A So I have no idea when it went up, but I know they have a major campaign on their website.

Q Right. This is off the CDC website --

A Yeah. No, I can see that.

Q -- last night. And tell me if everything on there look -- looks accurate.

A Okay.

Q Does that look accurate?

A It's an -- it's actually preventing human error. It's a little -- in other words, one could look at this and say that I was incorrect when I said on the same patient you could reuse that needle and syringe on that -- with that medication vial, for example, as long as you threw it out.

Q Okay.

A Okay. That not what this says. This says you shouldn't do that.

Q Okay. I wasn't --

A No, no, no. I know. I didn't mean --

Q Okay.

A I didn't mean anything by that. And all I'm saying is what they're trying to do is reduce the opportunity for anyone to -- to -- reducing the opportunity for human error by making it just one policy and that's it.

Q Okay. The --

MR. WRIGHT: I'm going to move its admission.

MR. STAUDAHER: No objection.

THE COURT: All right. What number is that, or letter and number?

MR. WRIGHT: What exhibit?

THE WITNESS: S1 or -- S1.

THE COURT: S1. That would be right.

(Defendant's Exhibit S-1 admitted.)

BY MR. WRIGHT:

Q The part that throws me is the single dose, this differentiation between multi and single, okay. And as I read this, this is a patient safety threat syringe reuse. And it says a single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. That part I get. Single-use vials contains only one dose of medication and should only be used once for one patient using a clean needle and clean syringe. Okay? See, I -- I read that literally as meaning --

A I would --

Q -- a single-use vial has only one dose in it. And after I use one dose, I toss it, which is inconsistent with the label; correct?

A The label on -- well, the label doesn't really say, does it?

Q What's it say?

A I'm sorry. I'm not laughing because -- because I can see the -- I mean, I don't happen to agree with that statement. I don't know if it's correct. Because, let's face it, why would you make a vial that contains -- you know, that's not consistent because you don't give all of this at once.

Q Right.

A You might give it twice or three times in the course of the procedure. So you could then draw it up. But -- and it says it's okay for 12 hours. It says use strict aseptic technique. It says single patient infusion vial.

Q Okay. Single patient infusion vial.

A I'm telling you, if my computer was working, I would boot it up -- which it isn't somehow. I don't know. I must have -- I left it on. I would boot it up, I would go to the FDA, and I would see what their definition was. I think -- I mean, I can't honestly address the veracity of this statement --

Q Okay.

A -- because we know this contains more than one dose. In other words --

Q Right.

A -- you're not going to give them, the patient, all of this at one time probably, unless maybe they weigh 300 pounds. Okay. So --

Q See, when I looked at the --

A No, I -- so I see your point. And the only reason I can, you know -- again, I'd like to see what the FDA, what their definition is. But also, as I said, sometimes in relooking at policies or recommendations, I mean, this wasn't a CDC recommendation to begin with technically. It's an aseptic practice that's part of -- should be part of routine medical care, but anyway. We go -- we -- CDC will go a little more to the extreme to, as I said, prevent human error. On the other hand, that is a definition. And that's why the only way I would know is if I looked it up.

Q Okay.

A And I actually don't think of it that way myself. So -- but on the other hand, you know, I think they're trying to make it so simple that no one has to think about it.

Q Right. And it's -- and it's -- what you think is simple is confusing when you --

A Right. I understand that, but when you find that people are not following a procedure that's been in place for 50 years, then you have to decide what is it you need to do to make sure that they follow it, even though you might be going a little more -- a little overboard, so -- in some people's minds. Maybe they just want them to think single, single, single, and that's it.

Q See the -- see the next definition of multi-dose says a multi-dose -- a multi-dose vial is a bottle of liquid medication that contains more than one dose of medication. Now, if I'm applying this CDC directive, I would look at that propofol vial there as a multi-dose vial because it contains more than one dose. Agree?

A That's your -- see, but -- I can't comment.

Q Okay.

A Because I can't comment. It's a single -- it's a single -- because I don't know the -- as I said, I need to find -- I would need to know how the FDA -- you know, this is an FDA approved label, otherwise it wouldn't be licensed. And it says single patient infusion vial.

Q Okay.

A So but I honestly don't -- don't know why you couldn't give multiple doses in a short period of time to the same patient from this vial.

Q Okey-doke.

A But there's a lot of pooling going on with a lot of medications in different settings.

Q The -- your -- not your, but one of the articles you sent that talked about the New York -- 2010 article about the New York outbreak.

A The -- oh, yes, the later one.

Q Yes.

A Uh-huh.

Q Multiple Clusters of Hepatitis Virus Infections Associated with Anesthesia for Outpatient Endoscopy Procedures. The conclusion of it, if I may go through with you, outbreak similar to the one described here -- of course it's talking about the second New York outbreak --

A Right.

Q -- you commented on. Outbreak similar to the one described here would not have been possible if intravenous anesthesia medications were not administered from a single vial from multiple patients; correct?

A True.

Q Absolutely. Black and white. For this reason we advocate, now that's the authors of this; correct?

A Yes.

Q For this reason we advocate eliminating use of all multi-patient vials for anesthesia medications to the greatest extent possible, and educating clinicians on the risks associated with their use. Would you agree with that?

A Yes, and it's been stated in many previous publications, even while I was at CDC.

Q Okay. And so one thing to do was just plain no multi-use vials at all for anesthesia. That's just taking out human error and misperceptions.

A Uh-huh.

Q And educating clinicians on the risks associated with their use; correct?

A Correct what?

Q That that's -- that's something that needs to be done.

A Yes.

Q Even in --

A Yes. Yes.

Q This is three years later, three years after the events in this case and still in June of 2010, it's still a lack of understanding on the part of clinicians. Is that fair?

A Well, tactfully, yes.

Q Tactfully?

A Tactfully.

Q Okay. This can be accomplished by more clearly labeling medications, e.g., propofol as single patient use only. Would you agree with that?

A It is labeled as single patient use.

Q Okay. Well, this says this can be accomplished. I mean, you may disagree with --

A Those are the --

Q -- these authors.

A Well, I'm just saying that, you know, they're offering suggestions, but that is what this vial says and --

Q Okay. And improving pricing of unit dose single patient use medications to encourage their use. What did that mean?

A I can tell you exactly what that means.

Q Good.

A Multiple-dose vials are much more economical than single-dose vials. The larger the quantity, the cheaper it is per dose, the less expensive it is per dose. And, in fact, that's somewhat how they came to be multiple dose. Larger vials can be used for multiple doses. But it also then led to this problem, contamination, when used along with improper preparation techniques.

Q Okay. So improving pricing of unit dose single patient use medications to encourage their use.

A Right. Because, actually, when we -- when I was still there we -- you know, we said, you know, wouldn't it be great to get rid of all the multi-dose vials. But in -- in the absence of that you have two choices. You know, two things that you can do is restrict them to a centralized area where you can't go back into those, or -- you know, with a used syringe, or, you know, just not use them at all. So the first works quite well, but it's much more economical, particularly for large corporations, to purchase the multiple dose vials.

Q Why do you think that?

A Why do I think that?

Q Yeah.

A From my experience working in hemodialysis settings where I did a lot of very specific activities. It's an area of high specialization, particularly in terms of preventing transmission, and there are a lot of issues with economics in those settings, and that is part of the reason for purchasing large amounts of very expensive drugs that aren't supposed to be reused.

Q Okay. How about -- I mean, this is a propofol case.

A I know, but --

Q No, I mean --

A -- really, aren't economics --

Q No, I meant --

A You know --

Q Okay.

A -- but that is -- it is an economical issue --

Q Okay. Do you --

A -- I think.

Q Do you --

A In many cases it is less expensive per dose to buy in large volume than in small volume.

Q Do you -- do you have any -- do you believe like 50 cc propofols are cheaper by volume than 20 ccs?

A I have no knowledge in that area.

Q Okay. One article I didn't get from you, but you may be familiar with,

A Yes.

Q Okay. It's called Injection Practices Among Clinicians in United States Healthcare Settings.

A First off, that's from the place called the Premier Safety Institute, so it's a private organization.

Q I can't find where these things are from.

A I can tell you.

Q Melissa Schaefer is one of the authors.

A The first author is Gina Pugliese. The journal is American Journal of Infection Control. It's aimed at nurse -- infection control nurses in the healthcare facilities.

Q Bedside reading for --

A Well, for --

Q -- your kind.

A -- some of us.

Q This study or survey in 2010, or at least it was published December 2010, study during --

MR. STAUDAHER: Could I at least see the article?

BY MR. WRIGHT:

Q -- May and June.

MR. STAUDAHER: I'd like to see the article, if I

could.

THE COURT: I'm sorry? Oh, you want to see it.

MR. WRIGHT: I'm sorry.

BY MR. WRIGHT:

Q May and June of 2010 is a survey of approximately 5,446 clinicians, 90 percent of whom were registered nurses. Okay?

A Uh-huh.

Q The -- and it was a survey dealing with injection practices, syringe reuse, and multi-use of vials. The respondents reuse -- I'm going to ask you a question after this -- reuse syringe for additional doses from the same multi-dose vial. Did you follow that?

A Uh-huh.

Q Okay.

A Yes.

Q A total of 797 respondents, 15 percent, indicated that they are sometimes or always reusing a syringe for additional doses from the same multi-dose vial for the same patient. Okay?

A Yes.

Q And then of that group they were then asked -- that was 797 respondents -- were then asked about reusing the vial that they had just reused the syringe on. In our study, 797 respondents, 15 percent, indicated that they sometimes or

always reuse a syringe for additional doses from the same multi-dose vial for the same patient. They were then asked to indicate the disposition of the multi-dose vial. 51 of the 797, 6.5 percent, who answered the question on disposition of the vial indicated that they save the vial for reuse on another patient. Okay?

A Uh-huh.

Q So that -- that's 51 of the practitioners in this survey in 2010 did the double -- double danger; correct?

A Yes.

Q Okay. And that -- and that double danger being not -- not only did they reuse needle syringe, same patient, to redose, they then put it together with using the remnants, the leftover in the vial on the subsequent patient; correct?

A That's 6 percent of those whose said that they reused, or is that 6 percent of the total?

Q No, no, 6 percent of the 15 percent.

A Okay.

Q 51 -- no, I'm -- 51 out of what I told you, 5,446.

A Actually responded to the survey.

Q Right, that's the --

A Is that the number of respondents?

Q Yes.

A And of those 15 percent said they sometimes reused syringes to go to -- to back into a multi-dose vial.

Q Right.

A And of those 15 percent, 6 percent said -- said what they had done with the multi-dose -- but they reused the multi-dose vial.

Q Right. So that would work out like 1 percent --

A Right.

Q I mean, 51.

A Right.

Q I mean, there's 51 practitioners in 2010, I mean, still mixing together these --

A That's 1 percent.

Q Yes.

A Uh-huh.

Q Does that surprise you?

A It surprises me that it's that low.

Q Okay. Because?

A Because injection practices are so bad in -- in the places that we do the investigations that -- I shouldn't actually -- I shouldn't say that it surprises me in -- if these are general hospital based nurses, then I should say it doesn't surprise me. It should be low. It's never going to be -- I mean, I would be surprised if it was zero.

Then I would be suspicious. But it's a small number.

Q Well, it's -- it said the --

A No, we should be happy with that result. Well, zero is not -- you know, as much as --

Q Okay.

A -- people would -- as much as we would all like things to either be 100 percent or zero percent, that's not reality. And I think that the fact that it's 1 percent is quite good.

Q Okay. Where -- where would you think those infractions were, outpatient or in the hospital?

A It could have been either.

Q You're right. It said although non-hospital settings --

MR. STAUDAHER: Your Honor, I'm just going to move to admit this if we're going to read from the whole document. I mean --

MR. WRIGHT: I'm not --

MR. STAUDAHER: -- I don't have a problem with that.

THE COURT: Well, he can ask her specifically from the document, or he can speak to admit it without your opposition.

Go ahead, Mr. Wright.

BY MR. WRIGHT:

Q Our data indicates that some of the most

flagrant -- flagrant infractions, syringe reuse on multiple patients with only a needle change and reentry into the multi-dose vial, leaving it for reuse on another patient, are being reported at least half of the time by professionals in hospital settings. So it's about what you thought; correct?

A I said it could be either.

Q Right.

A That's what I said. It could be either.

Q Now, it identifies mistaken beliefs that account for this failure of appreciation of the risks, and I want to go through a couple of them. There are a number of mistaken beliefs about the risks associated with syringe reuse and aseptic technique when handling injectable medications during preparation and administration that likely contribute to many of the outbreaks of healthcare associated viral infections such as hepatitis B and C. For example, there is a belief that contamination is limited to the needle portion when a syringe and needle are used together as a unit. Has that been your experience that there is this mistaken, this misapprehension out there?

A Yes, which means there's something wrong with our education, medical education system.

Q Okay. And there is also an incorrect belief that the syringe does not become contaminated if the plunger is only pushed to inject, and not pulled to aspirate or

withdraw. What's aspirate mean?

A Withdraw.

Q Oh, okay. Okay. So they're -- they're -- this is an ongoing misperception or myth --

A Or ignorance. I mean, I really don't know what to say that -- I don't know what to call it, but I will tell you that I -- yes, I agree that they say -- they will say that. And they will say, well, there's no blood in the tubing. Well, you know, the germ theory of disease was discovered by someone who was trying to explain that just because you couldn't see it didn't mean it wasn't there. And it's -- I honestly do not know why they believe this. They really should know better.

Q Despite the availability of guidance on best practices from CDC and other groups, it remains a lack of awareness and implementation of these recommendations by may clinicians. Agree with that?

A Yes. I don't think the -- yes.

Q Hold that thought. Have you seen M-1?

A Not recently.

Q Okay. You've seen it before?

A In different formats.

Q Okay. And is that -- well, you tell me what that -- that's dealing with the persistent myths and what the truths are to try to address the people who still aren't

onboard.

A That's correct. It's part of the campaign, the one and only campaign.

Q Yeah, that's --

A One needle --

Q -- the name on it.

A -- one syringe, only one time.

Q Okay. Thank you very much.

MR. WRIGHT: I have no further questions.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: May I proceed?

THE COURT: You may.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Doctor. I represent Mr. Lakeman back there, and I'm going to ask you a few questions and try to clarify some of your direct testimony. But before I do that, I'm trying to understand exactly what the purpose of your testimony is here today as you understand it. We've had three epidemiologists testify in this case. All of them have participated physically in the investigation of this outbreak. And as I understand it, you haven't done that; correct?

A That's correct.

Q So what did you understand the purpose of your testimony to be here today?

A I'm one of the world's experts on the epidemiology of hepatitis C, and in particular it's transmission patterns and in particular in healthcare settings. And my understanding was to speak to those issues as they relate to this particular outbreak.

Q And is this part of the consulting business that you said you have?

A You might -- a business? It's like -- yes, I suppose, except that I agreed to do this in 2008.

Q Okay. So while you were still employed at the University of Texas?

A Yes, I was contacted by the sheriff's office

Q Clark County?

A Uh-huh. Yes.

Q And you were contacted in 2008 by the Metropolitan Police Department?

A Yes.

Q Who contacted you?

A I would like to be able to tell you who it was and, unfortunately, I can't remember his name.

Q Okay. And then in 2008 --

A Don't tell him.

Q I won't tell him. Well, is he sitting here?

A I have no idea.

Q Did you ever meet with him face to face?

A Did I meet -- no, actually, I didn't. Someone else from -- they had a task force, I think, and someone else came to see me at the university. Again, it would have been at least a year later because Hurricane Ike occurred in between.

Q Was it after the CDC had conducted their investigation and issued their initial findings?

A Presumably.

Q Well, they did that in January of 2008. Was your visit --

A It would have had to have been after January 2008.

Q And did they contact you and say, you know, we have this theory. We have this theory as to the mechanism of transmission and want you to validate that theory?

A No.

Q Okay. What did they want you to do?

A They wanted me to provide -- to be an expert, a source of expertise in this area in hepatitis C transmission in this setting.

Q So did they contact you throughout their investigation from 2008 forward? Did they contact you --

A No, actually, I didn't hear from -- I then talked to the -- Mr. Staudaher, who explained, you know, that sort of what the -- my guidelines should be in terms of other

people calling me to discuss the case. The only thing I knew about it were the things that I directly read. Actually, they didn't tell me anything. They did not approach me with any particular -- any particulars, the police.

Q Okay. Well, I'm still unclear as to what you were to do for them. They contact you and they tell you we want you to be an expert in this area because --

A You are an expert.

Q -- you're renowned for that. What did they want you to be an expert to do? Did they give you anything written, instructions, or here's a theory?

A No. They wanted me, I think, as an outside observer and whose expertise is specifically in this area, and I'm very experienced, to provide either -- to provide information or --

Q Okay. And we don't --

A -- on this outbreak.

Q And what information did you provide to them.

A I provide to them directly?

Q Yes.

A The articles.

Q Okay. Well, the article I have -- one of the articles I have from you was downloaded three days ago. So, I mean, when did you provide it to them. When I --

A Three days ago.

Q -- mean them, I mean --

A Those articles.

Q -- Metropolitan Police Department.

A Then there were -- did I send that -- you have to understand that our -- actually, there could have been several years that went by between my first contact with Mr. Staudaher and my next contact. I knew that until I was told differently that there was the possibility that I would be an expert witness for this case.

Q Okay.

A But it, obviously, went on quite awhile and I just went on about my business.

Q How many contacts did you have with either the District Attorney's office or the Metropolitan Police Department either telephonically, emails, or person to person?

A A handful.

Q A handful? Six? Five? Six.

A Want me to look? I can look on my phone and see how many emails I have. There are not many.

Q Okay. So a few?

A Well, that's a handful to me.

Q Depends on which hand your using.

A I know. I know, but really it's -- there weren't that many. In fact, there weren't that many. They provided me with, you know, the final reports, which one of --

which are all public anyway. And --

Q When did you get those reports?

A Well, I already had them, but the District Attorney's office provided them to me in the last few months. I want to say maybe -- well, earlier this year. Okay. I'm sorry, I just --

Q So earlier this year you get the trip report from the CDC from the District Attorney's office.

A From their office. I already had everything.

Q And then you get from their office what else?

A The Southern Nevada County -- the district report.

Q Okay.

A And -- and 18 exhibits or 25 exhibits, or whatever all the exhibits were that had been filed at that time.

Q Did you get the report, statement of deficiencies from the BLC, the Bureau of Licensing and Certification?

A I remember it being mentioned, I mean, in my reading. But I don't -- if it was an exhibit, then I got it. If it isn't -- wasn't, then I didn't.

Q Well, I'm asking you what your recollection --

A I know. Well --

Q -- of what you received.

A -- I don't remember seeing the report and -- I don't remember seeing the report.

Q Okay. You need to let me finish my question before --

A Sorry.

Q -- answer, okay? Because --

A Yes, I --

Q -- we're recording.

A -- apologize. I apologize.

Q You're doing it again. We're recording this, okay. And the record has to be very clear. Okay. Was -- were you being compensated for this by the District Attorney's office or Metro or citizens of Clark County?

A Since I no longer work for the government, I do have -- I am going to be compensated, but I haven't been compensated as yet. I haven't even submitted a voucher.

Q Okay. But you're getting compensated for your testimony here today?

A Yes.

Q And for any work you did previously on the case?

A For the number of hours that I did to review the documents, yes.

Q And -- and what is your compensation that you're receiving? How much is it?

A For today, I don't know. But for -- you can see I'm a real business person. My hourly rate for reviewing documents or writing reports is $450 an hour.

Q And what is your fee for testifying in court?

A This is the first time I've done it as a private citizen, so to speak, and so I have no idea.

Q Okay.

A Well, I shouldn't say I have no idea, but --

Q Well, what's the idea you have?

A Well, let me put it to you this way, okay. Well, we have -- we didn't agree on anything. To be quite honest, I still think of myself as a public service.

Q Well, let's surprise them right now and tell them --

A Well, what I'm going to --

Q -- how much.

A -- let me tell you that I looked up what other -- what physicians do who have to take off, you know, and it's -- it's so far above what I would even consider that -- you know, they charge 5,000, $6,000 a day for testimony. And if it's out of town it's more. We're not even --

Q Are you from out of town or do you live here now?

A I'm from out of town.

Q Well, where -- where do you reside?

A I reside in Galveston, Texas.

Q So you were flown in here today for your testimony?

A I flew in last night.

Q Well, it's safe to say you're not going to be charging less than $450 an hour for testifying here today; right?

A Yes, I am, probably.

Q Oh, you are?

A Well, I would do it as a lump sum. I didn't count the number of hours, you know, in the day. I'm not going to charge them by hour since l left home. I just can't.

Q I might get --

A I'm just not --

Q -- into contract negotiations --

A -- that way.

Q -- after this career is over.

A I told you. It's not a business. It's just, you know --

Q Okay.

A It's something that I do when I believe in something.

Q All right. So let's get back to what you -- you were supposed to do here. You reviewed certain documents from the CDC, from the Health District, and from someplace

else. I don't know where else, but some articles or something?

A Well, I -- in the course of my career, I've read or reviewed almost all of the articles that are currently in the literature since I've written reviews and editorials and --

Q And so now you have -- at some point you have the Southern Nevada Health District Report and you have the CDC trip report?

A And their publication in -- and their publication in the journal.

Q And then from that, you read all of that, and you came up with an opinion, or you validated their opinion, one or the other. Which was it?

A I don't know. I -- I -- it was already -- I guess I validated their opinion.

Q Okay. Now, did you review or look at anything else other than what you've told us here today?

A You mean other than the literature, the publications and the literature and the major reports from the CDC and the Health District --

Q Right.

A -- and the exhibits that were on file, which, you know, were line listings of specimens and patients and things. I don't think so --

Q Okay.

A -- to the best of my recollection.

Q And your opinion was basically supporting the CDC's opinion that the mechanism of transmission in this particular case was the unsafe injection practices at the clinic; is that correct?

A Yes, that's correct.

Q And what methodology did you employ to come up with that opinion?

A I reviewed the methodology for both the epidemiologic investigation, the -- as well as the laboratory, as well as the virus sequencing performed in the laboratory, and then for which I had the results to determine if I agreed with the methods that were used and the conclusions that were drawn from those methods.

