walked us

1 through the scope-cleaning process that day and showed us how  
2 they did things.

3 Q The procedure that you just mentioned, was that  
4 one that you personally observed?

5 A Yes, I was in the room.

6 Q And who -- who was the CRNA, I guess, on that  
7 procedure; if you recall?

8 A That day it was Linda Hubbard.

9 Q And at the time you observed that procedure, was  
10 there anything that you took notice of in terms of how she  
11 handled the procedure or administered the sedation?

12 A I noticed that she was only wearing one glove,  
13 instead of two. Other than that, it was just the very end of  
14 the procedure, I believe. She had already given the  
15 injection, so there wasn't really that much to observe. We  
16 were just there for part of that procedure, not the entire  
17 one. So it was just a little bit of that on that particular  
18 procedure.

19 Q And I think you also said that you observed the  
20 scope cleaning on that day?

21 A Yes.

22 Q And was that something you personally observed?

23 A Yes.

24 Q And can you describe what you saw of that  
25 procedure, or of that aspect of the practice?

1           A     They walked us through step by step from when a  
2 scope came into the room, through the manual cleaning process,  
3 through the automated reprocessing of the scopes, just kind of  
4 step by step how they did everything.

5           Q     From your observations of that, did you -- did  
6 you see any deficiencies or anything that you were concerned  
7 about in terms of the scope cleaning?

8           A     The one that we noticed was that they used the  
9 detergent solution for two scopes. It was labeled for use on  
10 a single scope or set of instruments. But that was the only  
11 one that jumped out as not following the manufacturer's  
12 instructions.

13          Q     And the -- the fact that you'd seen that  
14 deficiency, how did that play into your assessment as to  
15 whether that was the -- the reason why hepatitis C was  
16 transmitted at this clinic?

17          A     I guess it was a cause for concern, and so we  
18 asked the CDC -- their experts on scope cleaning what they  
19 thought of it.

20          Q     Okay. And was that discounted at some point or  
21 at that point?

22          A     At some point after discussion, the people at  
23 the CDC felt that there was a cleaning process in place --

24               MR. SANTACROCE: I'm going to object as to hearsay.

25               MS. WECKERLY: Well, it's already been testified to

1 by them, but --

2 MR. SANTACROCE: Well, it's still hearsay.

3 THE COURT: Well, that doesn't mean it's not hearsay.

4 MS. WECKERLY: Okay.

5 BY MS. WECKERLY:

6 Q Well, based on -- based on your investigation  
7 collectively at some point, did you discount that?

8 A Yes.

9 Q Now, was that -- you sort of saw the end of --  
10 or a little bit of one procedure that day, and then you  
11 observed the scope cleaning, and did anything else happen that  
12 day aside from additional possible chart review?

13 A No, it was mostly chart review. Every day we  
14 were meeting with the clinic multiple times to let them know  
15 what we found. I believe on the first day we identified one  
16 or two more additional cases. We had the -- the list of  
17 recent cases that we've been notified of, and we were able to  
18 cross-reference those with the clinic patient list. So we did  
19 identify -- I'm not sure which day it was, but we -- I know we  
20 identified one on that day, and I don't know exactly when the  
21 rest of them were.

22 Q So it's -- as you're there investigating, you  
23 learn of at least one or two more cases from the September  
24 21st date?

25 A Yes, that's correct.

1           Q     And so at that point you're kind of at a bigger  
2 number even than when you started?

3           A     Yes, that's correct.

4           Q     You go back the next day? I guess that would be  
5 the 11th; is that right?

6           A     Yes, Friday the 11th.

7           Q     Okay. And what -- what do you do on that day?

8           A     We spent the morning observing procedures. So  
9 we had a number of us in the rooms observing procedures, while  
10 other people were still back abstracting information from the  
11 records.

12           THE COURT: How many people, total, went in with you  
13 from the Health -- at that time?

14           THE WITNESS: On that day we had myself, the two  
15 people from CDC, one or two BLC investigators were there, we  
16 also had two or three other people from the Health District  
17 doing the record abstraction at that point.

18           THE COURT: All right. Go on, Ms. Weckerly. Sorry.

19 BY MS. WECKERLY:

20           Q     You personally observed procedures on that day,  
21 that Friday?

22           A     Yes, I did.

23           Q     Who did you observe doing procedures?

24           A     I observed -- Linda Hubbard was the CRNA and Dr.  
25 Carrol was doing the procedures that morning.



1           Q     And how did you -- what was the observation of  
2 Linda Hubbard's practice with regard to administering  
3 propofol?