Q Okay. Were you aware when the CDC conducted their investigation that they were not sure as to which patient was in which room at which time?

A I was -- I am aware from reading the reports that it was -- that the records were very inaccurate.

Q Okay. How many --

A That's all I can --

Q How many procedure rooms were at Shadow Lane on July 25, 2007?

A Two. I don't know.

Q Is that a guess?
A Yes, that's a guess.
Q How many procedure rooms were at Shadow Lane on September 21, 2007?
A I know that they did 65 procedures.
Q And the question I asked you was how many --
A I'm sorry.
Q -- procedure rooms.
A I don't know.
Q Okay.
A Or don't recollect.
Q Okay. So my question was were you aware that the CDC did not know which rooms the patients were in and at what times when they conducted their investigations?
A No.
Q You were not aware of that?
A Well, no, not specifically at the time they conducted their investigation, no.
Q Were you aware that they didn't know that information when they issued their initial findings?
A No. What I was --
Q That's -- that's all I need to know. Were you sent copy of Exhibit -- State's Exhibit 156 and 157 as part of your examination?
A Yes.

Q So you looked at these?

A Yes.

Q And when did you receive these documents?

A In the last couple weeks, sometime in the last couple of weeks.

Q Okay.

A Like three weeks ago, maybe, four weeks ago.

Q When did you reach your conclusion or concur with the CDC's finding?

A After reading the reports. It had nothing to do with this.

Q It had nothing to do with this. So you reached your conclusions before you saw these two exhibits?

A That's right because I reached my conclusions based on the epidemiological investigation.

Q Were you aware that the CDC did not interview the RN that administered the heplock on September 21, 2007?

A I don't know.

Q Were you aware of the cleaning practices for the endoscopes and the biopsy forceps for September 21, 2007?

A I read the methods that were used in -- in the reports, they were quite detailed, for the scopes. The biopsy forceps were apparently -- they talked about some reuse of disposables, I guess, that -- a practice that had been stopped. But regardless, there was the investigation. The

results of the investigation indicated that there was no association between getting infected and those pieces of equipment.

Q Okay. Tell me what you understood the cleaning procedures to be for the endoscopes.

A It was a very long -- it was a very long and detailed explanation that involves the cleaning of the scope, the rinsing of the scope. Manual cleaning is extremely important. You have to get all of the organic debris that might be in there out before the disinfectant can work. Because organic matter like blood and things can prevent the disinfectant from getting to the actual scope or germs that might be left there, something that a lot of people don't appreciate. And then they had a -- they have a machine that then reprocesses the -- these scopes for high level disinfection.

Q What's the difference between disinfection and sterilization?

A High level disinfection actually kills everything but bacterial spores. Sterilization also kills bacterial spores.

Q And how was the clinic cleaning bite blocks and biopsy forceps on September 21, 2007?

A The biopsy forceps, I'm not sure. The cleaning blocks -- I mean, I'm sorry, the bite blocks I'd have

to look at the report. I just -- again, while I was aware when I was reading these reports, it's the epidemiological methodology they use to look at exposures associated with infections that I was -- that I'm focused on and whether or not they considered sufficient -- you know, they considered the issues of importance in that -- in the setting. That's what I was looking at. I'm an epidemiologist. That's what my expertise is in this disease area.

Q Well, Doctors Langley and Schaefer testified that prior to coming to Las Vegas they had a theory or hypothesis that the infection was transmitted through unsafe injection practices.

MR. STAUDAHER: Objection. Mischaracterizes their statements, Your Honor.

BY MR. SANTACROCE:

Q But they didn't rule out of other mechanisms.

THE COURT: And that's -- that's overruled. And, of course, I've told the ladies and gentlemen of the jury if anyone, you know, prefaces a question with a statement of what the testimony was and that's not your recollection of what the testimony was, it's your collective recollection that's important, not something the lawyers may say or something that I may say as to what the testimony was.

BY MR. SANTACROCE:

Q So they looked at other mechanisms of

transmission.

A That's correct.

Q Okay. One of those mechanisms was scopes; correct?

A Yes.

Q And you -- you ruled out that theory because they ruled it out; correct?

A I ruled out the theory by looking at the data they generated to show that there was no association.

Q Okay. What data did they generate?

A There's -- they showed the frequency with which, you know, the -- the use of the scopes, you know, depending on whether you got an upper GI or a colonoscopy, they looked at the frequency of the specific procedures and those people who got infected versus those people who didn't. That's -- that's how you --

Q I'm talking about the cleaning of the scopes.

A Hold on. You asked me how I drew that conclusion.

Q Right.

A Okay. That, in addition -- that was most important. But also I thought that regardless of a few deficiencies cited as like the detergent used --

Q And you thought those deficiencies were minor?

A Actually, from the point of view of

blood-borne virus transmission, yes.

THE COURT: Mr. Santacroce, we're going to need to take a break now --

MR. SANTACROCE: Okay.

THE COURT: -- so I'm going to interrupt you.

Ladies and gentlemen, we're going to take a brief recess. During the brief recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research. And please do not form or express an opinion on the trial.

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

(Jury recessed at 2:37 p.m.)

THE COURT: What do we have to look forward to for the rest of the day?

MS. WECKERLY: Well, we have Dr. Lewis and then we have the --

THE COURT: And that's Ms. Grueskin's physician; correct?

MS. WECKERLY: That's correct.

THE COURT: So we have to do him today, which I'm good with.

MS. WECKERLY: Okay. And then we have an insurance person, and then --

THE COURT: Well, Ms. Stanish says she has all the records, so that should go smoothly.

MS. WECKERLY: She's good with this one.

THE COURT: Yeah, so that should go smoothly.

MS. WECKERLY: And then -- well, we have -- we have -- I mean, one thing we could do is we have Bob as the witness, but I have a doctor for tomorrow, so I can --

THE COURT: Is that Romie?

MS. WECKERLY: No, Jurani.

THE COURT: That's his name Romie Jurani.

MS. WECKERLY: I thought it was Patero.

THE COURT: Well, I think it's his nickname.

MS. WECKERLY: Oh, okay. Maybe.

(Off-record colloquy.)

THE COURT: In any event. Does that mean we're done?

MS. WECKERLY: You mean for tomorrow, then?

THE COURT: Right.

MS. WECKERLY: Well, with Dr. Olson, and then part two of the other --

THE COURT: Right. And then that's it?

MS. WECKERLY: That's it.

THE COURT: So you're not calling Dr. Jurani at all?

MS. WECKERLY: No, because he doesn't really --

THE COURT: Okay.

MS. WECKERLY: I mean, he doesn't say anything that -- that I don't think we've covered.

THE COURT: Okay. All right.

MS. WECKERLY: And another GI tech. Just kidding.

(Court recessed at 2:39 p.m., until 2:55 p.m.)

(In the presence of the jury.)

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

And, Mr. Santacroce, you may resume your cross-examination.

MR. SANTACROCE: Thank you.

BY MR. SANTACROCE:

Q You were talking about what you described as insignificant lapses in the cleaning of the scopes. Were you aware that the BLC actually observed the cleaning of the scopes, ma'am?

A I know that the cleaning of the scopes was observed.

Q Do you know that the BLC was part of the investigatory team, along with Southern Nevada Health District and the CDC?

MR. STAUDAHER: Objection --

THE WITNESS: Yes.

MR. STAUDAHER: -- Your Honor. That's not actually correct. They weren't part of the investigatory team. They investigated separately.

THE COURT: Well, okay. They -- they were involved in investigating. Is that your understanding?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Well, they were present when groups were represented.

THE COURT: Okay.

BY MR. SANTACROCE:

Q And you understand that they issued a summary statement of deficiencies; correct?

A I saw the statement of such, yes.

Q Okay. Well, I'm going to show that to you now as Exhibit 80 E-3. This is their statement for the Shadow Lane clinic. And it notes that on January -- I'm not sure if it's a 6 or an 8, 2008. The GI technician was asked to describe the measured amount of EmPower with what amount of water. The GI tech stated add two to three pumps, not sure of the capacity of the basin, I do not have an answer to that. Were you aware the GI tech didn't even know how much sterilizing fluid to use, the ratio between the water and the sterilizing fluid?

A No.

Q Were you aware as to how many scopes were to be cleaned before the solution was changed?

A The -- my understanding -- I actually saw it in the protocol, but I can't tell you what it is now, but it was my understanding that the machine, given this is a relatively automated system, indicates when it needs to be changed.

Q Well, that's the third or fourth step in the process.

A Uh-huh.

Q There's processes before that. Are you aware of those processes?

A The specifics of each step?

Q Uh-huh.

A No, I could not repeat them to you.

Q Well, you are aware that scopes are a potential mechanism for transmission of the hep C virus; correct?

A No.

Q You're not aware of that?

A No. However, I would consider them in any investigation I did, but there has never been an instance in which that has occurred, in which it has been shown to occur despite the misleading titles of some articles.

Q Are you anticipating where I'm going?

A No, I don't know how I could possibly anticipate such a thing.

Q I don't think I asked a question about that, but okay. Are you -- you're aware of the article posted in the New England Journal of Medicine on patient -- patient transmission of hepatitis C virus during colonoscopies; correct?

A Yes, I am.

Q Why don't you tell us the background of that case?

A Well, it was the first one ever published, which is why it was in the New England Journal, considered one of the top medical journals in the world. But on closer reading of the article, you'll find that the investigators -- and by the way this --

Q Ma'am, I asked you to tell me the background --

A I can't.

Q -- of the article.

A I'd have to look at the article again.

Q Okay. Well, let me show it to you.

MR. STAUDAHER: Your Honor, I think she was answering his question. He said background of the article.

MR. SANTACROCE: She was trying to dispute --

THE COURT: Well, okay --

MR. SANTACROCE: -- the validity of the article.

THE WITNESS: No, I am not.

THE COURT: Okay. All right. She is going to look at --

THE WITNESS: Sorry.

THE COURT: That's okay.

She's going to look at the article, and then Mr. Santacroce will ask the questions, and the witness, as she did on the prior question, if she can't ask the question as phrased, she's obviously more than able to say I can't answer this question.

THE WITNESS: I'm sorry. Okay.

THE COURT: All right.

BY MR. SANTACROCE:

Q Have you read the background information?

A I don't know what background -- what you refer to as background information. My --

Q Well, let me --

A The importance --

Q Let me explain what I mean if you don't know. Can you tell me how many patients were involved?

A No, I don't remember.

Q Okay. Well, I just showed it to you, but I'll show it to you again.

A I didn't have a chance to actually look at the

page.

Q Okay. Well, take all the time you need. Read this part here.

A Yes.

Q Okay. Now, just to be clear, this is an article you downloaded three days ago; right?

A No, I've had it in my files forever. It just so happens I might have downloaded a new copy of it, but --

Q What does it say on the bottom.

A Okay. Sorry. I'm distinguishing between having downloaded a copy because my files -- and what I have in my files. So, yes, I downloaded it to send three days ago, but it was already in my files. It's been in my files since it was published.

Q When you downloaded it three days ago, did you read it?

A No, because I had already read it and I knew what it said.

Q Okay. Well, after having reviewed it now, how many patients were involved?

A Two.

Q And a source patient; correct?

A Presumably. I didn't get that far.

Q Okay. Well, it says Patient 2 contracted hepatitis C from a source patient in this particular study;

correct? In fact, they were a husband and wife who underwent endoscopic procedures; correct?

A If that's what it says.

Q Well, ma'am --

A I didn't have a chance. I didn't read it in that detail. I was looking at the paragraph that you pointed out. There were the two patients, the procedures, and they were talking about how the endoscopes were disinfected, cleaned and disinfected. That was what I was reading. I don't know -- I didn't see husband and wife. I didn't see -- I just don't remember. But what I know about the results of the investigation lead me to a different interpretation.

Q Well, why were they discussing the cleaning of the endoscopes?

A Just because -- because it's considered as a potential.

Q In fact, it was the leading likely cause of transmission of hepatitis C in this study.

A Only according to those investigators, but not according -- not in my opinion.

Q Are you saying these investigators weren't competent?

A I'm saying -- no, you said that. I did not say that.

Q Well, you said only according to these

investigators.

A As I explained, if you look at the discussion you will see that the investigators themselves admit they could not distinguish whether transmission occurred by the -- through the actual scope or through injection practices, unsafe injection practices used to administer anesthesia. It says that in the discussion. They didn't rule out or rule in either one because they couldn't do an analysis, an epidemiologic analysis. All they did was genetic sequencing to determine that the patients had the same virus as the source, and this is where they found it in the -- in the -- in that setting.

And I will tell you that when we went to New York in 2001, the New York Times, before we even arrived had already, of course, heard about it. And the first thing they -- they interviewed somebody, an expert, whatever, and whose first comment was they're not disinfecting the scopes properly, it's the scopes, it's the scopes. I heard that for a year before we were convinced, you know. So there actually is no documentation that the scopes are directly associated with infection. It has occurred in that setting, but that does not in any way -- as the authors themselves admit, they can't distinguish between the two. They just buried it in the discussion.

Q Well, I don't read it that way. It says we

suggest that during disinfection of the colonoscope after the procedure on the patients, we describe two recommendations on the endoscopic disinfection made by the American Society for Gastrointestinal Endoscopy and the British Society of Gastroenterology and the Working Party of the World Congress of Gastroenterology were not followed. From our investigation it appeared that the biopsy suction channel was never cleaned with a brush, and that the accessories that breached the mucosa, such as biopsy forceps and dia -- diather -- how do you pronounce that? Diathermic?

MR. STAUDAHER: Diathermic.

MR. SANTACROCE: Thank you, Mr. Staudaher, my resident medical expert.

BY MR. SANTACROCE:

Q The loop were not autoclaved after each use.

A Autoclaved? They're never --

Q Now, it says --

A -- autoclaved.

Q -- to me here, from our investigation that the scopes, the improper cleaning of the scopes, the failure to autoclave the reusable biopsy forceps were absolutely causally connected to the hepatitis C infection. You disagree with that?

A Yes, I do.

Q And you disagree with the authors of this

article?

A No. Read the discussion.

Q I have read --

A I'm sorry.

Q -- the discussion.

A It's a very misleading -- it's mis -- they say that, but they can't show an association between that -- between that and the infections.

Q So you say that there's a failure in their methodology?

A Well, they didn't have enough patients to show an association.

Q Okay.

A They had to consider -- you need to let me finish. They had to consider --

Q I didn't say anything that I know of.

A They had to consider all types of exposures, regardless of what the preexisting -- preexisting conceptions might be going in. And they don't mention it there, but when you then read the discussion, they come right out and say they couldn't distinguish between that and unsafe injection practices.

Q And this was an article published in the highly acclaimed, as you say, New England Journal of Medicine, and yet their investigation was flawed?

A I think they over -- they over -- I think their conclusions were not supported by the data in what you read. However, when you read the discussion, it is very -- they completely change their -- their perspective and say directly they could not distinguish between the role of what the scope might -- a poorly disinfected scope and the -- or unsafe injection practices.

Q What they say is they could not prove that the procedure was the cause.

A Okay.

Q Okay.

A Uh-huh.

Q But they spent a lot of time discussing the scope cleaning. And they actually said, as we've already read, that from their investigation that these scopes were not cleaned properly, nor were the biopsy forceps cleaned properly, and that these were potential causes for the transmission of the disease, which you flatly and categorically deny that hepatitis C can be transmitted through the scopes.

A I didn't say that.

Q Okay. What did you say?

A I said it hasn't happened -- it hasn't been shown to happen yet. It hasn't been shown to happen. And if you would give me a copy of the entire article, I would then

go on to read the part where they withdraw a little from their strong position about the scope.

Q Okay. Well, I'm sure Mr. Staudaher will give that to you. We've had other experts, other hepatitis C experts in this courtroom testify. Now, granted, they weren't world renowned, they were only local Las Vegas doctors, but they've testified that hepatitis C can be transmitted through reuse of dirty scopes. Do you disagree with that?

A It could happen. I suppose any germ could be -- could be transmitted through if it's contaminating a piece of equipment that's used on another patient. So, yes, it's possible, it just hasn't been shown to happen yet.

Q Were you aware that some GI techs and nurses testified that after the scopes were cleaned and hung to dry that they observed fecal matter coming from the supposedly clean scopes?

A No.

Q Were you aware that the clinic was reusing biopsy forceps?

A I was aware. It was in the report. It stated that they were reusing them.

Q Were you aware if the clinic had an autoclave system or not?

A A sterilization system? I don't know. I don't remember.

Q Well, according to the New England Journal of Medicine article it says that those biopsy forceps were to be autoclaved.

A Okay. Uh-huh. Well, that's -- I don't know what to say. I mean, if you're using disposables, then, no, they're aren't autoclaved.

Q I'm talking about reusable ones.

A Well, I understand it was --

MR. STAUDAHER: Objection. There is no evidence of reusable forceps at the clinic at that time.

THE COURT: Well, maybe you should ask ones that were reused. Is that really where -- what you're getting at, Mr. Santacroce?

MR. SANTACROCE: I'm going to find it here, Your Honor, if you can give me a second.

BY MR. SANTACROCE:

Q Again, referring to 80 E-3. This is the BLC report. It said on 1/6/08 the director of nursing indicated that staff had been instructed -- that's the wrong one. Sorry. One 1/16/08 the administrative staff indicated that the facility used disposable biopsy instruments, the policy and procedures had not been updated to reflect the current practice. In other words, at this particular time in January they had stopped using reusable biopsy forceps and went to disposable ones. Now, my question to you is were you aware

that during the infection dates, September 21st or July 25th that reusable biopsy forceps were being reused.

A Forceps intended to be reused after either high -- after sterilization is what you're saying were being reused? Is that what you're saying?

Q I'm saying -- I didn't say anything about the sterilization.

A Well, you're saying --

Q I said reused.

A Well, then I don't -- but I have to know whether they --

Q I didn't say they were reusable. I said they were being reused.

A No, you said reusable biopsy forceps --

Q Okay.

A -- were being reused.

Q Okay. Biopsy forceps were being reused. Were you aware of that when you --

A I saw it stated --

Q -- came to your conclusion?

A -- in the report. I don't know whether it was occurring on those days. Now, if they -- yes.

Q Were you --

A So I saw it in the report.

Q Were you aware as to how those biopsy forceps

were being cleaned?

A I don't remember what it said in the report, but I do know that the investigation looked at that closely.

Q How do you know that?

A Because there are data to show that people who didn't get infected had the same frequency of biopsies, if not higher, than patients who did get infected.

Q Well, let's -- let's talk about that for a minute. Showing you Exhibit 157. You said you saw this chart but you didn't rely on this chart to make your conclusions.

A I actually -- no. This chart has nothing -- was generated after the investigation and it's a nice -- it's a good way to look at some things and not others, so --

Q Well, let's look at this. You see this guy on the blue line, Ziyad Sharrieff?

A Uh-huh.

Q Source patient for July 25, 2007. Do you see that?

A Uh-huh. Yes.

Q Do you then there was one, two, three, four -- three patients, and then Michael Washington gets infected genetically linked to Ziyad Sharrieff. Do you see that?

A Yes.

Q Were you aware that both Mr. Sharrieff and Michael Washington had biopsies on that day?

A It was in the report.

Q And so you were aware of that?

A Yes.

Q Okay. Were you --

A It said so in the report. I was aware of it.

Q And do you know if the biopsy forceps used on Mr. Sharrieff and Mr. Washington were ever cleaned?

A I'm not aware of what the -- what the biopsy used on the -- what happened to the biopsy forceps used on the source patient and the infected patient, no.

Q And my question before was whether or not you knew the clinic had an autoclave system.

A I don't know.

Q And you are aware that according the article you provided that biopsy -- reusable biopsy equipment needed to be autoclaved; correct?

A The article has nothing to do with my knowledge of what needs to be autoclaved and what doesn't.

Q Well, do you think that biopsy forceps need to be autoclaved --

A Biopsy --

Q -- if they're going to be reused?

A Anything --

THE COURT: What you mean is your knowledge is independent of what you read in the article, is that what you

mean?

THE WITNESS: That's correct.

THE COURT: Okay.

THE WITNESS: If someone is going to stick a needle in your liver to biopsy it, for example, you certainly want it to be sterile.

BY MR. SANTACROCE:

Q Am I talking about that, or am I talking about biopsy forceps for endoscopic procedures?

A It doesn't matter. It's still --

Q Okay.

A -- something that's going to enter your body.

Q How do they need to be cleaned?

MR. STAUDAHER: Your Honor, I'm going to object to at least the characterization that they were at least reusable at that time. I don't know that there's any evidence to that effect.

MR. SANTACROCE: Well, the jury can --

MR. STAUDAHER: I just want to be sure that this witness has at least the proper information before she makes any kind of a conclusion.

MR. SANTACROCE: He can object ten times about that, Your Honor, but you've already instructed the jury.

THE COURT: Okay. Just ask your question.

BY MR. SANTACROCE:

Q How are reusable biopsy forceps cleaned?

A Assuming that they're made of the proper material they would undergo sterilization.

Q And sterilization can only be achieved through an autoclave system; correct?

A Of some type, yes. There are other systems, but yes.

Q And it's distinguished between high level disinfectant and sterilization; correct?

A In terms of the -- yes, there is a difference.

Q And the autoclave system is a sterilization method and technique?

A Yes, it is.

Q And according to your article, not yours, but the one you provided from the New England Journal of Medicine that those items needed to be autoclaved in order to be reused.

A The article -- that's what that article said.

Q Okay.

A Technology may have changed. Do you know why scopes are not -- do you know why the scopes are -- undergo high level disinfection rather than sterilization?

Q Ma'am, I've never even seen a scope personally, except for the one when I had my procedure done, and I didn't see that either.

THE WITNESS: The front page, first --

THE COURT: -- has the abstract?

THE WITNESS: -- page of the article, which is page 163 of this journal. And I was reading from -- not -- I was reading from the last sentence of the results.

MR. SANTACROCE: And, again, the article? The article name?

THE COURT: The name of the article.

THE WITNESS: Multiple clusters of hepatitis virus infections associated with anesthesia for outpatient endoscopy procedures.

MR. SANTACROCE: Thank you.

BY MR. STAUDAHER:

Q But in this particular case, the same type of sort of reuse is what we're talking about in --

A Yes. The only difference is it was needleless.

Q So a vent spike or something was used?

A Yes.

Q Why is that not protective to have a spike versus a needle going into the bottle?

A It's for protection -- these are -- have been put -- these are a variety of measures or technological advances have been developed and employed in healthcare settings to protect healthcare workers from accidental needle

sticks. So the less needles they handle, the less likely they themselves will get stuck with a contaminated needle. A lot of this resulted from HIV in the '80s, so -- concerns about transmission of HIV to healthcare workers in the '80s. So there have been a lot of these sort of technological advances in equipment use in order to reduce the amount of needle use by the healthcare worker. But it had to do with protection of the healthcare worker.

Q So the -- no difference in risk for vent spike versus needle?

A No. No.

Q If it's used in that way that was described?

A No. Presumably -- no.

THE COURT: Mr. Staudaher, I'm going to stop you. Some of the jurors need a break, so we're going to take our morning recess.

Ladies and gentlemen, we'll take about ten minutes for our morning recess. During the recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research, and please do not form or express an opinion on the trial. Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 10:29 a.m.)

THE COURT: I'll see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ma'am, before we let you take a break and we take our little break, out of the presence of the jury, Mr. Wright needs to ask you some questions regarding the basis of your opinions. Okay?

THE WITNESS: Okay.

THE COURT: All right. Mr. Wright, go ahead.

VOIR DIRE EXAMINATION

BY MR. WRIGHT:

Q Ma'am, have you read the Southern Nevada Health District report on this matter?

A Yes.

Q Okay. And the CDC trip report?

A Yes.

Q Okay. Any other reports on this one?

A There was a peer reviewed article published from the CDC in collaboration with the county health department.

Q Okay. Other than that?

A No.

Q Okay. And you're aware of the notifications, patient notifications that took place in this case?

A Yes.

Q Okay. And it basically went back four years and all patients who had been there who may have been exposed to this ongoing practice were sent letters and test -- and tested. And then there were results laid out, not in CDC's reports because this took place --

A Uh-huh.

Q -- after they had been here, after their trip report, but in Southern Nevada Health District's report. And do you, in reaching your -- the firmness of your convictions, let me put it that way, you've made a determination as to likely cause of transmission in this case; correct?

A Yes.

Q And that's the combination of unsafe injection practices and multi-patient use of propofol vial; correct?

A Yes.

Q Okay. Does -- does the later testing -- the -- the later patient notification and the results of that enter into your determinations?

A No.

Q Okay. Why do they do that if it has no basis whatsoever on --

A For the --

Q I mean, the correctness of my conclusion. Because I noticed in your New York case, in various cases like in the New York case when an anesthesiologist -- I think it

was the second one readily admitted to his behavior. And then letters were sent out, a couple thousand of them, and then other patients were found to -- to have been infected.

A Can I also tell you that in the first outbreak in New York -- New York has had actually quite a few -- and they also -- when they realized how long the practice had been going on with the one anesthesiologist, they also sent many, you know, patients over several years letters of notification to get tested.

Q Okay.

A Okay. Why do they do that?

Q Right. And -- and it seems to me, I'm not an epidemiologist, but it seems to me if certain conduct is going on and I believe it caused on two days these events occurred, okay, the transmission of hepatitis C and that the conduct has been ongoing for, say, a year, then I would look to the other 363 days of the year expecting to find other cases the same, other clusters, whatever you want to call it. Because if those were the two things on those two days that caused the transmission and the precise same thing was happening every other day of the year, it would seem to me I would find that on the other days of the year. And then that would confirm for me, bingo, I found the right thing and I -- what am I missing epidemiologically in my analysis?

A Well, the fact that they had sufficient

numbers of cases actually on one of those days to draw an epidemiological conclusion even separate from the laboratory sequencing, on the July date they only had one new case and the one source patient. And the only way to prove that that was the -- that they were related was by viral sequencing. I mean, if you only have two people -- okay. So wait, I'm getting there.

Q Okay.

A However, the purpose of the notification was knowing that this practice was going on for a long time and that many patients might have been exposed, it was the ethical -- the obligation of the health department to notify these individuals that they may have been infected and they should get tested.

Q I -- I got that. I --

A Okay. So for their own -- for their own purpose, the resources -- to be quite honest, the resources involved and then taking all of those patients and doing the same kinds of studies that were done on those two days was probably not available.

Q Okay. And I'm not --

A And that's true for most of the large notifications that are done. If you're not -- you know, in this -- in many instances now, even without evidence of transmission, if a hospital or a healthcare facility notices

-- finds that a practice is -- some practice has not been done correctly, they will send notifications, even though there's been no evidence of infection.

THE COURT: So in other words, the point of sending the notification had nothing to do with confirming their hypothesis or their theory, but it was to give patients notice so that they could be tested and get treatment or modify their behavior --

THE WITNESS: That's correct.

THE COURT: -- or whatever they were going to do. Is that --

THE WITNESS: That's correct.

THE COURT: Is that a summation?

THE WITNESS: Very good.

THE COURT: Okay. Thank you.

THE WITNESS: Yes.

THE COURT: Is that fair?

THE WITNESS: That's exactly correct.

BY MR. WRIGHT:

Q Okay. The problem with that is there's testimony to the contrary in depositions. Not -- not yours or anything, but of -- of the Health District and what they expected to find. I mean, I'm not faulting anyone --

A No, no, no, no, no.

Q -- for notification whether you found it or

not. My -- what I still don't have an answer to is if I'm the epidemiologist and I say here's two days out of a year in which hepatitis C was spread by this method of transmission and then I look and say -- and that identical conduct occurred on the other 363 -- 62 days, whatever, of the year, I would expect to see other -- the same conduct. In other words, I'd expect to see --

A I understand, the same set of circumstances. You would expect --

Q Right.

A But that -- in order to -- it may have been the initial intent to do that, but given the frequency of positives, hepatitis C positives in the general adult population, particularly in that age range getting, you know, GI studies, you're going to find a lot of positives. And I think it might -- and I -- now I'm speculating that while the original intent might have been to identify other clusters, the number that they came up with made it impossible for them to actually do that kind of investigation because, remember, you have to find the source patient, a source patient, you have to determine what the differences in -- they would have had to go through everything that they did for those two days just for -- for all those other positives.

And actually in New York, the first outbreak I investigated, that we investigated in 2001, they did the same

thing, and they went back four years. And they found a lot of positives for both B and C, but they could -- you know, I think they identified a cluster, maybe, but they couldn't do the same kind of analysis. But that's not the purpose of the investigation. The purpose of the investigation is to identify what happened, how it happened, and if it's -- it shouldn't happen, prevent it from happening in the future.

Q I -- I --

A Yeah, so --

Q I follow all that.

A Right.

Q I just still -- I told you --

A The purpose of -- the real --

Q -- I'm not an epidemiologist --

A Right. But that --

Q -- but it seems to me if -- if it happened this way and this is my conduct and then I did the identical thing --

A Yeah.

Q -- 100 times --

A Uh-huh.

Q -- and it's convinced because I did it this way it caused it to happen --

A Uh-huh.

Q -- then on the other 99 days I would expect to

see it again if that was truly the cause.

A You wouldn't necessarily see it every day. You have to have someone --

THE COURT: You have to have --

THE WITNESS: -- who is infected --

THE COURT: -- hepatitis to start --

THE WITNESS: -- as a source.

BY MR. WRIGHT:

Q Well, right. I'm saying --

A Okay. So -- yes, but how would you show that and how -- what amount of resources should the health department when they have many other things that they have to consider, dedicate to this? This is not for, no offense, legal reasons. This is for public health. So to protect the public they have done their due diligence by identifying the potential source, who was at risk, and notifying them --

Q I understand.

A -- to get tested. And that was the -- that's really the overall purpose.

Q This is a criminal case.

THE COURT: I think we're getting --

BY MR. WRIGHT:

Q And I understand --

A I know that, but I'm not --

Q Let me ask --

MR. WRIGHT: Pardon?

MR. STAUDAHER: Your Honor, I think --

THE COURT: Mr. Staudaher is objecting. I think we're getting beyond --

MR. WRIGHT: No, I --

THE COURT: -- the focus.

MR. WRIGHT: Just one wrap up question.

THE COURT: Okay. One more question.

MR. STAUDAHER: He can do this on cross-examination.

THE COURT: Well, no, there was --

MR. WRIGHT: I can't do it on cross.

THE COURT: Wait a minute.

THE MARSHAL: Counsel, enough.

THE COURT: There was a purpose --

MR. WRIGHT: I --

THE COURT: Excuse me. There was a purpose for allowing this questioning to go on and it was a limited purpose and I think we're getting beyond the purpose. And so, Mr. Wright, you say you have one more question.

MR. WRIGHT: Yes.

THE COURT: You can ask your final question. Again, because the questioning was dedicated to a particular issue --

MR. WRIGHT: I understand.

THE COURT: -- and I think we're getting beyond that. And so ask your final question and then we're going to

take a little break.

BY MR. WRIGHT:

Q As I understand it, if it was conclusively shown that over the four years all 63,000 persons were tested, okay, every one of them was tested and there wasn't any hep C, it turns out it was below the threshold level that would have been expected, okay, if I could show that no one in four years got hep C at that clinic it would make no difference to you in reaching your determination that for those two days the method of transmission was what you found; correct?

A That's correct.

Q Okay.

A But unlikely.

THE COURT: Okay. Well --

THE WITNESS: Unlikely that that would be the case.

THE COURT: All right. If you need to take a break, ma'am, just exit --

THE WITNESS: I'm okay.

THE COURT: -- through those --

THE WITNESS: Do you want me to just --

THE COURT: You can sit there if you want to.

THE WITNESS: Fine. I'm fine.

THE COURT: We're going to take a break.

(Court recessed at 10:42 a.m., until 10:46 a.m.)

(Outside the presence of the jury.)

THE COURT: Yes?

MR. WRIGHT: I just want -- I just wanted to tell the witness that that exchange was outside of the jury's presence. So when I examine you in the courtroom --

THE COURT: And ask the same things again --

MR. WRIGHT: -- we don't act like they've heard it.

THE COURT: -- don't --

THE WITNESS: Don't sound as if why are you asking me the same --

THE COURT: Yeah.

MR. WRIGHT: Right. We don't discuss it.

THE COURT: Sure. Yeah, so obviously don't say -- don't say as I just told you five minutes ago --

THE WITNESS: Yeah. Okay.

THE COURT: -- blah blah blah.

THE WITNESS: No, I appreciate -- I appreciate that. Really, I have to be reminded. I don't do this as a routine.

(Off-record colloquy.)

MS. STANISH: Judge, I'm on the phone with Nia Killebrew --

THE COURT: Okay.

MS. STANISH: -- and she's out and about. And I thought if we could just put her on speaker phone if you could make the order to her to reveal Mr. Meana's --

THE COURT: Okay.

MS. STANISH: You ready, Nia, or are you in the check out?

THE COURT: What, is she like at Vons or something?

MS. STANISH: Yeah, that's fine. Can we just -- just to put on the record --

THE COURT: She can call in. I mean --

MS. STANISH: Let's see if this works. Nia, can you hear me?

MS. KILLEBREW: I can.

THE COURT: Can you hear me? This is Judge Adair.

MS. KILLEBREW: I can, Judge. How are you?

THE COURT: Good, thanks. Basically, I need to direct you to disclose to all of us the amount that the Meana family received in settlement of the various claims and lawsuits they may have filed. So if you could do that. Hello?

MS. KILLEBREW: I can do that. I don't have the amount that I can tell you right now. I can email it or have someone bring it in an envelope to the Court today.

THE COURT: Okay.

MS. KILLEBREW: The only thing that I need, you know, is some minute order or some kind of documentation on the record that you're ordering me to do so --

THE COURT: Right.

MS. KILLEBREW: -- so my client's --

THE COURT: -- Ms. Husted is making that --

MS. KILLEBREW: [Inaudible].

THE COURT: Ms. Husted is making that part of the minutes right now. And you don't need to, you know --

MS. KILLEBREW: Okay.

THE COURT: -- rush it over today, as long as we get it, you know, by an email or something like that. We don't have to put that on the record today. So, you know, don't worry about sending over a runner or rushing back to your office or anything like that. You know, just sometime today or tomorrow morning if you get that over to the lawyers, that would be great.

MS. KILLEBREW: Okay. I'm out of town, but would it be easier for me to just -- I mean, my office is right across the street -- to have a runner bring it over in an envelope to your -- to your chambers?

THE COURT: Sure. That --

MS. KILLEBREW: Or would you rather have me disclose it to counsel?

THE COURT: Sure. That's fine.

MS. KILLEBREW: Okay.

THE COURT: All right.

MS. KILLEBREW: I'll just do that.

THE COURT: Okay.

MS. KILLEBREW: Not a problem.

THE COURT: Okay. Great. Thank you.

MS. KILLEBREW: Thank you so much.

THE COURT: Okay.

MS. KILLEBREW: Bye, everyone.

THE COURT: Bye.

MS. STANISH: Bye.

THE COURT: Okay. We can bring the jury back.

(In the presence of the jury.)

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

And, Mr. Staudaher, you may resume your direct examination.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION (Continued)

BY MR. STAUDAHER:

Q With regard to your review of the records in this particular case, we're talking about the Health District report. What else did you review?

A The trip report from the CDC, which is their initial follow up report right after they return from the investigation, and then their publication in a peer reviewed journal of their -- of the final analysis of the CDC's investigation portion.

Q So the -- in the chronology of things that you looked at, did you look at them in a particular order, did one

build on itself, that kind of thing, or did it matter? Was the trip report first and then the article, or vice versa?

A Oh, definitely. The trip report definitely because that comes out right after they return from their investigation, like within a short period of time.

Q Is it typical to have an outbreak investigation published in a peer review journal after such an outbreak?

A Yes.

Q So the trip report is -- how would characterize that report?

A Well, it's publicly available, but it is -- it is part of CDC's procedure that you summarize, even though they might be preliminary, the results of your investigation immediately upon return so that that's communicated back to the inviting state and they have everything that you have at that moment.

Q Is it fair to say that are there sometimes errors in those initial reports?

A Yes, probably. Yes.

Q When it gets to the stage where you actually publish the paper, though, in the peer review journal, does that go through some sort of vetting process with other investigators? I mean, how is the journal sent out before it's actually published?

A The draft or the manuscript, which is what we call the prepublication report is sent out to the co-authors on the -- on -- on the paper to read and make any suggested revisions. It doesn't necessarily mean that all errors, if there were errors, would be caught at that time, but hopefully everything that's in the -- in the manuscript is accurate as far as the co-authors know. In addition, when it gets submitted to a journal for peer review, which is a separate process, it is reviewed by individuals who were totally not related in any way to the -- whatever the study was that's being reviewed. So the journal sends it to its own peer reviewers to decide whether it's of importance and worthy of publication in the journal.

Q And once it finally gets published, it's been through that whole process; is that correct?

A Yes, including, I should say, clearance at the CDC level.

Q So in this particular case you looked at those particular parts of the -- that sort of detailed the investigation; is that correct?

A Yes.

Q Now, we've talked about some of your kind of conclusions about scopes and the -- or the biopsy forceps, things like that up to this point.

A Yes.

Q In general, looking at the results in this particular case, did you come to a conclusion as to how you believe the transmission occurred through the records that you reviewed?

A Yes.

Q And what was that?

A My conclusion is that the unsafe injection practices used routinely in this clinic resulted in contamination of medication vials, in this case propofol, with hepatitis C virus that was then transmitted to other patients.

Q Okay. Anything in the reports related to that that called into question that analysis or that conclusion? Any results that you saw? Anything in there?

A I don't know. I'm thinking.

Q -- in there?

A I just want to make -- no.

Q Have you ever heard of the term serial contamination?

A Yes.

Q Do you know -- can you tell us what that is, first of all?

A Basically you have a source and it's transmitted down the line. I mean, you know, it's transmitted to each subsequent individual who is exposed.

Q Have you seen this actually in your own

investigations?

A Yes, I have.

Q Have you -- I mean, is this something that has been around for awhile?

A The idea of it, yes, and having seen it in the context of hepatitis B virus because it's so infectious and so much more easily transmitted that we've seen it in a variety -- and we've been able to test for it for a much longer period of time and we've seen that in a variety of settings and done experimental studies to show that it can happen, but it doesn't have to.

Q Okay. What do you mean it doesn't have to?

A When you refer -- I'm assuming when you mean serial transmission that every single individual after the source gets infected?

Q No, not necessarily.

A Oh, okay.

Q And let's talk about that. Serial contamination meaning just people downstream of the source patient --

A Right.

Q -- are contaminated serially.

A Yes.

Q And do you know how that could happen in a situation like that?

A Well, if you have a common source of virus like a multi-dose vial or several contaminated vials of medication, then people who are exposed to that vial of medication downstream, so to speak, from its point of contamination will be exposed and potentially infected.

Q Is there a dilution effect that involves that sort of serial contamination that might have a play here?

A Yes, there is because, you know, there's a certain amount of virus that is in the contaminant, and as the vial gets used up, presumably the level of contamination will go down or you really don't have any idea which dose is going to contain virus and which isn't.

Q Now, in this particular case there were two specific days; correct? We're talking about a July date, July 25th and a September 21st date. Your -- go ahead. Did you want to say something?

A May I correct what I just said? It just occurred to me the question you're asking. I didn't answer the question you were asking about how the serial contamination might occur, whether or not you would get -- whether it would be different the further downstream. If you were -- if the source was in the same -- if you only had one source of virus, then presumably as the -- as the vial gets used up you'll have less contamination and lower infection rates the further out you go.

However, if it's from different vials, if multiple -- if you have multiple sources of potential contamination, then that might be difficult to see. In an experimental setting, however, that's exactly what happens is you -- because you have -- as you go along, downstream you have less and less, your infection rates start to drop.

Q So at some point you wouldn't expect there to be infection rate with a common initially contaminated source, or -- or can you --

A Presumably, but not always.

Q Now, on the two days in question that we're talking about here, and you've reviewed the information pertaining to those; is that correct?

A Yes.

Q You said that you believe -- if I -- I'm not trying to reiterate, but is it the same conclusion for both days?

A Yes.

Q And what do you base your conclusions off of?

A The only -- first of all, the only significant result that the CDC could find was that all of the patients who became infected received procedures on the same day as a chronic -- you know, as the source patient. And all of their procedures occurred after the source patient. In the September -- on the September day they have a few infections

that can actually look at it in an analysis using numbers and statistical techniques. On the July day, there is only one infection downstream from the source patient. So the only way to link those is by genetic sequencing.

However, the fact that the only -- the only technique or procedure that could be implicated, that they could identify as being inappropriate and not according to good aseptic technique was how the multi-dose vial -- how the anesthesia was delivered, essentially, and to multiple patients. And so since that had been occurring all along, there was no reason to believe that wasn't the source in July as it was in September.

Q Now, the source in July, let's talk about that day just for a second. You said there was just one infected patient from the source patient on that day. You said the only way that there could be a link is through genetic sequencing --

A Right.

Q -- correct?

A Yes.

Q Was that -- was that done in this case?

A Yes, it was, and they were -- they were genetically related.

Q And are you -- I mean, you've -- I assume since you've been at CDC you've seen that kind of analysis

done in the past, is that right, where they do linking?

A Yes.

Q Is there any issue with regard to the methods or procedure that you saw employed in this particular study for that work, for the sequencing work that called into question the results?

A No, it only gets better as time goes by.

Q Okay. Now, on the 25th date, the July 25th date, were you aware based on the records that the CRNA involved on that day was the one who administered the heplock and administered the medication?

A Yes.

Q Is there -- although the infected patient on that day did not fall under the same category, it was a nurse that put in the heplock initially --

A Yes.

Q -- at least according to the records, is there any issue there with regard to, you know, potential error in what the transmission was or the source of the transmission based on that information?

A I don't -- I don't think so. The reason being that the procedures that the nurses use to put in the heparin locks were correct, and they were observed to be correct, they routinely were correct, and so there is no reason to believe that the placement of the heplocks were related. They

certainly didn't find that in September, and when they investigators were onsite observing the staff, one of the CRNAs continued to administer anesthesia in the same way, in an unsafe way by using -- you know, reusing a syringe on a single patient and then using that vial on multiple patients.

Q Were you aware that a communication was made to a second CRNA about that same practice?

A Yes.

Q And you were aware of the results of that, the admission of the reuse there?

A Yes.

Q Those two things combined, those are different, if I understand you, that in that New York 2001 study where you didn't have any observed mechanism by which you could see or determine transmission?

A Until -- that's correct, until we looked at the purchase records.

Q So that's what led you to your conclusions?

A To confront the person who had been denying the unsafe practices, yes.

MR. STAUDAHER: I pass the witness, Your Honor.

THE COURT: All right. Cross.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Good morning. My name is Richard Wright. I

represent Dr. Desai. You did not participate -- let's see, you left CDC in 2006.

A Yes.

Q And so you had no participation in this investigation in Las Vegas in January?

A Other than talking to Brian Labus over the phone

Q Okay.

A Over the telephone.

Q Okay. And the -- when did you talk to him?

A It was in the middle of the investigation, just before they -- just before they went public to -- did the public notification.

Q Okay. So that would be -- I mean, we know from dealing with all the dates here in the courtroom it went public February 27. It went public and notifications went out to patients February 27, 2008. So prior to then; correct?

A Yeah, like the day before.

Q Okay. And you -- you had received -- were you contacted by lawyers from the clinic to consult with them? I read that.

A Let me think a minute, only because I do get contacted a bit. Yes, I think so. Yes.

Q I -- I read somewhere of efforts to reach out to you by civil litigator -- civil lawyers for the clinic at

the time seeking to use your expertise --

A You're absolutely --

Q -- and consult.

A Thank you. You actually brought it back. Yes, that's correct. And, in fact, because I knew nothing about the outbreak at the time, it was early on, they did -- they were referred by a colleague and I turned them down when I -- when they described the situation. And then I immediately called my contacts at CDC to see what was going on because it sounded, you know -- sorry, from an epidemiologist's point of view, it was quite exciting.

Q I -- I read --

A I'm sorry.

Q I read the articles you forwarded. Okay? All of these articles and the Morbidity -- what's that thing called?