4           A     She would inject the patient with the propofol,  
5 and when the procedure was done, any remaining propofol that  
6 was in the vial stayed on the table she had set up for all her  
7 equipment, and after several patients she took several  
8 syringes and filled them from the existing vials of propofol.

9           Q     Okay. So she would fill, like, one syringe from  
10 a couple different vials?

11          A     Yes. She had multiple vials out there, and she  
12 basically just removed all the propofol from those four or  
13 five vials that were sitting there into multiple syringes.

14          Q     Did that get your attention or cause you  
15 concern?

16          A     Yes.

17          Q     Why is that?

18          A     Propofol is labeled for single-patient use. It  
19 was being treated as a multidose medication at that point, and  
20 so that's one of the concerns with injection-safety issues,  
21 the use of essentially multidose vials -- or single-dose vials  
22 incorrectly as multidose vials.

23          Q     On the day that -- that you were there, do you  
24 remember the size of the vials that were being used?

25          A     I believe the ones that we saw were all 20cc

1 vials.

2 Q Did you observe the preop area of the clinic at  
3 all on Friday or any of the other days?

4 A Yes, that was kind of the main area, so you had  
5 to walk through that to go to anywhere else.

6 Q From your observations of the preop area, did  
7 you see any deficiencies in terms of saline flushes or  
8 administering heplocks, anything that caused you concern?

9 A There was a separate room where they did the IV  
10 setup, and so that wasn't in the main preop area, that was a  
11 separate room, and I didn't do observations of that particular  
12 room.

13 Q Okay. The CDC investigators with you, did one  
14 of them observe that area?

15 A Yes.

16 Q Now, when you were at the clinic, did you have  
17 any conversations with any of the employees who were there?

18 A Yes.

19 Q Was one of them -- a conversation you had with  
20 Vince Mione?

21 A Yes.

22 Q Did he tell you anything about syringes?

23 MR. SANTACROCE: I'm going to object to hearsay.

24 MS. WECKERLY: It's a prior inconsistent statement.

25 THE COURT: All right. Go ahead.

1 BY MS. WECKERLY:

2 Q You can answer. What did he tell you?

3 MR. WRIGHT: I join the objection.

4 THE COURT: I'll see counsel up here for a minute.

5 (Off-record bench conference.)

6 BY MS. WECKERLY:

7 Q Sir, I was asking you about the conversation you  
8 had with Mr. Mione. Before you tell me what was said, can you  
9 -- do you remember what day it was that you had the  
10 conversation with him?

11 A Yes, it was Friday right before lunch, and we  
12 were observing procedures.

13 Q So obviously it was at the -- obviously it was  
14 at the clinic. Was anyone else present besides yourself and  
15 Mr. Mione?

16 A Yes, Melissa Schaefer and I were standing there  
17 talking to him.

18 Q And was it in a procedure room, or just kind of  
19 in the hallway, or how would you describe the area?

20 A It was just outside the door of the procedure  
21 room, so it was kind of in the -- the more common area.

22 Q And the comments that he made to you, were they  
23 prompted by a question that you asked, or was it just  
24 something that he said in the course of another conversation?

25 A No, we were asking a few questions.

1 Q Okay. Do you remember what you -- what you  
2 asked him?

3 A Melissa was asking the questions, so I didn't  
4 ask him. I remember the general tenor of the conversation,  
5 but not the specific questions.

6 Q Do you remember if he said anything about  
7 syringes?

8 A Yes.

9 Q What did he say?

10 A He said that they were instructed to reuse  
11 syringes, but that he didn't do it.

12 Q Okay. And he didn't indicate who instructed  
13 him; is that fair?

14 A That's correct.

15 Q When you -- when you were told that information,  
16 did it cause you concern about a source or a means of  
17 transmission?

18 A Yes, it did.

19 Q And why -- why would that be?

20 A With the reuse of the propofol vials that we've  
21 seen, plus the reuse of syringes to access those vials, there  
22 would be the potential for a disease transmission between  
23 patients.

24 Q Okay. How long were -- were you and your  
25 investigators and the CDC at the clinic in days? How many