A Morbidity and Mortality Weekly Report. It's CDC's public health notification of important events.

Q It sounds like a Halloween magazine. But it is really dry reading.

A To you.

Q Correct.

A The rest of us can't wait to get our hands on it, and it's embargoed, too.

Q The -- I mean, this is esoteric stuff we're

dealing with. The -- I read your article about, and I had nightmares, about the testing the chimpanzee dried monkey blood to see how long the virus lives in dry chimpanzee monkey blood. And the results were how long does the hepatitis C virus live outside, like when it's -- some blood is left on an instrument. What's the results?

A The results were that the -- the only way you can demonstrate infectively is with an animal model because you really can't do it in -- in the laboratory, so -- and only non-human primates. So the results were that we had three time points to look at, 16 hours, four days, and seven days. And only the 16-hour sample was infectious. So we know that it persists for at least 16 hours outside the human body. It could be dried on a surface, not visible to the human eye, and still cause infection.

Q Okay. And the three-day old -- three-day old blood, using my --

A Four-day.

Q -- layman's terminology --

A It's okay.

Q Four-day?

A Four days.

Q Four days the -- it was no longer infectious, the virus had died.

A Right.

Q And the same with the seven-day?

A That's correct.

Q And -- and that's -- learning from your article, that's different than the hepatitis B, where that -- it -- the hepatitis B virus survives when exposed to the environment for --

A It was only looked at for seven days, okay, because of the limitations of doing these kinds of studies. So its infectivity was demonstrated seven days, but it's a very hardy virus. It's easy to kill, you know, if you use disinfectants on it, bleach does a great job, but it survives a long time. And when people ask -- actually ask our opinion, if they call and say, you know, I've had this thing with blood on it for two years, should I consider it infectious with B? We would probably say, yes, you should just consider it infectious. They've actually found evidence of the virus, not necessarily its infectivity, seven years after it was dried. But unknowing -- you know, we don't know if it's infectious.

Q Okay.

A Hepatitis C clearly does not survive that long because you have to combine your experimental work with reality and what you see in terms of transmission patterns. And it was clear from transmission patterns that hepatitis C was not like HIV, which does, once it leaves human body, it -- it's no longer infectious. But because of its transmission

patterns, we suspected it had to live for some period of time outside the body, and that's why we did the experimental study.

Q Okay. As -- as a hepatitis expert, I contract hepatitis C today, and the odds are like seven out of ten times I will have no symptoms, asymptomatic. Is that what it's called? Is that right?

A Yes.

Q Okay.

A Right.

Q Like three out of ten times I will get the classic symptoms that we've heard about testified here, jaundice --

A It'll send you to the doctor.

Q Right. Okay. And so I may not -- I may not know I even have it --

A Yes.

Q -- seven out of ten times.

A That is correct.

Q And the -- how -- how quickly -- and I guess once I'm past six months and I'm most -- once I'm past six months, I just acquire it today, six months from now, assuming I knew I acquired it, six months from now it's quite clear I'm not going to get the classic symptoms; is that right?

A That's correct. I mean, the classic symptoms

-- the incubation period is short. It can be as short as 14 days, supposedly as long as six months. But likely within two to three months of exposure, if you haven't become symptomatic you're not going to be for the first phase of infection, the new phase of infection.

Q Okay. So once -- and then the -- we've heard testimony here in the courtroom, I'm past six months so it's what we've called -- we're calling chronic hepatitis C. And chances are I will end up dying of old age and not hepatitis C.

A From an odds point of view, absolutely.

Q From a what?

A From an odds -- look where we are. From an odds point of view, yes.

Q Okay.

A Likely you will.

Q Okay.

A It depends on a variety of factors.

Q Okay.

A Whether you drink, you know, do other things that might harm your liver that all of that potentiates.

Q Okay.

A You know, it puts different risks on it, but, yes, that's correct.

Q Okay. And if I contract it today, the -- like

what do -- what do the studies show or what's your analysis of how quickly I may develop cirrhosis of the liver from hepatitis C?

A Presuming you're over 40?

Q That I am.

A Age --

Q And drink.

A Age -- well, if you had hepatitis C your doctor would tell you not to drink at all, but -- except maybe champagne at your daughter's wedding. But depending on your age and a variety of other factors, you're male so it increases your risk, as well, and that you can't do anything about. So all other factors being equal, you could develop cirrhosis in 5 years, 2 years, 20 years, or 40 years.

Q You just don't know.

A No. I mean, there's an average.

Q What's the average?

A 20, 30. 20 we'll say. And that most of those -- that -- that's -- also includes a range of -- you know, averages always have ranges. So that's the average, but it can be much shorter, and I've observed that directly.

Q Okay.

A In my follow up studies that I conducted at CDC. So -- but it has usually -- often, in moist people it has a long what we call latent period where nothing happens

and you don't know you have it until you have that yearly physical. The doctor finds you have liver -- elevated abnormal liver enzymes, meaning your liver is inflamed. They test you for hepatitis C, and you just found out you have it.

Q Okay. And if I have it and I didn't know I had it, I had a blood test and the doctor says you've got hepatitis C, and I don't have any symptoms at all from it, didn't even know I had it, I could still undergo the treatments we've heard about here in the courtroom, which is a 48-week interferon and ribafarbon (sic) or something.

A Ribavirin, yeah.

Q Okay. I -- I could do that even if I had chronic and no symptoms?

A Actually, that makes you a better candidate for --

Q Okay.

A -- resolving your infection. However, there are guidelines for treating people and the guidelines have to do with the severity of your liver disease, which may not be manifest or clear based on your lack of symptoms. So they do laboratory testing, possibly imaging studies, possibly a liver biopsy to determine the stage of your liver disease. And people with mild disease may not have been treated in the past. They may be more likely to be treated now because some of the drugs -- because the treatment is more effective and

can be shorter. But in general you have to sort of show that you're progressing in your liver disease to be treated. On the other hand, some physicians treat everybody.

Q Okay. Have you heard of Dr. Richard Perrillo, a neuropsychologist?

A I know a Robert Perrillo who is a hepatologist.

Q Nope, this is Richard Perrillo.

A And he's a what, neuroscientist?

Q Neuropsychologist.

A Neuropsychologist, no.

Q Okay. He testified here in the courtroom about hepatitis being neuroviral and attacking the brain and causing -- hepatitis C causing dementia which he distinguished from brain fog.

A You mean like the rest of us have.

MR. SANTACROCE: I'm sorry. I didn't hear you.

THE WITNESS: It wasn't a scientific comment. Can I take it back?

MR. SANTACROCE: No.

THE COURT: No.

THE WITNESS: Like the rest of us have.

THE COURT: Oh, okay.

BY MR. WRIGHT:

Q He testified that he reached this conclusion

of hepatitis C causing dementia, as well as the treatment causing dementia. And he based it upon he had seen 19 patients with hepatitis C and they had dementia. Do you -- are you familiar with any -- any of his work or studies or does any of that ring a bell with you?

A No.

Q Okay. The --

A But I can comment.

Q Give me your comment.

A Okay. This is a common misconception, particularly by physician researchers. I don't know if he's a physician, but they look at cases only and they don't end up doing a study. They look at case reports or just people with the disease and they see that they all have this in common, whatever it might be, in this case hepatitis C and dementia, and they come to a conclusion about the cause or some association. But you can't. Case -- case reports can be very useful because they can -- you know, they can show that further study might be necessary in that area, but they can't -- you can't draw any conclusions from cases, just looking at cases.

Q And that's the difference between association and cause and effect.

A No.

Q No?

A Association --

Q Well, let me -- let me ask it this way. I mean, the way it was explained to me the -- why an association doesn't prove cause and effect, let me put it that way. I was told in the late 1940s before there was a polio vaccine, that there was an anti-polio diet put out by the government that you should not eat ice cream or soft drinks because everyone that had polio had been eating a lot of ice cream when they caught polio. They were eating a lot of ice cream and soft drinks. And so ultimately it turned out that polio was transmitted in the summer when it was hot, and so the -- they had misinterpreted. There is merely an association. Everyone caught polio when -- when it was hot and that's when you eat ice cream and drink soft drinks.

A Actually, I'm sorry if I interrupt. That is not an association. That's actually -- it's called an ecological fallacy in scientific terms and from an epidemiological point of view. I'm sorry. That's exactly what it is. It's like there are more telephone poles in -- or people -- there's a higher risk of getting -- or a higher rate of cardiovascular disease in places that have more telephone poles. Why is that? That is not an association. It's an ecological fallacy.

People who have -- who don't live in -- well, when this was used as an example, telephones were not exactly as

common as they are now, and in urban areas where people had less exercise and ate -- and had worse diets had more cardiovascular disease than in rural areas where they worked out, worked on the farms or whatever, and had fewer telephone poles. It's an ecological -- it's a misinterpretation.

THE COURT: So it would be a coincidence that has --

THE WITNESS: It's a coincidence.

THE COURT: -- no bearing on actually the cause of disease or the symptoms of --

THE WITNESS: That's right.

THE COURT: -- the disease or anything like that. Okay.

THE WITNESS: And as a scientist an association has the same implication as a cause and effect if you use it -- if you use it in the same way. Like something is associated with infection, a particular event or -- means in epidemiological terms that there is some kind of cause and effect.

So when you do studies that can't establish a cause and effect, what we do is say we found a characteristic related or associated with positivity, testing positive, which is a little -- it may be -- it may be a very obscure kind of -- but it's very important in our line of work to be very clear about what we consider studies that can demonstrate real associations with getting infected or getting a disease and those that are just a characteristic of populations, for

example, with the disease. I know it sounds esoteric, but it's important.

BY MR. WRIGHT:

Q And some -- some of the statistical -- do you -- do you all compute it like statistically, the probability that it was this or that?

A Yes, after having done an appropriate study. So the study methods have to be just as appropriate as the analysis. And bad data in, bad data out. You know, good data in, hopefully your results are valid. But there have been -- there's a lot published, not necessarily in hepatitis C, that's not valid.

Q Okay. The -- Brian Labus stated in -- in his -- in the report that the likelihood of getting hepatitis C --

THE COURT: Keep your voice up.

BY MR. WRIGHT:

Q The likelihood of getting hepatitis C for a patient who went to the clinic on September 21, 2007, was 38 million times the likelihood of a person who didn't go to the clinic on September 21, 2007. Okay?

A Uh-huh.

Q What does that show?

A I've read the sentence, too. I don't know --

Q I mean, I presume --

A -- what calculation --

Q -- it's true.

A I agree. I -- no, I read the sentence, too. I don't know what calculation he was making or the report was making, what calculation that was based on.

Q Okay.

A And it wasn't explained.

Q It -- it is fair to say that you -- you simply read the reports and you concur with the conclusion of CDC?

A Yes.

Q Okay. And their conclusion was that the most likely cause was the combination of unsafe injection practices with the multi-patient use of propofol vials?

A Right, which is also considered under the overall phrase of unsafe injections.

Q Oh, okay. That -- that -- somehow I was viewing an unsafe injection as the actual --

A No, it also involves the reuse of a vial for a multiple -- or the reuse of the vial for multiple patients.

Q Okay. And the --

THE COURT: Keep your voice up.

BY MR. WRIGHT:

Q Your -- on that New York, your first case of New York 2001, was that your first colon --

A My first -- the first investigation of an outbreak of hepatitis C in a GI practice.

Q Okay.

A Private GI practice, yes.

Q Okay. And that -- and was that an anesthesiologist?

A Who was reusing syringes and needles. Reusing needles and syringes and on the same vial and going back into a multi-dose vial, actually.

Q Okay. And was he -- was it a he, the anesthesiologist?

A It was.

Q Okay. Was he using -- reusing needles and syringes between patients or simply to re-dose a single patient?

A Simply to -- to re-dose. He was discarding between patients.

Q Okay. The -- and --- and he had denied it?

A Yes.

Q Okay. And then ultimately admitted to it?

A Yes.

Q Okay. And the Oklahoma case you talked about, the one you talked about here, that was a reuse of syringes -- reuse of needle and syringes on multiple patients?

A That was taking one syringe, filling it with enough medication for ten patients, and going from bed to bed administering the medication.

Q That's what I'd call serial.

A Yes, that's serial.

Q Okay. And so that -- you all call that overt syringe -- needle and syringe reuse? I saw that in one of these articles.

A Oh, you mean like direct versus indirect contamination?

Q Right.

A Yeah, that would be direct contamination of the syringe as opposed to indirect. Indirect being through -- through the vehicle of a multi-dose, like contaminating the medication vial. Right.

Q Okay. And you -- you were asked about serial contamination. And what does that mean to you?

A It means that a line of people, so to speak, or patients, have received -- have been exposed serially.

Q Okay.

A You know, in --

Q I got it. And the --

A -- a sequence of some time.

Q Okay. And I think it was your New York investigation there was a multi-dose common vial and that appears to have been contaminated with hep C by a source patient, and then that -- that one vial was used over three days and that one vial, which was contaminated, thereafter

transmitted hepatitis C to other patients getting out of that same vial, is that fair?

A That's correct. Although, there were some patients in sequence who did not become infected.

Q Okay. And the -- here, and I'm unsure if it's that clear in the Southern Nevada Health District report, but Brian Labus testified that he had two theories by which the transmission, talking about September 21st, could have occurred where it went from room to room because there were two different procedure rooms.

And he said it could have been a single -- theoretically it could have been a single 50 cc contaminated vial, one vial of propofol contaminated because if you add it up, all of the dosage for all of the infected patients and you just gave them each like their first dose out of the one vial, there was enough total that it could have all happened through one vial. That was one theory he testified to. Second theory dealt with contaminating multiple vials because the -- and having open multiple vials at the same time. And he called that serial contamination of vials. Okay?

A Uh-huh.

Q Okay. Have -- have you, in the cases you have seen and studied, have you come across serial -- using that definition of serial contamination of vials? Did any of your cases involve that?

A I'm thinking.

Q Take your time.

A I don't think so. I don't remember that being the case, but the practices at this clinic of having multiple vials open at the same time in the same procedure room and some of the -- and their techniques in general were pretty, well, unfortunate. And so, you know, there is really no reason to have multiple vials open at the same time, particularly if you don't have more than one anesthesia person in the room at the same time. So -- but my understanding is that they did. And --

Q Okay. Well, where do you get that understanding?

A From the report of the observation --

Q Okay.

A -- of what they were doing at the time the investigators were there.

Q Okay. Well, that was Linda Hubbard. I mean, you don't know that, but Linda Hubbard was not there on September 21st or July 25th. And she --

MR. STAUDAHER: Objection. Mischaracterizes the evidence. She was present on July 25th.

THE COURT: I'm sorry?

MR. STAUDAHER: July 25th.

MR. WRIGHT: Okay.

THE COURT: All right. So --

MR. WRIGHT: Okay. I didn't remember her being there. I'll accept that --

THE COURT: And the jury --

MR. WRIGHT: -- clarification.

THE COURT: -- will recall --

MR. WRIGHT: Okay.

THE COURT: -- what it recalls. And that's what it's important, what the jury remembers.

BY MR. WRIGHT:

Q Okay. Linda Hubbard wasn't involved with the source patient or infected patient on July 25th, and Linda Hubbard was not involved on September 21st. Other CRNAs did not testify to you opening multiple vials. They -- they have testified to pre-loading, for lack of a better word. I mean, in the morning drawing up out of one 50 cc, filling five syringes, and other than that simply using a vial until it's empty. Multi-patient, I'm not arguing that, but if you take that open vials out of the equation on September 21st, meaning having more than one vial open at the same time sitting there, do you follow this serial contamination of the vials theory?

A I don't think I understand the question --

Q Okay.

A -- actually.

Q Okay.

A If you don't have more than one vial, then --

Q Open.

A Open? Well, you can serially -- you can contaminate it if you open another vial and use a contaminated syringe. Or if you use a new syringe, withdraw some -- some, you know, whatever is left in the contaminated vial into a syringe, and then go into a new vial to get a little more.

Q Okay. The --

A But, you know, these are all hypotheticals, and my understanding was that, you know, the vials, multiple vials were open at the same time. I mean, there's no reason why either of those scenarios couldn't have happened. I don't know if they did. They also --

Q Right.

A They may carry, you know, their own -- I mean, it's common in some settings. I'm not saying this one. But, you know, you put what you drew up in your pocket when you change rooms.

Q Okay.

A Or a vial, you stick the vial in your pocket that you're using and you change rooms and you then use that vial as opposed to whatever is in that room available.

Q The CDC trip report noted that there was no -- based upon observations and interviews, they didn't haul propofol room to room.

A That's true. However, that may not be the case.

Q Right. We're -- we're --

A I'm just saying a --

Q Right. I mean --

A It's possible.

Q It maybe had --

A I don't know.

Q Okay.

A I don't even know if they had pockets.

Q I don't either. We've heard about tackle boxes, but not pockets.

A Fanny packs I've seen now, you know.

Q So you were -- you're aware of no published articles or cases involving serial contamination of vials, and the evidence in this case --

A In which -- what are you -- tell me again your definition of serial contamination of vials?

Q Having multiple vials get contaminated by all with the virus of the original source patient, and that's how it moves from room to room into later in the day.

A I don't --

MR. STAUDAHER: Objection, Your Honor. That mischaracterizes --

THE WITNESS: Yeah.

MR. STAUDAHER: -- Brian Labus's testimony.

THE WITNESS: It's --

MR. STAUDAHER: -- about that.

THE WITNESS: It's not serial contamination of vials in my mind.

BY MR. WRIGHT:

Q Okay. The -- the evidence in this case has been that Brian Labus in March 2009, before -- still having not written his report in December 2009, contacted CDC to ask them if there was any case or any published literature that could document serial contamination of vials as he presumes happened in Las Vegas. And the response was --

MR. STAUDAHER: Objection, Your Honor. Hearsay.

THE COURT: Well, overruled. She's testifying as an expert.

Mr. Wright.

MR. STAUDAHER: So hearsay is allowed?

THE COURT: Well, Mr. Staudaher, that's enough. I said she could answer the question.

Mr. Wright, state your question and be mindful to speak into the microphone --

MR. WRIGHT: Okay.

THE COURT: -- because you start off strong, and then you start drifting away and we -- we're having trouble hearing you.

BY MR. WRIGHT:

Q Brian Labus contacted CDC in March 2009 asking if they had any articles or cases in the published literature that document serial contamination of vials as we presume happened in Las Vegas. And the CDC responded that they didn't have any such thing other than one pooling incident, and the CDC stated that they thought there was enough information from your investigation that this is clearly a plausible explanation.

THE COURT: Is there a question?

BY MR. WRIGHT:

Q Does -- would you concur with that response from CDC?

A What I would concur is that they were using practices that would -- could result in contamination of medication vials with a blood-borne virus, and that that virus could serve as a source for transmission to multiple patients.

Q Okay.

A So why couldn't -- I'm -- I still don't understand exactly what definition we're using for serial contamination.

Q We -- these are -- this is Brian Labus's --

A I know. But I -- I don't know what he meant, either, so --

Q I don't either.

A Well --

Q Six years later.

A I -- you know, there -- I don't really know what you're asking. I don't see why multiple vials, if they're out, couldn't have become contaminated if they use the same -- either pooled them into a contaminated syringe or -- or used -- reused a syringe on a different vial that was open.

Q Okay.

A But I don't know what you -- that's the --

Q What I'm asking, and I'll ask it again.

A Okay.

Q Their response was there is no case like it, and there is nothing in the published literature regarding his presumed contamination of vials by serial contamination. Do you agree with that?

A I agree with I can't think of a published study involving a specific contamination of different vials --

Q Okay.

A -- in the same place. However, I can say that we have had an out -- we -- that there have been serial transmission from a common source to multiple patients downstream.

Q Right.

A But I can't -- I don't know why -- I don't -- or -- or contamination of medication vials from blood

splatter, which would have contaminated multiple medication vials, even if they weren't being reused.

THE COURT: Would the contamination of, say, multiple vials all have had to come from the source patient, meaning the source patient --

THE WITNESS: Yes.

THE COURT: -- contaminated all the vials --

THE WITNESS: Given the --

THE COURT: -- as opposed to --

THE WITNESS: -- incubation period --

THE COURT: -- patient to patient to vial to patient to vial to patient? Do you understand my question?

THE WITNESS: Say it again.

THE COURT: Would the single source patient have had to contaminate all of the vials in your theory?

THE WITNESS: No.

THE COURT: Okay.

THE WITNESS: One vial could have contaminated another.

THE COURT: Okay. As long as you're using the same syringe from -- or mixing the two vials together.

THE WITNESS: With the same way that you breached the sterility of the product --

THE COURT: Okay.

THE WITNESS: -- by using something for one patient

on another, yes. So one vial could have served as a source for another vial.

THE COURT: If you mix the dosage or the syringes.

THE WITNESS: Right.

THE COURT: Okay. I get it.

BY MR. WRIGHT:

Q So a fellow named Priti with CDC --

A A woman.

Q Oh. I'm sorry. A young lady named P-R-I-T-I --

A Patel.

Q Okay. Responded that there are no articles or cases like it, but you're theory seems to be a plausible explanation.

A It could happen. I don't really see --

Q Okay. I'm just --

A -- whether it's -- you know, it could.

Q Okay.

A Given how --

Q And that's a plausible explanation as to what --

A It's a plausible scenario for contamination.

Q Okay.

A Is the best --

Q And plausible means?

A It could happen.

Q It could happen. Okay. Now, on -- on 7/25, July 25 -- I don't understand why we don't look at the two events separately like what happened on July 25th and what happened on September 21st.

A Is there a question? Are you asking me?

Q Yeah, why -- why -- if September 21st hadn't even occurred and we're just investigating July 25th where there was a source patient, there's genetic connection sequencing, in other words the victim, the infected patient received the hepatitis of the source patient; correct?

A Yes.

Q And the -- we conclude that it must have been unsafe injection practice.

A Okay. So you're asking me how we -- well, first of all, they did the same kind of investigation that they tested patients to see if there were any other infections around the same time. So they conducted the same kind of investigation separately. I mean, clearly, two different time points. And -- but they didn't -- they only had the one infection, which from an epidemiological point of view, you wouldn't have been able to, quote, associate it with the source patient unless you did genetic sequencing.

Q Okay. But then it happened that it was connected.

A Yes.

Q Okay.

A So how could that happen? Well, there has to be some break in technique for a blood-borne virus to go from one patient to another. And having been able to associate the -- or having observed the unsafe injection practices which were ongoing at this clinic, it would stand to reason that the July 25th incident had the same -- was likely to have been caused by the same mechanism as the September incident --

Q Okay.

A -- transmission episodes.

Q But it -- it could have happened that way.

A Yes. You can't prove it, but, yes --

Q Okay.

A -- it makes perfect sense. And from a public health point of view, that's what -- it's important to know what it is that needs to be changed or communicated to prevent it from happening in the future. That's the purpose of the investigation.

Q Okay. And it -- and it's not a -- have you ever participated in a criminal investigation?

A No.

Q Okay. And you all -- you all, meaning you healthcare epidemiologists, CDC, are going in and you want to as quickly and thoroughly as possible find out what is

occurring so that you can both stop it, correct it, and notify anyone who is potentially at risk; correct?

A That's correct.

Q And are -- are you aware that Brian Labus -- you testified on direct about the importance, especially with the new investigators, the newbies who were out there in field, don't jump to conclusions, don't -- don't zero in on one cause, or likely cause, and stop. You have to do everything; correct?

A Yes.

Q Brian Labus has testified that the investigation started at the clinic on Wednesday, the 9th of January, late in the afternoon, and the next day on Thursday they did chart review, they meaning CDC and Brian Labus and BLC and all these team members.

A Uh-huh.

Q And the next day on Friday they knew of the propofol multi-patient use and observed reuse of syringe on patient to redose, and by Friday evening, two days into the investigation, he had determined the likely cause. Does that make sense?

A That's the question, does it make sense, or did it --

Q Yes.

A -- is it -- could it have -- did it happen

that way? I can't --

Q Okay.

A I don't know. Since, I can see that that's happening -- that happening, especially given the history of consistency of these outbreaks being due to the same cause over and over and over again. However, the CDC did do a complete analysis of all the other kinds of exposures that could have occurred regardless of what his conclusion was on Friday afternoon.

Q Okay. His -- I mean, he testified that he had determined that --

A I can't -- I can tell you that in their publication they presented the data showing the other types of exposures that they looked at and ruled out because there was no association between those other exposures and getting -- and acquiring hepatitis C.

Q Okay. Now, the -- the unsafe practices that keep going on and on and on in the literature and in real life practice, here the evidence has been that the -- the -- on Wednesday afternoon when the -- Mr. Labus and Dr. Fischer and Dr. Schaefer went in, the clinic told them they are multi -- they are injecting with multi-dose propofol, multi-dose vials, whatever the terminology was, multi-dose --

A Single-dose vials used on multiple patients --

Q Correct.

A -- is actually what they were.

Q And is -- is what they acknowledged and exactly what their practice was. And this -- and the evidence has been here in this courtroom that that was a common practice throughout this community in outpatient settings.

MR. STAUDAHER: Objection, Your Honor. I don't believe that's the testimony or evidence as it is right now.

THE COURT: Don't spin the evidence, Mr. --

MR. WRIGHT: I'm not spinning the evidence.

THE COURT: Mr. Wright.

And, ladies and gentlemen, once again, it's your recollection of what the testimony was and how you interpret that in terms of, you know, common --

MR. WRIGHT: Okay.

THE COURT: -- uncommon. It's up to you. Again, I'll remind you.

That's what I meant, Mr. Wright.

BY MR. WRIGHT:

Q Keith Mathahs is a CRNA, okay, who was observed, and he testified here in this courtroom that it was the same practice at Sunrise, it was the same practice at Southwest, it was the same practice everywhere he was involved.

MR. STAUDAHER: What practice are you referring to specifically? That's the point that I'm --

MR. WRIGHT: Multi --

THE COURT: Can you be more specific in your questioning, Mr. Wright.

MR. WRIGHT: It was specific before he said --

THE COURT: All right. Well --

MR. WRIGHT: -- it wasn't --

THE COURT: -- Mr. Wright --

MR. WRIGHT: -- the evidence.

THE COURT: -- state your question again.

BY MR. WRIGHT:

Q We are talking about using a single-dose propofol vial on multiple patients, acting like it's a multi-dose vial rather than single-dose vial.

A The problem, if you just look at it that way, is bacterial contamination and has nothing to do with serial virus contamination.

Q Okay.

A Because a single-dose vial, something labeled for single-dose has a very short period in which it can be opened and used. It has no bacteria static preservative in it to prevent contamination and when it's -- after it's been opened. So it's bacterial contamination that is intended, a multi-dose vial that's -- excuse me, a vial that's labeled as multi-dose versus single-dose. And I think -- and the package insert is very clear about this for propofol. But not every

outbreak has involved propofol, and some have involved vials that are labeled for multi-use. The issue here is the re-dosing with the same syringe.

Q I'm going to get to that.

A Well, yes, but --

Q Okay. Well, I just --

A Okay.

Q No --

A Okay.

Q We'll get -- we'll get where you want to go.

A But it isn't -- it isn't necessarily the -- I mean --

Q Well, I'm --

A Well, that might not --

Q You're not going where I'm going.

A Well, okay.

Q I'll drive, and then you can get what you want. And if you think I'm asking unfair questions or something, I'm -- I'm trying to focus in on this why this lack of recognition, this lack of understanding, this lack of awareness in the community of the danger involved in using like a 50 cc propofol vial as multi-dose. Okay? I mean, do you understand that just -- the things just keep going on despite your -- all -- all the best efforts to say don't do it? Do you agree with that?

A What I -- you're not in isolation. Well, you shouldn't use a single-use vial unless you use all of it at once. You shouldn't use it for, you know -- you shouldn't have it open for more than the time. It has nothing to do with -- I mean, it has very little to do with the fact that it's labeled for single-use in terms of virus transmission.

Q Is that --

A Then it has --

Q -- part of --

A -- more to do --

Q -- the confusion?

A Well, you can't take it -- in my opinion it's not -- you can't take that as an isolated event, reusing the vial.

Q I'm not isolating it.

MR. STAUDAHER: Your Honor, I'm going to object to letting -- I would like him to let her finish her answer before he --

THE COURT: Were you -- okay.

Were you finished with your answer, ma'am?

THE WITNESS: Yes, that I can't -- that his -- the question is not answerable in that way.

BY MR. WRIGHT:

Q Okay. As part of --

A It has no significance.

Q Okay. The significance I'm asking is -- is why do these -- we've had a CRNA in this courtroom, Mr. Sagendorf, who is presently a CRNA practicing in California for two large outpatient clinics and he testifies right here within the past month that they still use propofol as -- single-use on the label, they use it as multi-dose in their clinics. They use it for multiple patients.

A Uh-huh.

Q Okay. And I --

A I'm not shocked.

Q You're not shocked. I'm not shocked either. And -- and we understand best practices. We've heard all about best practices. And all I'm focusing on, we'll get to the needles in due course, but the -- somehow, and this may be the confusion between the multi-dose and single-use has to do with the preservatives and how long it can last once it's open; is that fair?

A Yes.

Q Okay. Because, I mean, you talk to practitioners and they say I'm using it quickly. Once I open propofol, it -- it says right in there if you read everything that it's good for six hours. And if I am using it all within that time frame, there is no harm in me using it all up. Do you understand what I'm saying?

A Yes, I understand perfectly.

Q And they -- and if you read the propofol vial --

MR. WRIGHT: Where is our propofol vial? It's an exhibit.

BY MR. WRIGHT:

Q We've had witnesses testify that it's safe to use it if once you open it, if you use it all within six hours. And none of that -- none of it -- if you can --

A See it?

Q See it. None of that is explained on that label. Is it?

A I have to read the label.

Q Okay.

A However, anyone who uses a drug, any drug, should be -- a professional who uses a drug, any drug, should be fully familiar with that drug.

Q Agreed.

A Okay. So --

Q Best practices. I agree.

A Now, the other issue is I think in my opinion there is confusion regarding multi-use and single-use vials and how they contributed. This outbreak could have just as easily occurred with a multi-dose, a vial that was labeled for multi-use. Because the issue wasn't so much that it was a single use vial. It's that they contaminated the vial and

then used it on multiple patients. And that could just as easily have occurred with a vial that's labeled for multi-use. Okay.

Q Okay. I agree. But why -- why do we have -- we had another CRNA testify in here named McDowell. McDowell, I don't remember his first name. But he wanted to argue with the investigators --

A I bet he did.

Q -- when they told him you use that 20 cc, and then you throw it out and you can't use it on another patient. And he literally argued that as long as I am using aseptic technique and I use a new needle, new syringe every time I enter that vial, there is no way on Earth you can ever show me I will contaminate a patient. And he wants to argue with them to -- to use the vial up and not throw any away. And so why doesn't it sink in?

A I have no idea why it doesn't sink it.

Q Okay. But --

A I have no knowledge or data --

Q Okay.

A -- to tell you why it doesn't sink in.

Q Who in CDC --

A It says single patient infusion vial. That's what it says.

Q I found it on there, but I needed a magnifying

glass.

A I can't believe I can read it myself.

Q I can't either. But --

A It does say it. And the package insert is -- it says it in big letters.

Q But no package inserts come with this.

A No.

Q They come in flats of 20 with no --

A However, if you were a physician or a nurse and you were using this routinely on patients, you would hopefully have locked it up in the PDR and know everything about it.

Q I don't disagree with best practices.

A I'm just saying. However, the issue here, in my opinion, is not the fact that this says it's for single patient infusion. It's the fact that they contaminated it.

Q We're going to get to the --

A But, you see, it's irrelevant epidemiologically --

Q Epidemiologically, but --

A -- and scientifically.

Q -- this is a criminal case --

A I know --

Q -- okay --

A -- but I'm science.

Q -- and people's knowledge matters. It matters whether they are mistaken in their judgment or are they consciously, knowingly doing something they're not allowed to do. So I understand epidemiologically it may not matter, but --

A Well, then that wouldn't -- that also would not -- if they didn't know that they were doing something wrong, then it would apply to whether it was -- they were -- it wouldn't matter if it was single-use or multi-use, they would still be contaminating the vial.

Q Right. Because I may think I am engaging in proper practices. Let's move on to your favorite, the contamination. Okay. Needle and syringe usage. What was observed here? Keith Mathahs is the fellow who -- who is in the report who was observed by Dr. Fischer. In the clinic, in front of the CDC inspector with her little -- I don't want to call it her badge, her little plastic badge on, knowing there is a hepatitis outbreak, she is observing his practice.

And this CRNA takes a new propofol vial, I'm presuming he wiped the top off, you know, with the alcohol, all of the aseptic stuff, inject the patient, procedure is ongoing, patient needs another dose. He takes the same needle and syringe, holds it up, takes off the needle, puts it in the Sharps container right in front of the CDC inspector, gets out a brand new sterile needle, puts it on, and redraws out of the

same propofol vial.

A Uh-huh.

Q Procedure ends, Dr. Fischer steps in, interviews Keith Mathahs, and her testimony is he was not aware that his practice was risky or dangerous. And he believed that he was being aseptic by changing the needle. Okay. Why does -- where -- why does he think something like that?

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Yeah, that's sustained. You need to phrase that --

MR. WRIGHT: Okay.

THE COURT: -- a different way. If there's anything in the --

BY MR. WRIGHT:

Q Why do those instances like him -- I mean, have you seen a situation like that during your investigations where the person just wasn't cognizant, aware, understanding of the improper behavior the person was engaging in?

A Yes. Not this specifically, but other investigations --

Q Okay.

A -- involving unsafe practices, we'll say.

Q Okay. And you're dealing with Keith Mathahs, got out of CRNA school before Dr. Fischer was born in the late

'60s. Okay.

A But not before I was born or graduated. And I can tell you that his -- his original nursing degree is based on a practice taught to him in nursing school, and that practice routinely involves -- or the curriculum routinely involves aseptic technique for -- for giving injections, for preparing and administering injectables.

Q Right. But those techniques have evolved.

A No.

Q Well, in the late '90s, in these articles I've read, in the late '90s, 1990s, you still had between 20 and 35 percent of the practitioners believing you could multi-use a needles and syringe on multiple patients if you change the needle.

A I know. It's unbelievable, isn't it?

Q Right. And -- and what were the standards then?

A The standards have been the same all this time. I cannot -- the standards -- aseptic technique is not something that has evolved over time. Although, obviously, disinfection and sterilization techniques have changed, the term and what it implies, asepsis, you know --

Q Clean.

A -- has not changed. Okay. So the fact that they believe that by changing the needle they are maintaining

a sterile connection, I don't under -- I have no idea why they believe that.

Q Well, who in the CDC -- I mean, you keep putting out -- I'm talking not you --

A It's okay.

Q -- but the CDC --

A I'm used to it.

Q -- puts out these common myths, puts out posters on misperceptions, and -- and keeps trying to drive this in to the practitioners, and it still persists. And so who is studying the why it doesn't trickle in to the perception of the practitioners? I mean, something is wrong in the teaching, something is wrong in the delivery of the message. I mean, I can't believe that like -- I'll show you a study where 28 percent of the --

A I saw the --

Q -- practitioners --

A -- same study --

Q -- still believed it was okay to reuse needle and syringe on -- on the same patient. All I'm doing is reusing needle and syringe on same patient, and then threw it away. 28 percent of the practitioners.

A Actually, you can do that. You can reuse a needle and syringe on the same patient.

Q Not CDC. We heard best practices was you go

in, you use it once, once, once, and it's gone. That's what we heard here from Dr. Fischer and -- and Dr. Schaefer.

A Once only.

Q Okay.

A It all -- it's a package. It's not -- you're isolating the events. They're referring to a package. They are trying to drive home a point or a practice and they're trying to make it simplistic. And, you know, I'm -- what we used to say, and still do, is you have two choices. You can either keep your -- if you want to use a multiple-dose vial on multiple -- on more than one patient, or a single-use vial, whatever, you better keep it separate from the treatment area so that people cannot go back into it with a used syringe or needle. You keep it separate in a centralized medication area. What, they're going to walk out of the room to get another dose? I don't think so. So -- or you don't reuse. That's the bottom line and has been for -- since the -- well --

Q Okay.

A -- since I came to CDC. So we've been pushing this home and dialysis centers forever. And the only -- that is one area where I do know, or I can speculate, rather, why staff are not carrying out appropriate infection control practices that have been recommended since the 1970s.

Because there -- the cohort of personnel who were

there in the '70s, '60s and '70s and early '80s who saw all these transmission episodes that are now being -- that were then prevented by good infection control practices, as well as a little vaccine, have never seen an outbreak because they were prevented. So they don't understand the need for some of these recommendations that are made for that specific setting, okay, which are very -- much more extreme than for other settings.

And that was the only -- I mean, they just are -- it's like parents who don't want to vaccinate their children against childhood diseases. They have never seen a case of polio or a case of measles and don't know how severe it can be. And, therefore, they would -- you know, they can't appreciate what vaccines to, you know, for the population. It's somewhat of a familiarity. On the other hand, would you operate with an unsterile -- well, yes, actually, I've seen that, too.

Q Okay. Well, I get --

A I've seen that, too.

Q I understand.

A Where a surgeon thinks that if he washes it in the sink, his instrument, with soap and water, he can use it on the next patient because it's his instrument and he's very attached to it, he/she. So I -- it's -- I can't explain why it doesn't get through.

Q But -- but -- maybe I'm Pollyanna-ish, but I just don't think 28 percent of the healthcare providers in this one study appreciated the risk. I mean, I misstated that. 28 percent of them, I think, misapprehended, misunderstood the behavior they were engaging in, as opposed to 28 percent of them were just saying hell with it, I don't care if I'm going to harm someone.

A That I can't say. I have -- I don't know the rationale for reusing. I just know that they did. When they surveyed outpatient surgical centers, 28 percent were reusing.

Q It was shocking.

THE COURT: Can I see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ma'am, we're not going to finish with your testimony at a reasonable time before lunch.

So, ladies and gentlemen, we'll just go ahead and take our lunch break now. We'll be in recess for the lunch break until 1:30.

During the lunch recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Do not do any independent research by way of the Internet or any other medium. And please do not form or express an opinion on the

trial.

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

(Court recessed at 12:22 p.m., until 1:34 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session. And, Mr. Wright, you may resume your cross-examination.

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q Doctor, one of the articles you forwarded, U.S. Outbreak Investigations Highlight the Need for Safe Injection Practices and Basic Infection Control. In -- in talking about the practitioners continuing to utilize single-dose vials as multi-dose vials despite best practices recommendations, what -- I'm going to read you a portion of this article and then ask you if you agree with it. Okay?

Transmission potential is magnified when facilities use vials or bags of medication and infusates that contain quantities in excess of those needed for -- for routine single patient use. Although these medications are often labeled as single use, i.e., single dose, the large volume in the container may lead to the perception that they are suitable for multi patient use. Do you agree with that?

A Yes.

Q Okay. And that -- that was a long -- I'm not sure of the infusates and all of the words there, but when it comes in a big package, like 50 cc and it's utilized in an outpatient setting where you normally use 10 to 20 ccs for a procedure, having that big vial invites the belief that you can use it for more than one patient; is that fair?

A The belief? I don't know if I agree with that, or rather misperception.

Q Okay. The misperception that it can. And in this case, the evidence that has been introduced thus far was that 20 cc vials of propofol were initially being purchased, and then the purchase person, a fellow named Jeffery Krueger, the charge nurse, talked to a Baxter representative who said, hey, we have 50s, do you want some of those. Okay? And 50s were then introduced to the clinic. Had -- had that not happened and they just kept with 20s, that would have decreased the opportunity for something like this to happen?

A If 20 milliliter vials were used up on a single patient, then the opportunity for contamination of the vial for the next patient would not be there.

Q Okay. And I think, as you made clear this morning, if I just stuck to using one vial per patient and throwing it away, or if I just stuck to using one needle and one syringe one time, either of those -- this -- this type of transmission wouldn't occur; correct?

A Likely not.

Q Okay.

A Correct.

Q Okay. Most likely this -- this type --

A Yes.

Q -- of transmission. And you, I think, agreed that using the same needle and syringe to redose the same patient for propofol would be okay as long as that propofol vial is then thrown out?

A That's correct.

Q Okay. Now, is part of the confusion that continues to manifest itself by lack of following best practices in the practitioners, is part of the confusion due to the varying definitions of single patient use, single use and single-dose vials?

A No.

Q No?

A I don't believe so.

Q Okay.

A In my opinion it's not the vial that's the problem. The vial -- we're human. Sometimes we actually make policies because we're human. And so we might go a little further with our policy in order to prevent human error, okay, from affecting a particular procedure --

Q Okay.

A -- knowing that we're human. So it isn't the fact that the vial -- this would still have happened even if the vial was labeled multi-use given their other practices.

Q Correct.

A Okay.

Q I mean, but -- I'm with that. The -- I mean, because if you had simply tossed the vials at the end of each use for a patient, no problem. If I had reused syringes on every patient and tossed the vials, no problem; right?

A That's correct.

Q And if -- if I use the vials as a multi-dose vial, despite what it says on it, and I used a new needle and syringe every single time I entered it, every single time I dosed a patient, no problem; correct?

A As long as there wasn't blood splatter, yes.

Q Right. I'm just giving it a -- okay.

A Yeah. All things being equal, yes.

Q Okay. And the -- my -- I'm -- I'm more confused about the interchangeability of calling a vial single dose, single use, and single patient use. Okay?

A Uh-huh.

Q And maybe I'm too literal and I'm not a healthcare practitioner, but I -- I read something and I see distinctions between a dose and a patient use. Do you?

A No.

Q Okay. Well, see, I do. When I think of something as a single dose, to be used once, that means I take it -- I take out a dose, I throw it away, and I use it. And if the patient needs another one, I get out another one for another dose. Am I wrong?

A You're interpretation, yes, is incorrect.

Q Okay. Okay. Because dose and use are synonymous --

A In this instance.

Q -- in CDC land?

A Yeah, in -- no, in medicine In this instance in medicine. Remember, the FDA approved this packaging.

Q For good or bad.

A I'm just pointing that out. I mean, they approved the wording that is on these kinds of pharmaceuticals. So I'm just telling you what we -- that's -- that's the interpretation.

Q Okay. Because I'm going to show you an exhibit. But now maybe it'll make sense since a use is the same as a dose. Do you recognize that?

A No.

Q Okay.

A I mean -- I mean, I haven't been on the website recently to look at their recommendations.

Q Okay.

MS. WECKERLY: I get what you're saying on some of the counts. She just testified the claim would have been less if the units were less. That's true on insurance fraud. I get what the Court's -- I'm not conceding it -- I get what the Court's theory is on the flat rate.

THE COURT: Here's the deal, Ms. Weckerly. That's all well and true for some of these where it's a unit by unit. On some of these where it's rounded down and stuff like that, you may have a problem showing it exceeded what they would have been paid. But that's up to the defense to figure it out. I'm not going to sit here with my abacus trying to work all that out. But on some of this, like I said, if it's unit, you know, if you've got a clear 12 units and they're billed 12 minutes and that's one unit and they're billing two or three units, amount doesn't matter, it's more. If it's one of these round down, round up, there may be an issue there that it is more. So again, just pointing that out.

MR. SANTACROCE: Back to the issue, what are we doing with her testimony?

THE COURT: Well, I'm thinking about it. Anything else you want to say?

MR. SANTACROCE: No.

MS. WECKERLY: Just on an unrelated matter. We need a ruling on the bad acts because otherwise we've got to --

THE COURT: Oh, right. There's still the one bad

acts out there.

MR. STAUDAHER: The one witness, yes.

THE COURT: Yeah, the one, the complaints. I mean, here's the thing on that. You know, I think, again, it's -- obviously, anything going to the merits of the complaint is hearsay, is completely inadmissible. The only thing is the relevancy of the notice as to the somewhat shoddy procedure. Balancing it, the prejudicial value I think is quite high. I think the probative value is relatively low and is duplicative of everything that we've heard. There's been abundant evidence of Dr. Desai's a cheapskate and they don't want to spend money on supplies and he's indifferent to the concerns of his patient to the point of actually being callous. There's abundant evidence of that.

So to me, this goes to all of that type of evidence, not to the real critical issues here which is what did he know about the syringes, what directions did he give on reusing the syringes and was, in fact, that the manner of transmission, particularly as it concerns Mr. Lakeman. That's the critical issue here.

In terms of all of the other, the insurance fraud, I think the motivation is greed and the issue of the complaints and the notice has nothing to do with that issue, insurance fraud theft. So it's totally irrelevant there and it's only relevant on the criminal neglect and the issues. I think it's

extremely prejudicial and the probative value is duplicative of everything else we've already heard which is somewhat tangential to the real issue here is was the reuse of the syringes encouraged, directed, mandated, something like that. Which could have even been mandated by the shortage of supplies. I mean, it doesn't have to be you do it. If you've got five people and one syringe, you know, you're going to have to reuse them.

Doing the weighing analysis, I just don't -- I just don't see that, coupled with the hearsay issue which I think we would have to -- I would try certainly to limit it. But the risk of hearsay coming in, allegations that weren't supported or substantiated, I think is too dangerous. So that's where we are.

I'm taking the -- again, typically, you're not going to strike the testimony just because it was weak testimony or it was incomplete testimony or it was inconclusive testimony. As we all know, that's not the typical remedy for the witness. You just argue that later. I recognize Mr. Santacroce, there's a little more prejudice here because the jury, unlike another witness, like a percipient witness of a street crime or something like that, the jury may not understand how to really evaluate that testimony and that's my concern. They're not going to know that there should be backup and how this is all supposed to come in. So I'll consider that further,

although I'm unlikely to strike it. But I understand that that's the danger of it, that the jury won't be able to evaluate it because you need some kind of --

MR. SANTACROCE: Or evaluate it incorrectly.

THE COURT: Well, what I meant was they won't know how to question it or they won't see what's missing. That would be -- anything else?

MR. WRIGHT: A separate matter. I'm subpoenaing Nia Killebrew for the amount the Meanas received insurance wise.

THE COURT: Okay.

MR. WRIGHT: So I'm going to tell her -- I don't know what the amount is. I'm going to ask her if she'll give us the amount if the State won't --

THE COURT: Perhaps we could just do that by way of stipulation.

MS. WECKERLY: We can do that by stipulation. We can find that out.

MR. WRIGHT: I'll find out and she may --

THE COURT: Yeah. Why don't we just do a stipulation --

MR. WRIGHT: -- need to --

THE COURT: -- and stipulate that the Meana family received blah, blah, blah.

MS. WECKERLY: I think she's gone Friday anyway, so we could -- we can just find out and stipulate.

MR. WRIGHT: Okay.

THE COURT: And that could be done at any time.

MR. WRIGHT: Okay. Well, I just was going to tell you it's a little bit -- I -- who else is coming in? His wife?

MR. STAUDAHER: No.

MS. WECKERLY: Oh, no. That's it.

THE COURT: That's it.

MR. WRIGHT: Oh, okay. Right. I mean, I thought that was it and so that's why I was -- I'll get it from Nia. She may need to come over and get an order that she has to do it.

THE COURT: Yeah. She's going to have to get the order that she can disclose it. But then there's no reason to call her as a witness.

MS. WECKERLY: Unless you want to.

MR. STAUDAHER: We'll stipulate to that.

MS. WECKERLY: If you've got a lot of questions.

THE COURT: Yeah, I mean, it should be a stipulation. I'm sure she's very busy counting her money at her beach house in Newport, which I think she actually had before all of this. She's been successful for years.

MS. WECKERLY: We'll find a way to get the information and then we'll stipulate to have her disclose it to the Court.

THE COURT: You know, if she's comfortable with it to save her a trip, I'm happy -- I could do it by way of written order or she could come over and however, either way.

MR. STAUDAHER: Could the Court do it telephonically?

THE COURT: Sure. If she's willing to accept that, you know, she can call in and I'll just tell her. I mean, we'll do it on the record like with Court Call or something. That would work as well.

MR. WRIGHT: Very good.

(Court recessed for the evening at 3:08 p.m.)

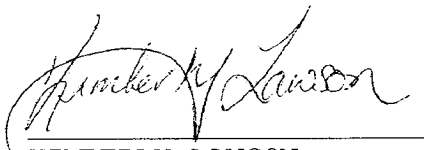
CERTIFICATION

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

Electronically Filed
03/11/2014 01:22:37 PM

CLERK OF THE COURT

TRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	)	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 40

THURSDAY, JUNE 20, 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.
Also Present Telephonically:	NIA KILLEBREW, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

I N D E X

WITNESSES FOR THE STATE:

E X H I B I T S

LAS VEGAS, NEVADA, THURSDAY, JUNE 20, 2013, 9:14 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: All right. I just wanted to go on the record out of the presence of the jury. We're still waiting for a couple of late arriving jurors.

On Mr. Santacroce's motion to strike the testimony of the last witness, that is denied. While the Court is concerned about the fact the State isn't proving up the numbers, I don't think striking the testimony is the remedy. I think the remedy is for defense to point that out in their argument that the, you know, testimony may be incomplete or inaccurate or confused or whatever it is you want to argue.

I don't think the remedy is for the Court to evaluate the testimony and then step in and say because I don't, you know, agree with the way the State presented it that it should be stricken. So that motion is denied, and I would remind the State, who is not listening --

MS. WECKERLY: No, I'm listening.

THE COURT: -- that, you know, basically you need to confine your arguments to what the testimony actually was, and in your closing arguments to be very mindful of what the testimony was and not deviate from that. So that's all I'll -- my only comment on that. But the motion, the joint motion to strike the testimony is denied.

MR. STAUDAHER: And just for the Court, also based on the issue of whether they're -- that document that was attached that she testified to was part of the record. We actually are -- have a photocopy of a .pdf version. We'll have the actual version of a COR production from the company with that document attached as -- as being part of it that we will move to admit to allay that issue.

THE COURT: Okay. And then since it's a .pdf version, can you just email that to the other side so they can --

MR. STAUDAHER: I think I did already.

MS. STANISH: Yeah, we received some --

THE COURT: Okay. So you already got that? Okay.

MR. STAUDAHER: The actual hard copy is following. It should be here this afternoon --

THE COURT: Okay.

MR. STAUDAHER: -- or tomorrow. I've got the .pdf now, but I'm -- if -- I'm going to wait to see if we get the actual hard copy by tomorrow to go ahead and -- go ahead and make that as part of the evidence.

THE COURT: Okay. And then I think that was the only pending legal issue. Okay. And then as soon as all the jurors get here, we can get started.

(Court recessed at 9:17 a.m., until 9:24 a.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the deputy district attorneys, the presence the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

And the State may call its next witness.

MR. STAUDAHER: The State calls Miriam Alter to the stand, Your Honor.

THE COURT: All right.

MIRIAM J. ALTER, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Miriam J. Alter; M-I-R-I-A-M, middle initial J, last name Alter, A-L-T-E-R.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Dr. Alter, what kind of a doctor are you?

A I have a PhD in infectious disease epidemiology.

Q And can you give is a little bit about your background and training in that area? Tell us where you went to school, what you've done, that kind of thing.

A Okay. Actually, my original degree was Bachelor of Science in nursing from the University of Pennsylvania in 1971. And then went on, actually, to do

infection control in hospitals. Went to Johns Hopkins University for my master of public health and PhD in infectious disease epidemiology, and then went to work for the Centers for Disease Control and Prevention in Atlanta, where I worked for 25 years in the division of viral hepatitis. And as an epidemiologist, that meant investigating epidemics, which is, you know, just the term for the -- the formal definition basically.

Q Well, let's go -- let's go back to the CDC involvement. So when do you actually go to the CDC?

A In 1981.

Q And you said you were there for --

A 25 years.

Q -- 25 years? And it's going to be really hard if we talk over each other, so -- because we have to record this.

A Thank you.

Q If you let me finish my question, I'll try to let you finish --

A No --

Q -- your answer.

A -- it's okay.

Q Okay?

A Sorry.

Q As we go forward, this time that you said you

were in the area of viral hepatitis, did you say?

A Yes.

Q Was that for the entire 25 years, or --

A Yes.

Q So you -- I mean, that was your whole area the entire time?

A Yes. There are --

Q Go ahead.

A Yes.

Q You started to say there --

THE COURT: I'm sorry. Was that yes?

THE WITNESS: There are -- it is -- there are five different types of known hepatitis viruses. They're transmitted in different ways, they have different risk factors, so it's like being involved in five different -- completely different diseases. And their transmission patterns and their public health interventions are also completely different. And there was technology that evolved during the -- all that time that provided a lot of variation in your day to day activities, so it doesn't -- it wasn't boring at all.

BY MR. STAUDAHER:

Q You said five different areas within that? Five different viruses; is that right?

A Yes.

Q Okay. So can you describe for us the differences? And then you said they had different transmission patterns, can you tell us about that?

A You're probably familiar with the term hepatitis A, hepatitis B, hepatitis C, you might also have heard of hepatitis D and hepatitis E. And hepatitis is just a non-specific term for inflammation of the liver. And you can have an inflamed liver for many reasons that have nothing to do with infection. You drink too much, you jogged that day, a variety of medications can have a side effect that can infect your liver because your liver detoxifies almost everything that you take into your body. So it's a filter. It's a big filter.

And if you have too much of something that is toxic to your body, then the liver can react adversely and it produces chemicals in your blood stream which show that you have liver inflammation or liver disease. And all of these things cause the same symptoms and some of the laboratory test results will be the same. But for infections with these viruses, even though they're all called hepatitis viruses, that's because they all inflame the target organ. Where they go when they first enter the body is to the liver, and that's where they replicate and grow and multiply and then get released into your blood stream. That's it's only commonality.

So hepatitis A as you're probably familiar with is very common among young children. It's due to poor hygiene. The route is actually fecal oral, eating contaminated foods, that type of thing, changing diapered children without washing your hands.

Q So hepatitis A is not a blood-borne type of --

A It can be under very unusual circumstances, but it has a very short period in which the virus is in the blood, so it's unusual. The circumstances under which it's transmitted by blood are unusual and are not part -- are not common -- commonly -- common in the hospital, in the healthcare setting.

Q So hepatitis E, if I under -- or, excuse me, A, as I understand it that would be -- the transmission route would be fecal oral from contaminated food and the like, is that fair?

A Right. You know, and particularly among contacts in the household where, you know, someone is preparing the meals and, you know, food can get contaminated.

Q So what is the next one?

A Hepatitis B and hepatitis C are both blood-borne viruses. They're completely different viruses. In fact, all these viruses are completely different. They're only commonality being the term hepatitis. And they're both transmitted by the blood-borne route, which means that virus

from the blood of one person goes -- if it gains entrance into the blood stream of another person, it can cause infection. This occurs through breaks in your normal barrier, mucus membrane or skin barriers.

So this can happen by, before screening, blood transfusions, injections, contaminated injections both from illegal as well legal drug use, sex are the primary modes of transmission. Now, for hepatitis B, actually, sex is one of the biggest risk factors even though it's a blood-borne virus. And for hepatitis C, direct blood to blood is the most common method, although it is transmitted sexually, as well.

Q Is that a lesser component, though, of transmission?

A Yes. For C, yes, it is.

Q Now, you mentioned the other ones. I think you said D and E, also. What is -- what are they?

A Hepatitis D and hepatitis E, again, two entirely different viruses. Hepatitis D is actually -- is -- is not as common in the United States, and it's also a blood-borne and sexually transmitted virus. But it's got a problem in its genetic code, and it can only be transmitted along with hepatitis B. So -- but it's not that common. So it has the same transmission modes.

Hepatitis E has the same transmission mode as A -- see, I told you it was not a boring career -- in that it's

transmitted by the fecal oral route. But it's rarely seen in the United States and other western type countries. It's more common in countries that have poor -- really poor sanitation and monsoon rains that then swell the rivers and you've got a lot of refugee camps and the rivers -- the drinking water is downstream from the latrines and you see the point. So they become contaminated and you get large outbreaks.

Q I'm going to focus primarily on the hepatitis C aspect of things, maybe B if it -- if it's germane to whatever you need to tell us. But you had mentioned that you did over this 25 year period outbreak investigation; is that -- is that correct?

A Yes, that is correct.

Q Can you tell us what that means and how you typically go through when you get a call, or how -- how does it happen? How does it work?

A Being a federal agency, the Centers for Disease Control and Prevention has to be invited by the state health department to come into the state and investigate whatever it is the state thinks is a problem, unless, of course, those rules are suspended in an emergency. But other than that we usually receive a call from the state or county health department telling us they think they have a problem and they'll describe it to us, and we -- and -- and then after usually a few discussions they will invite us in.

And so several -- usually several people from the division that's appropriate for that disease will -- who have been trained in epidemic investigations will go to the state and assist the state and local health departments in the investigation. So you want to confirm that, in fact, they have an outbreak. You want to confirm what the outbreak is due to, in other words you want to confirm the case, the case diagnosis and -- before going any further.

Q And before I go any further, I neglected to ask you are you still working at the Center for Disease Control?

A No, I am not.

Q Where is -- are you still working at all at this point? And when I say that as in an academic or any other setting?

A I retired from CDC in 2006 and went to the University of Texas medical branch in Galveston as the Robert E. Shope professorship in infectious disease epidemiology.

Q And you were there until what year?

A The end of 2011.

Q And then did you completely retire, at least from that aspect of your career?

A From the -- well, I still teach. I'm an adjunct professor. I teach, I consult, help people with study design and making sure that -- you know, helping them with

their methods for researching any kind of disease, which is what epidemiology is. And -- and I also do a little private consulting.

Q In this particular instance, I mean, were you asked to consult regarding an outbreak that here occurred locally?

A Yes.

Q And we'll get to that in a moment, but I want to go back to the -- the beginning, the --

A Right.

Q -- outbreak investigation that we started with, you know, the process that you go through. You said that one of the things that you do is -- I mean, you being the CDC, and I'm having you wear that hat for the moment, if you would. When you get the information and you decide if you're -- what you're going to do to help the state that's asking for your assistance, you mentioned that you had to do some sort of confirmation or confirmatory testing. Can you describe what that is?

A Well, in this particular instance?

Q Well --

A Or in any --

Q -- in general.

A -- instance?

Q For hepatitis C, let's say.

A Actually, in any instance you would want to make sure that the test results were consistent with the diagnosis that you were being told these people had. So you either rely on a formal laboratory report from local health departments, or from the local laboratories, whoever did the testing, as well as usually, if you have time, asking them to send samples to the CDC so the CDC can begin its own testing, just in case additional testing is required.

Q So what kind of testing would the CDC do over and above whatever was done locally?

A Well, that depends on what was done locally. But for hepatitis C, often the screening antibody test is the only test that can -- may be done initially. And that test needs to be confirmed that it's actually real and not a false positive. And then you want to go on to determine whether or not that person continued to -- had recovered or continued to circulate virus in their blood.

Q Do you ever do any kind of genetic sequencing and matching to try and see if you can source the patient, so to speak?

A We do, yes. We often are called upon to do genetic sequencing to determine the relatedness of viruses from different patients. Under those circumstances -- under most circumstances we only do that -- see, I still talk like I work at CDC -- we only do that if an investigation is also

being carried out.

Q Assuming an investigation is being carried out, I know we kind of jumped the gun with that a little bit.

A No, that's okay.

Q But assuming that has occurred and the testing -- you've confirmed whatever you needed to confirm at that level, now we're onto the genetic sequencing. What kind of information are you trying to get out of that kind of work?

A That's really -- you really -- you want to jump that -- because you wouldn't -- you want to jump that far? Q Then let -- then let's back up, then. I don't want to jump that far.

A Okay.

Q So let's go back to the investigation stage and let's pick up where we left off and you continue on.

A Okay. So -- so we arrive, you know, and we look at the information about the cases that they already know about. And then we try and identify additional cases from a variety of sources. In this particular disease, many people don't show any symptoms initially. So it's really hard. So you may not get a lot of clinical case reports, but there may be some that were overlooked. And you -- so you'll do a variety of surveillance over on different day to day basis or by surveying physicians most likely to see people with hepatitis and determine if there are additional individuals.

Most importantly, however, you then interview or at least review the records of these patients to determine their characteristics. What is it about them that might be common? Are they -- you know, this is the first thing you want to do. You want to find out everything you can just about the cases you know about because that will allow you to generate hypotheses that you can then test with your studies, with the study you're going to end up performing.

Q Okay. So you -- you go through that process.

A Right.

Q What would be the next logical step, then?

A Well, then because of the disease being non -- subclinical in a lot of cases, meaning people don't have any symptoms, they -- we would -- if we can focus in, in this instance you can usually -- you can focus in on two days, one a date in September and a date in July.

And so you then want to test all the patients who had procedures around that area to see if you can identify additional infections. Which the more cases you have, the more you have to analyze, the more robust, in essence, your analysis is, not with respect to the laboratory sequencing, but with the epidemiological analysis. And I'll explain that.

So we would go and focus in on what we think might be the exposure period and what was common to the patients, in this case it was those two days, and attempt to identify the

infection status of all the patients before, during, after to see if we could identify additional infections.

Q Okay. And once you start going through that process?

A After we've done that, and you never get everybody, after you do that then you start looking at the -- in this case since the only common factor among the original cases was -- were their procedures at this particular clinic, you're going to look at the clinic and what all of those patients had in common during their procedures while they were at the clinic.

And you -- and then you start thinking about, well, what exposures would cause blood-borne transmission? Remember, blood has to get into the blood stream of a susceptible individual. So it has to -- there are only certain ways that can happen. So it has to get through your natural barriers of skin or mucous membrane.

And so you start generate -- so you then -- you look at all the clinic's procedures and you observe the procedures that might be an issue or different exposures that might -- and you go through everything written, procedures, you interview the staff, you interview the patients, and you observe and you read the -- yeah, and you observe. And then that helps you focus your formal study, which will compare infected patients with uninfected patients to see what was

different. And that -- that's the essence of epidemiological methods. And can I give an example that might be --

Q Sure.

A A new drug, someone is developing a new drug to treat diabetes, let's say. So in order for the drug to be licensed by the FDA, they have to test it to make sure that it works and that it's safe. But let's just go to the work part. In order -- they need to show that if they treat people with diabetes with this drug they get better more often than if they're not treated with that drug, okay. But it's never 100 percent. I mean, in other words, no drug is 100 percent effective.

So let's say they treat people with a certain type of diabetes with this drug and 60 percent get better. But of the people who weren't treated with the drug, only 10 percent got better. Well, that's a pretty big gap. And, you know, it's a very simple explanation, but you can -- you know, that's in the news all the time about -- nothing is ever 100 percent is the point.

And so you can see that the drug actually did have an effect, even though -- on people who took it versus people who didn't with the same disease. So that's an example of what you are doing here. You are comparing the types of exposures patients who got infected with had versus patients who didn't get infected. What's different?

Q So what kinds of things in a -- and you know the setting that we're talking about.

A Yes.

Q An endoscopy clinic, outpatient setting, patients having basically two types --

A Right.

Q -- of procedures.

A So obviously you're going to look at the date of the procedure, you're going to look at the timing of the procedure compared with everything you know about the infection status of the patients who had the procedures during the time period of interest. You're going to look at specific procedures such as the type of procedure they had, what scope was used, what the -- what medications they received, how they received them, and the process of giving them the medications. You'll look at the staff members who were assigned to those individuals. You'll look at the timing of the cases relative to the potential source patient because presumably you had to have a source patient, someone who was infected in order to serve as a source for transmission to other patients.

Q Along those lines, I mean, do you -- when you look at various things related to -- and let's -- let's talk about an endoscopy clinic type thing, what types of things would you look at as possible modes of transmission in that setting?

A Well, the first thing people look at are the scopes themselves to see if they've been properly disinfected between patients. And -- as well as what type of procedure the person had. Because if you have an upper GI versus a lower GI, they're two different scopes. So someone who gets a colonoscopy has a scope that's completely different from someone who gets an upper -- an upper GI. So even if the records were not accurate, you would know that the same scope was not used. Plus, it requires time to perform high-level disinfection on each of the scopes that are used.

So basically the first thing you would do besides looking at the procedure for disinfect -- cleaning and disinfection of each scope is what procedures the patients had and compare the frequency, let's say, of colonoscopy in the infected patients versus the frequency with which uninfected patients had that procedure, the frequency of biopsy in the infected patients versus the frequency of biopsy in the control patients, and whatever else is involved, let's say, in -- you know, that might be unique to these procedures.

And what you're looking for is a -- well, when I say a statistically -- a statistical, significant -- significant statistical difference between the frequency in the infected and the frequency in the uninfected to point you in the right direction, point you in the direction of where the contamination might have originated.

In this situation it was not the scopes because the frequency of procedures, the different procedures were not different between infected patients and uninfected patients.

MR. SANTACROCE: Objection as to that conclusion. If she's making a personal opinion, that's fine. But if she's making a definitive statement as to the legal conclusion, I object to that.

THE COURT: All right. Well, I think it's clear it's her opinion as to --

MR. STAUDAHER: Yes.

THE COURT: -- based on reviewing the records. Correct?

THE WITNESS: That's correct.

THE COURT: Okay.

BY MR. STAUDAHER:

Q And you're not here to make legal conclusions; correct?

A No, I'm here for science --

Q So you're just going to --

A -- and medicine.

Q -- tell us what you know based on your analysis and 25 years of doing this --

A Yes.

Q -- is that fair? Okay.

THE COURT: And, ladies and gentlemen, at the

conclusion of the trial when I give all of the instructions, there will be an instruction pertaining to this type of testimony, which will cover not only testimony you've heard from this witness, but, you know, other witnesses that we've heard through the course of the trial. And it will describe -- I'm not going to paraphrase the instruction because I get in trouble for doing that, or could get in trouble.

So, Mr. Staudaher, go on.

MR. STAUDAHER: Thank you.

BY MR. STAUDAHER:

Q So at least your opinion based on the issue of the scopes was that it was not the scopes in this case?

A From an epidemiological point of view, it was not the scopes.

Q Now, there were other areas. You mentioned biopsy forceps, things like that.

A There was no difference in the frequency with which the patients who were infected got biopsies compared with patients who were not infected. Now, often an overall comparison like that might not show you -- might not show anything. And based on observations and information that you get while you're there, you might say to yourself, well, I don't know, I don't feel like I've looked at this sufficiently and you might then want to, you know, cut it down into different categories like that morning, that afternoon, or the

next day, or by a certain person, you know, to see if these procedures, for example, either the scope or the biopsy had any relationship to the infections on a smaller scale or a different scale just to make sure that you've covered your bases.

Q Okay. Did you see anything along those lines that cause you concern?

A No.

Q So at least from that perspective the same analysis for the scopes and the snares, did that, is it fair to say, eliminated those as --

A Yes.

Q -- transmission possibilities?

A Yes.

Q What about the issue of cleaning? What if it was not what was believed to be the case?

A Well, despite -- even though they did cite some -- some small, minor deficiencies, their high-level -- their cleaning and disinfection of the scopes was according -- was very strictly followed.

Q So --

MR. SANTACROCE: I'm sorry. I didn't hear that. Very strictly what?

THE WITNESS: Followed.

MR. SANTACROCE: Followed.

BY MR. STAUDAHER:

Q According to the records and so forth that you reviewed; right?

A Yes.

Q What if that had not been the case? What if the scope cleaning had been less than, well --

A Optimal?

Q Optimal. That's a good word.

A Well, one, you would have made them change, and, two, you would have -- you're looking at it, but still you'd have to consider the epidemiological -- see, to me, that's very -- epidemiology is a very powerful tool all by itself. And if it's done right, when you can make that comparison of patient, the frequency of a procedure in -- in the infected patients versus those who didn't get infected and you see absolutely no difference, then even though disinfection may not have been ideal, you've got to look elsewhere. You have to look elsewhere for other types of exposures. And, in fact, I don't think we've ever had an actual outbreak related to -- of a blood-borne virus related to the scope itself.

Q Let me talk to you about the --

A At least hepatitis C anyway.

Q Since you've done this for -- for quite some time, are you familiar with the literature in the area?

A Yes.

Q And when I say that, I mean records of and reports of infections across the United States.

A Yes.

Q For many years?

A Yes.

Q Have you actually been involved in outbreak investigations pertaining to endoscopy type clinics or centers or transmissions in that setting?

A Yes.

Q Have you done a number of them in that regard?

A Yes.

Q Now, as far as the investigation, I mean, I imagine that over the 25 years that you were there that your role at least in the process maybe changed a little bit, supervisor, actually in the trenches, that kind of thing, is that fair?

A That's fair.

Q Did you actually go out and do investigative work at some stage of your career?

A Yes. Early in my career, which is true for everybody at CDC, you get to go out and actually do the investigations. And as you remain at CDC and keep getting promoted, then you're in a supervisory capacity and on the phone usually every day with your what we call epidemic

intelligence service officers who are sent out, you know, who are the ones you're supervising who are actually onsite doing the investigations.

Q So what is the purpose of that interaction that you have with the people that were actually in the field once you're in that role as a supervisor?

A Well, presumably we know more than they do because they're young and we're not, and we have a lot of experience. And so we're making sure that they are getting all the information they should be getting, they're drawing the proper conclusions, they're doing the types of comparisons that they need to do, that they've covered all the bases that they need to cover at each step along the way because you don't want to have to go back.

Q So if you are -- if you have somebody even that's relatively new in the field, a year or less, whatever, and you're having communication with that person, I mean, how does that -- how does that work? What do they -- what kinds of things do they tell you and then what do you respond as far as follow up?

A If they're listening to me or not?

Q Well, I mean, is there a way to determine if they listened to you? Do you follow up --

A If they're listening to me --

Q --and say did --

A -- then they --

Q -- you do that?

A Well, hopefully they're, you know, on the right track. They'll be telling me -- first they're telling me all about the cases, and they're going to be telling me how they're going about identifying the steps that I described earlier. I want to hear that they've done all those -- they've gone through all those steps and what the results have been, okay. And so if anywhere along the way I think that they need to delve further, I will tell them to do that.

Q And then do you ask them in follow up what was the result of that?

A Absolutely. And then as they start to -- when they generate -- for example, then they're going to have to design a question of some type. So they'll send it to us, email is a wonderful thing, and we will look it over and offer suggestions. And probably they've taken some examples of questionnaires used in previous outbreaks with them, as well as publications of previous outbreaks to help them, you know, along the way, and they'll revise it and, you know, use that. And then we'll decide upon it together upon a method of study, how the study will be conducted to determine the source of the outbreak, the extent of the transmission, and what we need to do to prevent it, either prevent it from continuing or prevent it from occurring someplace else.

Q Whether you've been in situation where you're a supervisor or actually in the field doing the actual investigative work, do you -- as part of your epidemiologic investigation, do you ever have a situation where you see something that is -- you know, you've got your, I assume, your likely causes, or the possibilities anyway for a situation like we're talking about here, correct, as far as how it would actually occur?

A Right.

Q If you see one of those things in practice, you're out there and you see them do something like that, do you stop there, or do you continue to look at other things to make sure?

A You continue to look at everything that could possibly be a cause. And this actually has been an issue between supervisors and young investigators. Because the young investigator who hasn't completed their training in epidemiology will say, well, it's so obvious, you know, it was this or that. And we'll say, no, you have to do the study. You have to show definitively that it was this or at least, you know -- you have to show that it was likely this versus something else in order for your investigation to be useful.

Q Is that invariable in all cases that you go through that process?

A Yes.

Q Okay. Have you ever been involved in a case where you did not go through that process, you just shortchanged it and --

A Not at the CDC, no. Not when the CDC was involved onsite, no,

Q Now, as far as the literature that you described or that you said that you have at least been aware of over the years, I mean, are we talking about one, two, three studies? I mean, how many studies are we talking about?

A That I'm aware of, hundreds, but that I've been involved in, many. But, you know, since -- especially in the last decade, 10 to 15 years because they've been increasing in -- there's been an increased reporting of these episodes of transmission in outpatient healthcare settings. So it's many. I don't know how many, but many.

Q Does that have to do with anything related to whether testing was available back then versus now?

A I think -- I think that for hepatitis C it is -- there's an increased awareness, and also I think a health department that identifies a case that tests positive may be -- and the only -- and someone without traditional risk factors might be more likely to call us and say we have this case that might have had a healthcare exposure, but we don't know. Whereas, now that we have the ability to go in and test people so we can determine the extent of the problem as

opposed to relying on just clinical symptoms probably makes it more likely that they will report it or recognize it.

Q With regard to those studies, have -- and I'm talking about the -- not necessarily just the ones you've been involved with --

A Right.

Q -- but the hundreds of studies that you've -- you've looked at over the years, have a number of those been in areas involving colonoscopy, endoscopy, that kind of thing, in a -- in a setting where those kind of procedures are done?

A Yes, a number have been.

Q Have you been directly involved in any of those?

A Yes, I have. In fact, directly involved in the first one we ever investigated for hepatitis C.

Q Can you tell us about that one?

A That one occurred in New York City.

Q And the year, roughly, if you know?

A 2001.

Q Okay.

A And it was actually interesting because four people developed acute symptoms of hepatitis, symptoms of hepatitis and were actually hospitalized. And they were middle-aged people without traditional risk factors. And it just so happens that the gastroenterologist on call that

weekend was their gastroenterologist and he recognized that all four of them had had procedures at his -- in his practice, at his private practice. And so he called the health department and reported it. And that was the initiation of the investigation.

And what we found is that these four patients had procedures over a three-day period. It was actually about 48 hours, but a span of three days. And so we -- in order to look for more patients in addition to existing data, like surveillance, etcetera, we chose that week before, during, and after those three days to find as many patients as we could and test them to determine if we had any other infections.

And to make a long story short, we did find a source patient. Someone known to be chronically infected who had the first procedure of the day on the first of those three days. And we found -- and then we found that all of the patients who became infected, newly infected, followed that patient, but also over a 48-hour period. So they began on different days. They had their procedure on different days, but consecutively.

And after an intensive investigation in which we compared all types of exposures, including the scopes and the injection practices, the anesthesiology, the sedatives, we couldn't identify a difference, something that stuck. Everybody -- the procedures and writing were correct, the observation of personnel actually performing procedures was

correct. There were some problems with the high-level disinfection, but nothing that would -- everybody had a different procedure, particularly the source patient had a colonoscopy and the next infected patient -- next patient to become infected did not.

So, you know, there were a lot of -- they just -- there was not commonality. And because everyone gets sedation from, you know, the same sedation, you really can't -- you can't compare them with respect to that. And so on the last day that the team was there it was suggested to them that they might want to look at the purchasing records for needles and syringes for the anesthesiologists. And they did.

And they found that while the IV catheters, number of IV catheters coincided with the number of patients who had procedures, not one to one, but close, however, the number of needles ordered compared with the number of procedures didn't even come close. So there were like 600 needles, new, you know, sterile needles ordered that attach to syringes compared with, I don't know, over 2,000 procedures.

And since we know that patients got multiple doses of sedation during their procedure, they should have been using a sterile needle, especially because they had multiple dose vials. In this case it was a different type of sedative than the one involved here which actually comes in multiple dose vials, but the anesthesiologist had denied reusing

syringes and needles. Well, this suggested that, in fact, that was not true.

And when confronted with the purchasing information, the anesthesiologist admitted to reusing syringes and needles on one patient, discarding the syringe and -- and going back into a multi-dose vial with the same needle and syringe that he used to inject that one patient with subsequent dosages -- doses of sedative, and then that multi-dose vial was then used for the next patient, with a new sterile syringe and needle. But that vial was now contaminated, presumably contaminated. And it turns out that they had just switched to large vials of this particular sedative.

And we were able to show that if -- if a new vial had been opened on the day for the first patient who was the source of the outbreak, it would have let -- given the average dose that the patients received of this particular drug, would have lasted the 48 hours or over the three-day period that the patients became infected. And -- and the procedure was that these vials would be used if they were -- if they were not used up at the end of the day, they were kept for the next day.

So it was actually only that way that we were able to determine that in fact there were unsafe injection procedures being used in the clinic that put patients at risk of -- of transmission. It was the only thing we could

identify, and, it turns out, is a common problem. Much more common than we'd like to believe.

Q So when you looked at that, I mean, that's 2001. I mean, that information gets published, I assume?

A Yes.

Q Okay. So 2001, fast-forward to you and this case today, did you see similarities, striking similarities between the two cases?

A This -- these practices of reusing needles and syringes or even just syringes and contaminating vials that are then used on subsequent patients is -- has been the source of many outbreaks, and continue to be primarily, but not exclusively, in outpatient settings.

Q So in the studies you've looked at in outpatient settings, just so I'm clear, this issue of contaminated multi-use vial being used on the next patient kind of thing is something that has been reported multiple times --

A Right.

Q -- before?

A Yes, it has.

MR. SANTACROCE: I'm going to object. Asked and answered. Your Honor, can we approach?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: All right. Mr. Staudaher, please proceed.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q And I'm not even sure where we left off, but I'll try to pick up. I was -- at one point I was asking you about the various studies related to these types of clinics. Are you with me again?

A Yes.

Q This type of thing, the 2001 study that you mentioned, as well as your review of this particular case, are there other like outbreaks that have occurred with similar results?

A Yes.

Q Okay. And in the studies that you have looked at over the years, I think if I -- I just want to make sure the -- the scope issue that you mentioned, has that ever been shown to be a source of transmission in any of those?

A No.

Q What about some of the other items that were -- that were looked upon by the CDC as possible modes of transmission?

A No. The only -- other than an infected healthcare worker who was abusing narcotics and therefore contaminated a multi-dose vial of a narcotic by self injecting

and then contaminating the -- you know, using the contaminated needle and syringe so that it was the healthcare worker's virus that was transmitted from patient to patient. Other than that, all of them have been the result of what we now refer to as unsafe injection practices.

Q Can you describe for us what you -- what you view as an unsafe injection practice?

A Well, anything that enters the body through your normal barrier, skin or mucus membrane, should be sterile. You would expect to go into an operating room and everything that they use would be sterile if it was entering your body, and injections are no different. And so once a needle and syringe have been used to access your blood, whether it be through IV tubing or direct, you know, through a vaccine injection or something, it's now contaminated. It's no longer sterile.

So if you reuse it on the same patient with the same medication, that's fine. But if you reuse it and any part of that is used on another patient, you've broken the barrier of sterility and that next patient is exposed to a non-sterile product.

Q In the -- in the literature and training and so forth, and I'm talking about primarily here nurses, nurse anesthetists, things like that, are you familiar with the training that those individuals go through on that issue?

A Yes.

Q Can you tell us about that?

A Nursing, when you go to nursing school, no matter what school you go to, they actually have in textbooks and in practice a curriculum that specifically addresses the safe way to provide injections or injectable therapy, whether it be directly, you know, into your -- you know, like by vaccine or through an intravenous setup of some type, and they're very specific about the fact that these practices must be what we say must conform to aseptic technique. Aseptic meaning the lack of any contamination.

Q So is it fair to say that in that information that you've reviewed, the textbooks and the like, is that part of the basic training?

A Yes, it's part of basic nursing training.

Q With regard to that, even though there are outbreaks that have occurred over time, is that information continuing to be disseminated on each one of these outbreaks?

A Yes, the information continues to disseminated.

Q So not only in training. I mean, I'm talking about the textbook kind of thing.

A I must -- I may have misunderstood your question. When you say after the outbreak -- when we do the outbreak investigation, we then disseminate the information

that unsafe practices are being used and this is what you should do. But in a continuing medical education you mean? Like yearly --

Q Actually, the first part is what I was asking. After an outbreak --

A We publicize in various ways what it is that people are doing and what they -- what they're doing wrong and what they should be doing.

Q So I want to ask you about another outbreak, if you're familiar with it. In August of 2002 in Oklahoma there was another outbreak of hepatitis C related specifically to actions of a CRNA. Are you familiar with that?

A Yes.

Q Can you tell us about that?

A Is this the pain clinic or the oncology clinic?

Q If there's a document that you need to refresh your memory, I can provide it to you.

A Just -- yes, would you mind? I'm just like -- right now I just --

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: Sure.

MR. STAUDAHER: And, counsel, I'm showing the MMWR, Morbidity and Mortality Weekly Report, September 26, 2003, Volume 52, Number 38.

MR. WRIGHT: Thank you.

BY MR. STAUDAHER:

Q And this is page, I believe, 903 of that.

A Okay. It was the pain -- pain clinic.

Q If you -- if you need a moment to look at that you can do so and then I'd like to ask you a couple of questions.

A Oh, yes.

Q Okay. Can you tell me about this?

A In this instance the -- this was a pain remediation clinic where people go to get pain meds for chronic pain, like back pain and a variety of other maladies. And the individual providing -- who was providing the pain medication to these patients through a heparin lock, actually, which is -- you've probably already heard that described -- with a -- filled a large syringe with the pain medication, and then went from one patient to another with the same syringe and injected them with the appropriate amount.

I think the same needle, too. That I'd have to double check; regardless, from one patient to the next using the same syringe which was filled with the pain medication until it was empty. And they could trace the infections that were transmitted by virtue of who was there that day, what bed they occupied, etcetera.

Q So another unsafe injection practices

outbreak?

A Yes.

Q And in that same article, I can bring it up to you again if you need to, was there a dissemination of that information through the actual organization of CRNAs at that time?

A Yes.

Q I mean, nationwide dissemination?

A Yes.

Q Now, related specifically to some other articles that you may be familiar with, and the next article I want to ask you about is a entitled -- for counsel -- multiple clusters of hepatitis C virus infections associated with anesthesia for outpatient endoscopy procedures. And I think one of the officers is -- excuse me, authors, is a Bruce Gutelius?

A Uh-huh.

Q I don't know if I pronounced that correctly. Can you tell us what this is about?

A A case of acute hepatitis C was identified and, in fact, possibly more than one by the clinician, again, who noticed that the only commonality between the patients was procedures at this particular -- at actually two different gastroenterology practices. And when they did the investigation, actually, the transmission involved both

hepatitis B virus as well hepatitis C virus. So they had clusters in each clinic setting with both viruses.

And in this instance it was a similar scenario in which a -- they were reusing syringes, but needless. You know, they now have needless devices so that healthcare workers are protected from sticking themselves, essentially, and so you're only using the syringe.

And they put a vent -- they put a little spike in the multi-dose vial, although this might have been single-dose, but multi-dose vial and they stick the syringe in and then they pull out the medication and then they -- the IV may also be needless, in which you can inject just directly with the syringe. And the syringe was being reused on the same patient to get additional doses, and even though it was discarded and a new syringe used for the next patient, the vial was already contaminated from the source patient.

Q So -- and I've got the article here if you need to look at it. It appears as those propofol was the drug.

MR. WRIGHT: Where was that?

THE COURT: That is this article here.

MR. WRIGHT: Which -- no, I mean, which city?

THE WITNESS: New York City.

MR. WRIGHT: Okay. A different New York one?

THE WITNESS: Pardon?

MR. WRIGHT: A different New York one than the first one?

THE WITNESS: Yes, but a different one.

MR. WRIGHT: Thank you.

THE WITNESS: It occurred much more recently.

BY MR. STAUDAHER:

Q As a matter of fact, the date of this article is -- it looks like it was published in 2010, but it's talking about a report in 2007, March of 2007; is that correct?

A Yes.

Q And I don't want to -- if you need to look at it --

A No, it's -- usually there's quite a lag between.

Q Okay. So it's not unusual --

A But although, is that the -- no, you're looking at the actual publication. It was probably in an MMWR prior to that.

THE COURT: Why don't you show it to her so we can make sure --

THE WITNESS: Sorry.

THE COURT: -- that --

MR. STAUDAHER: It's okay.

THE COURT: -- it's correct.

THE WITNESS: No, that is -- those are the dates.

BY MR. STAUDAHER:

Q Okay. Yes.

A Yes, those are the dates of publication and when the outbreak occurred.

Q March of 2007 outbreak, publication 2010?

A Yes, in a peer reviewed journal.

Q Will you confirm that -- that it was propofol?

A Yes.

Q Yes, it was?

A Yes, it -- I'm sorry. I tend to be long winded, so I try and be short. Yes, it was a single patient use vial of propofol for multiple patients with reuse of syringes to re-dose patients.

Q So, again, some --

MR. SANTACROCE: I'm going to -- I need a clarification. If you're reading, I'd like to know what you're reading -- where you're reading from exactly.

THE WITNESS: Actually, right now I'm just reading from the abstract, but I just read this article again for the 10th time last night.

MR. SANTACROCE: Well, it appeared to me you were reading an answer from that document. If that is, in fact, the case I'd like to know which page.

THE WITNESS: Okay.

THE COURT: Is it the front page that --

IN THE SUPREME COURT OF THE STATE OF NEVADA

DIPAK KANTILAL DESAI, Appellant, vs. THE STATE OF NEVADA, Respondent.	)	CASE NO. 64591

APPELLANT'S APPENDIX VOLUME 35

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

INDEX TO APPENDIX VOLUMES 1 through 41

Electronically Filed
03/11/2014 01:20:57 PM

CLERK OF THE COURT

TRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 39

WEDNESDAY, JUNE 19, 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.

INDEX

WITNESSES FOR THE STATE:

EXHIBITS

LAS VEGAS, NEVADA, WEDNESDAY, JUNE 19, 2013, 10:31 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: You can proceed however you want on cross-examination.

MR. WRIGHT: Well, I thought she doesn't know any of this, they kept her in the dark.

MR. STAUDAHER: She doesn't know what transpired with them looking at the records or the discussions we had with the lawyers in here related to her. She doesn't have that information. Unless they want to -- we've tried to exclude that information from her, actually.

MR. WRIGHT: Well, presumably, since she's the knowledgeable person and knows everything about all the records, she'll know about this other contract, right?

MR. STAUDAHER: I don't know -- I can't make a representation of what she knows as far as the two different contracts or not. She has access to the records as part of her job, but they didn't apparently have that contract at the time. That's what she was tasked to go do was to get that record.

THE COURT: All right. Going forward this morning, here is what we will do. We'll put on the -- I'm assuming the Meana family witnesses. We'll look at the video. We'll go to lunch. You will provide the documents, State, as soon as you

get them to Mr. Wright. If there are questions that need to be asked before we go forward, defense and State can ask them of the witness together in the hallway or in the vestibule or whatever.

Mr. Wright, you can cross-examine the last witness however you want to cross-examine her. And if we need to bring her in out of the presence of the jury to sort out this confusion regarding what the lawyers said and what she said, we can do that off the record if you request us to do that, so that you have a better understanding going forward. We don't have to do that. I'm making that option available to you. Certainly, that doesn't aid the Court. I mean, that's just for the benefit of the attorneys.

Or if you want to do it more informally, you and Mr. Staudaher or Ms. Weckerly and Mr. Santacroce can just talk to her, as I said, in the hallway or in the vestibule or whatever you want to do. And then if you want to put it on the record with her, we can do that as well.

So I see those as the options going forward. Then if there seems to be some other issue, then we'll deal with that when that comes up. But that may be a way of figuring out what this dispute is before you have to blindly rush into cross-examination. I think those options are available to you if you choose to take them.

MR. WRIGHT: Okay. I just raised it right now so

that she could like -- it seems simple to me that she ought to have all the records, like all of the contracts since she's the records custodian, the person most knowledgeable for the company. So that's what I'm just putting it on notice. She ought to have all of these records instead of just what the District Attorney wants her to have.

MR. STAUDAHER: That's -- I think that's a misaccurate statement. It's not what the District Attorney wants her to have. The Court tasked her with getting certain documents. The company got certain documents. I'm going to go out there right now and provide those to her in addition to the ones that everybody has had and that she's testified to. So that's where we're at. That's not something that the State has skewed one way or the other, it's something that I think the Court directed to happen and we're just trying to --

THE COURT: Well, directed at the defendant's request. I mean, let's be clear. I'm not dictating what records people bring. Those records were ordered by the Court at the defendant's request.

MR. STAUDAHER: Now we're just trying to get those records to the witness.

MR. WRIGHT: I thought we were going to get a knowledgeable witness. She testified she wouldn't know how to apply it even if she had the records. That was her testimony.

MR. STAUDAHER: She did not have the records to look

at to see. If she has the records and now can do what she needs to do with the records as they are. The records are what they are, whatever they say. It has the conversion. If it has the information, it does. If it doesn't, it doesn't. So I just need to get them to her at this point so I can give her a chance to look at them.

THE COURT: All right. So, Mr. Staudaher, you're free to go hand her the records. Obviously, not to discuss them. And the bailiff will bring in the jury.

(Jury reconvened at 10:38 a.m.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the Deputy District Attorneys, the presence of the defendants and their counsel, the officers of the Court and the ladies and gentlemen of the jury.

Ladies and gentlemen, before we proceed with the cross-examination of the last witness from yesterday, the State is going to call some other witnesses and then we'll resume with the last witness sometime later in the day today.

State, call your next witness.

MS. WECKERLY: Marjorie Meana.

MARJORIE MEANA-STRONG, STATE'S WITNESS, SWORN

THE CLERK: Please state and spell your name.

THE WITNESS: Marjorie Meana-Strong. M-a-r-j-o-r-i-e, M-e-a-n-a, hyphen, S-t-r-o-n-g.

THE COURT: Thank you. Ms. Weckerly.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Ms. Strong, were you living in Las Vegas in 2007?

A Yes, ma'am.

Q Did your parents live in Las Vegas as well?

A Yes, ma'am.

Q Who is your father?

A Rodolfo Turillio Meana.

Q And your mom?

A Linda Guerrero Meana.

Q And during the time period of I guess the summer of 2007, how often would you see your father?

A At least three, four times a week. And f we don't see each other, we spoke over the phone every day.

Q And I don't want you to tell me what you said, but during that summer of 2007, what were your observations about his physical health at that time?

A He was a typical father in his 70s, active. He ran errands with my mom every day. He was driving. He sometimes would hold a part-time job as a security person, but at that time he was already retired. They would do a lot of the retired people's routine. Go to the grocery store, walk around. He would walk a minimum of a mile, mile and a half

every day.

Q So he was capable of walking at least some distance every day at that time?

A Yes.

Q And he was able to go places with your mom? He was ambulatory?

A Absolutely, yes.

Q Without saying what he said, how was he mentally at that time?

A He was very alert. He read a lot. He would read the paper every day, listen to the news. He would -- my dad loved to read and he liked knowledge, so he did a lot of fact finding. He used the computer a lot too, so.

Q Did he seem at all depressed during that time, that summer, to your knowledge?

A No. Not to my observation, no.

Q Are you aware -- you're aware that in September, on September the 21st of 2007 your father had a procedure done at the endoscopy center.

A Yes. I was very aware because that day my mom does not drive and because the procedure, the doctor told us that the procedure meant he couldn't drive after the procedure, my husband Jeff Strong was the one that drove him that morning. So yes, we were aware.

Q Okay. So your husband actually drove him to the

procedure at the center?

A Yes. He drove my father and my mom was with them and my Uncle June was with them. Then he picked them up too after.

Q But if I'm understanding you, you weren't actually there though.

A I was not there, I was at work.

Q Okay. Sometime after that, did your dad's health change at all?

A Yes. A few weeks after that he said he felt like he had a very bad cold. First he thought it was a very bad cold. But the more symptoms he told me, I said dad, to my observation that looks like you may have flu-like symptoms. He had it for a while.

Q Let me just interrupt you one second.

A Yes, ma'am.

Q When you saw your dad during this time period, how would you describe how he was physically?

A He slept a lot. He was getting tired a lot. He just kept -- my observation, he just wasn't himself. He was very tired. He wanted to sleep a lot. Usually he would go out after lunch, go somewhere with mom, but he can't go past lunchtime anymore. Then he slept a lot. Then there was at one point where he would go to the bathroom and he said my --

Q I don't want you to say what he said, but you

described him as being sort of fatigued during that time?

A Yes, he's always tired. He couldn't eat a lot. He was actually -- he said I don't -- I saw for a fact that when I would go see him it looked like he lost weight. I mean, I could tell from his face, his body. And my mom even said that he wasn't eating a lot for weeks.

Q At some point after that period, were you aware that he had some tests indicating that he was positive for hepatitis C?

A Yes, we were aware. A blood work was done because he had to go to the -- I encouraged him to go to the doctor first because of the fatigue and the flu-like symptoms. And then many weeks later was when it was revealed that he tested positive for hepatitis.

Q Okay. Now I want to kind of fast forward a little bit. After that diagnosis, did you ever see medication at your parents' house associated with some treatment for your dad?

A Yes.

Q What did you actually see at the house?

A I saw the actual box of the medication and it says interferon. And there was paperwork there that I read regarding the interferon and we needed to have it refrigerated properly in the refrigerator.

Q During that time period, what were your

observations about your father physically at that time period?

A When -- when he had the hepatitis C already, he just started not being himself. He slowly, not just physically -- his physical looks were changing. He started losing weight to when he would have yellowish look on his eyes which we later found out was jaundice. He would have a problem with his bowel movements, between the bowel movements and the urine. The urine would have a yellow substance. But what was hard for the family, especially with mom and my uncle, was that he couldn't drive them anymore. He couldn't walk too much. He was sleeping a lot.

He was -- at times he started getting angry for no reason. More like he was sad. He was depressed and we know he was depressed because we would see his mood changes. We would say happy things and take him places. He doesn't want to go, he doesn't want to eat.

Q When you say he would get -- when you say he would get angry, was that different than how his general demeanor was before all this happened, before September the 21st?

A It's very different. My dad is ex-military, very simple, a very peaceful happy man. So he never -- he doesn't really show any anger signs or sad signs on his face, facial expression or deflection on his voice. So there was a remarkable difference. Even my mom noticed it. I would

notice it or she would call me in the middle of the night and let me know.

Q To your knowledge, did your dad complete the interferon therapy?

A No. I know he did not.

Q Now --

A The --

Q Go ahead.

A I'm so sorry.

Q Do you know -- do you know how long he was on it?

A He was just on it about a week, if I'm -- yes, about a week.

Q When he went off of it, did his physical health or mental health improve or change at all from your observation?

A No, it didn't change at all. And the frequency of his physical and mental deterioration started getting worse from then on.

Q Now I want to move to 2012. Okay? During the early part of 2012 was your dad able to walk and drive at that point in time?

A December before 2012, even before that, I went to every single doctor's appointment with him, so I was always with him. And we -- I was told he cannot drive anymore

because it was explained that his -- as his liver functions deteriorate and he gets what they told me and I've heard, hepatic episodes, ammonia levels go up into his brain and start shutting it down.

MR. SANTACROCE: I'm going to object as hearsay.

THE COURT: Okay.

BY MS. WECKERLY:

Q Let me ask you this. During I think you said December of 2011, you were responsible for driving your dad places.

A Correct.

Q Previously he had been able to drive.

A Yes, ma'am.

Q Okay. During that time period, was he able to walk around like he had prior to September of 2007?

A Yes.

Q How far was he able to walk during this later period?

A He was a normal dad in his 70s that would walk at least two to three miles.

Q I think we're miscommunicating. You described how he could move around and he walked before.

A Yes.

Q Before the procedure in September 2007. And I'm sorry if I'm not communicating it clearly. In December and

January of 2011, 2012, was he able to do that same kind of physical activity like walking around like he had previously?

A No, not at all. In fact, I had to help purchase a walker. Already, a few months already before that we had to purchase a wheelchair because he can only walk maybe not even ten minutes and it would be too tiresome for him. So for him to go places he would need to be in a walker or when he's too tired and I would have to assist him in his wheelchair.

Q Did you ever witness or did you participate in any other care associated with him during that time period? Like, I don't want to know what he said, but did you have to do anything at home to assist with his physical care?

A I did everything.

Q What would everything be?

A I would make sure and check his, when we're not at the doctor for them to check it, I would check his blood pressure and then check his temperature. There were times in and out of the hospital because he would be on a catheter. So they taught us how to use that. Towards a few weeks before March 27th of 2012, it was 24 round care between my mother and myself. So my sisters came to help. And when we could not, we had to hire a caregiver for the nighttime for about nine hours just to let us rest. He was very bedridden already and he would go in and out of being able to talk to. And he can't bathe himself.

Q So he required pretty much round-the-clock care. Is it fair to say that everything had to kind of be done for him during --

A Yeah, everything had to be done for him. And what was also consuming was not just taking care of him, he had to be in and out of the doctors a lot. And if he wasn't in and out of the doctors a lot, he was in the hospital for extended periods of time sometimes.

Q At some point during 2012, did your father fly to the Philippines?

A Yes.

Q Were you there? Did you go with him?

A We were all with him. All his four daughters, his wife Linda, including myself. There were six of us that flew him on March 27th of 2012.

Q And how long did you stay?

A We were -- my other sister that lives here and myself were there until the second week of April.

Q When you left the Philippines, was your father -- was he still alive?

A He was still alive, yes.

Q At some point after that, did you become aware that he had died?

A Yes.

Q How long after you left?

A About a couple weeks after I came back -- we came back here to the United States.

Q So you were here?

A Yes.

Q After your father had died, did you, I guess, coordinate or assist the Las Vegas Metropolitan Police Department in being able to observe an autopsy done on your father in the Philippines?

A Yes. I had to call them the day that my father died, which was April 27th. Detective -- it's okay to state name?

Q It's okay. But a detective --

A A detective and the coroner flew.

Q And did you go too?

A Yes. With my sister and myself, yes.

Q So you actually went with the doctor from Clark County and the Metro detective with your sister back to the Philippines to help facilitate this autopsy.

A Yes, ma'am.

Q Thank you.

MS. WECKERLY: I'll pass the witness.

THE COURT: All right. Thank you. Cross.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning, Ms. Strong.

A Good morning.

Q I'm Margaret Stanish. I represent Dr. Desai. I first want to start with just seeing if you can help me develop a timeline of what you just described with a little more particularity, if you can. All right?

A I will try my best, ma'am.

Q I understand. Let's start with the September 21st, 2007 visit to the center for the colonoscopy as kind of a starting point. Can you tell me how long after that you noticed your dad having flu-like symptoms?

A It was already about fall at that time, so I would say maybe approximately, please don't quote me on it, maybe three or four -- about three weeks, four weeks after that, towards October, end of October.

Q And if you know, I understand you encouraged him to go to a doctor. Do you know what doctor he went to?

A Well, because of the insurance, he would always go first to his doctor which would be Dr. Jurani. He's a general doctor. It was just a simple ailment, I mean illness, so I told him let's go there and let him see what's wrong, dad.

Q Okay. And then, as I understand your testimony, he continued to deteriorate.

A Yes, ma'am.

Q And you noticed him getting the jaundice and

being fatigued, correct?

A Yes, ma'am.

Q Can you tell me when about that occurred after the September 21st date? How many weeks or months are we talking about?

A The frequency of the -- of those things I mentioned became more frequent. I would say maybe within another few weeks after that, maybe two to -- at least two to three weeks after that. But when he would go to the bathroom he actually -- I actually saw it because he told me this is not -- he said I got to show you something.

Q Well, what I'm trying to get at is, I'm trying to get your timeline of when he went to different doctors, if you know. So you see that he gets the jaundice.

A Yes.

Q You notice problems with his urination. What -- at that point, do you know who he went and saw?

A He went to see Dr. Jurani.

Q Again?

A After which timeline, ma'am?

Q Well, as I understand it, a few weeks after the procedure he has flu-like symptoms.

A Yes, ma'am.

Q And then a few weeks more he's jaundiced.

A Yes.

Q And having urination problems. At that point, do you know where he went?

A He went to Dr. Jurani, yes.

Q Do you know -- you mentioned that you observed him having a box of the interferon medication.

A Yes, ma'am.

Q Can you kind of put that on a timeline for us?

A I would say that would be maybe around March, 2009. It's not in '08, so it would be many months after that.

Q So -- if I'm understanding the timeline, and I understand you're estimating.

A Yes, ma'am.

Q I understand that. He's showing the symptoms within a few weeks of going to the clinic. He doesn't start the interferon treatment until March of 2009 or thereabouts?

A I mean, it's -- I'm so sorry, it's been a long time ago.

Q I understand.

A So it was either later of 2008, you know, almost late winter or beginning of 2009. I mean, that -- I remember those dates just because it was wintertime, around wintertime, almost springtime.

Q Had you -- I understand at some point in time you were accompanying him to the doctor appointments since he couldn't drive. Were you accompanying him to doctor

appointments before he started the interferon treatment?

A Before the interferon treatment?

Q Right.

A Once -- not a lot because he was still able to drive at that time. So Linda, his wife, my mom Linda would always be with him.

Q Okay. So prior to the interferon treatment which you think was in March of 2009 or late '08, he was able to get -- he was able to drive still?

A Yes, ma'am.

Q And am I understanding your testimony that he took the interferon treatment for one week?

A That's -- yes. From my -- from me seeing it at the house and asking -- and I literally asked him --

Q We can't talk about conversations.

A Okay.

Q But so I'm looking at -- I understand you saw the package, you read it, you made sure it was in the refrigerator. Do you know if he was taking another medication that was administered by a shot?

A No, ma'am.

Q You don't know or you're --

A I know he did not because I did not see it anymore.

Q All right. Were you aware -- do you have

firsthand knowledge, if you do, of your dad's other health issues prior to getting the colonoscopy?

A Little bit, yes, ma'am.

Q Could you tell us what you know?

A From knowing -- from being there with them, yes. He has some blood pressure problem and he has ulcers.

Q Did he ever have to have surgery on his gallbladder?

A Yes. That was a long time ago, but yes. He had gallbladder surgery, yes.

Q Do you know how long ago that was?

A '90s.

Q In the '90s.

A Maybe mid 90s.

Q All right. Did he have -- did he suffer from prostate cancer?

A No, ma'am.

Q Did he -- were you aware whether he had any kind of chemotherapy?

A No, ma'am.

Q You're not aware of whether --

A I'm not aware and I know he does not have prostate cancer.

Q All right. Do you know if he had any kind of prostate issue?

A He had enlarged or benign -- enlarged prostate.

Q I see. You don't know whether or not he had to have chemotherapy at all?

A No, I know he did not have.

Q All right. Am I to understand that one of your sisters resides in the Philippines or two of them?

A Yes, ma'am.

Q Okay. I understand you traveled to the Philippines. Was it you or your sister who resides in the Philippines that assisted in arranging the autopsy in the Philippines?

A Are you talking about the date that my dad passed away now?

Q Yeah. I am fast forwarding to --

A I'm sorry. I just want to make sure.

Q That's all right. I understood that you, at least stateside, coordinated with the metropolitan police to arrange for an autopsy in the Philippines, correct?

A Yes, ma'am.

Q And what I'm asking is was it you or one of your sister who resides overseas that actually coordinated with the Philippine authorities?

A Oh, the Philippine authorities?

Q Right.

A It wasn't -- it wasn't directly from us.

Q Okay.

A We authorized it. But then by the time my sister that resides here in the U.S., Marlene and I flew there. Then we were told that they were the ones that's doing the actual autopsy there.

Q Okay.

A That's -- we were just verbally stated.

Q Okay. I just wasn't -- I just wanted to clarify if you had any involvement in coordinating with the Philippine authorities.

A No, ma'am. We have to deal with my dad's death. I mean --

Q No, I understand. I just meant for purposes of the autopsy. All right. That's all I needed to know. Thank you.

MS. STANISH: I have nothing further.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: I don't have any questions.

THE COURT: All right. Thank you. Ms. Weckerly, redirect.

MS. WECKERLY: No redirect, Your Honor.

THE COURT: Do we have any juror questions for this witness? No juror questions? Ma'am, thank you for your testimony. Please don't discuss your testimony with anyone else who may be a witness in this case. Thank you and you are

excused.

THE WITNESS: Thank you.

THE COURT: The State may call its next witness.

MR. STAUDAHER: State calls Maynard Bagang, Your Honor. I may be slaughtering that name.

MAYNARD BAGANG, STATE'S WITNESS, SWORN

THE CLERK: Please be seated. Please state and spell your name.

THE WITNESS: My name is Maynard Bagang, M-a-y-n-a-r-d, B-a-g-a-n-g.

THE COURT: Thank you. Mr. Staudaher, go ahead.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Sir, what do you do for a living?

A I'm currently employed by the Las Vegas Metropolitan Police Department as a police officer.

Q How long have you done that work?

A I've been a police officer for approximately nine years now.

Q I'm going to take you back in time to 2007, specifically April of 2007. Before I get there, do you have any special language skills?

A I speak Tagalog and the local dialect of the Philippines which is Kapampangan, sir.

Q Because of those skills, that knowledge of the language of Tagalog you said?

A Yes, sir.

Q Were you contacted by Detective Whitely from the Las Vegas Metropolitan Police Department to assist in an autopsy that was going to be performed --

A That's correct, sir.

Q -- in the Philippines?

A Yes, sir.

Q And specifically on April 27th of 2012, did you become involved?

A Yes, sir.

Q Can you describe for us how that happened?

A I was performing my military duties, because I'm in the Navy Reserve, I was in Coronado, California when I received a phone call from Sergeant Misty Pence from the Las Vegas Metropolitan Police Department informing me that I will be traveling from Las Vegas to the Philippines that same day. She gave me the briefing on what I am supposed to do when I get to the Philippines and at the end of the process, bring back the items that I'm supposed to escort.

Q Was the reason that you were sent there because of your language ability?

A Yes, sir.

Q Did you grow up in the Philippines or how are

you associated with that particular country?

A I grew up in the Philippines and I went to college in the Philippines, sir.

Q So when you get this information, do you come back to Las Vegas?

A Yes, sir.

Q And then what happens?

A Got back in Vegas. I flew out that night, April 27th via Korean Airlines. I got to the Philippines April 29th in the morning, it was a Sunday. And that's when I met with the U.S. Embassy representative FBI agent to escort me to my hotel room.

THE COURT: Sir, you have sort of a soft voice. Keep your voice up.

THE WITNESS: Yes, Your Honor.

BY MR. STAUDAHER:

Q There's a microphone right in front of you, if you could try to get as close to that as you can.

When -- actually, you're traveling. Are you alone or are you with anybody else?

A I was with the Nevada coroner, Dr. Olson and also one of the daughters of Rodolfo Meana, Marjorie.

Q So all of you are on the same flight?

A That's correct, sir.

Q When you get to the Philippines, do you

coordinate with Dr. Olson?

A Yes, sir.

Q Are you with Dr. Olson during the time that you're facilitating or at least getting the issues related to the autopsy completed?

A Yes, sir.

Q Tell us once you get there, that whole process about the autopsy and what you did, if you were there, that kind of thing.

A When I got there, first of all, I was introduced by the FBI agent to the Philippine local law enforcement agency, which is the National Bureau of Investigation. Because we're going to need their help to facilitate the autopsy. We're going to need a Philippine coroner. So I briefed the National Bureau of Investigation representative and also the Interpol chief based in Manila requesting the -- requesting a Philippine coroner to perform the autopsy. Then that same day, that was Monday, April 30th, they were able to provide the Philippine coroner and we went to the funeral home where I met with the [indiscernible] staff members and also one of the daughters of Rodolfo Meana. That's when I asked them to show me the body so I can identify the body. And then they did show me the body and it was Mr. Meana.

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q I'm showing you what has been marked as proposed State's 239 and ask if you recognize that item.

A Yes, sir, I do.

Q And what is it?

A This is a driver's license of Rodolfo Meana.

Q Is this the same person that you identified when you went to the Philippines?

A That's correct, sir.

MR. STAUDAHER: At this time I'd move for admission of State's 239, Your Honor.

THE COURT: Any objection?

MS. STANISH: No, Your Honor.

MR. SANTACROCE: No, Your Honor.

THE COURT: All right. 239 is admitted.

(State's Exhibit 239 admitted.)

MR. STAUDAHER: And I know we can't put it on the --

THE COURT: Right.

MR. STAUDAHER: But I just want to have it as an admitted exhibit --

THE COURT: That's fine.

MR. STAUDAHER: -- his driver's license photo.

BY MR. STAUDAHER:

Q So the purpose of you going there, was it in part to identify the right person that was going to have an

autopsy performed?

A That's correct, sir. My main purpose is to identify the body, facilitate and witness the autopsy and escort Dr. Olson to bring back the samples back here in the United States.

Q So when you say witness the autopsy, does that mean you're actually physically there when it's taking place?

A Yes, sir, I was.

Q Who else is there? I mean, I assume that the Philippine coroner and so forth are actually doing the autopsy. Is that fair?

A That's correct, sir.

Q You're there. Is Dr. Olson present?

A Yes, sir.

Q What is her role in this?

A Her role was to witness the autopsy and collect the samples, the tissue samples and blood samples.

Q Were you there when that occurred?

A Yes, sir.

Q So once the samples come into the possession of Dr. Olson, are you involved with the -- I mean, the husbandry, the care of those samples in any way before they get back to the United States?

A Yes, sir. My job is to escort the doctor. She took custody of the samples and put the samples in a secured

safe inside her hotel room.

Q And then when you got back to the United States, did she maintain possession of those to the coroner's office?

A Yes, sir. The samples were hand carried and we bypassed the airport security from the Philippines all the way to Las Vegas.

Q So there was no intervening, where you had to release those samples to somebody else, for example, like customs or so forth?

A No, sir. Everything was set up by Homeland Security and we bypassed all security of the airports.

Q So when you are present during the autopsy, are you there for the entirety of the autopsy?

A Yes, sir.

Q So you don't step out for a break or anything during that time?

A No, sir.

Q After you got back to the United States, did that pretty much complete your role in this case?

A That's correct, sir.

MR. STAUDAHER: I pass the witness, Your Honor.

THE COURT: All right. Thank you. Cross.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good morning.

A Good morning, ma'am.

Q Officer, how do I say your last name?

A Bagang.

Q Bagang?

A Yes.

Q Officer Bagang, just clarify a few points. Is it the case that a law enforcement official in the United States must go through formal diplomatic channels in order to what you described in another country?

A That's correct, ma'am.

Q So it's not unusual that if a stateside law enforcement officer needed to conduct an investigation or get some information in connection with their case, they would have to go through Interpol, FBI, State Department or whatever U.S. authority is located in another country?

A I'm not familiar with the process, but I believe that's what occurred because it was Homeland Security of the Las Vegas Metropolitan Police Department who set up everything for me.

Q All right. And as I understand it, when you got there you had to actually do the formal request of the various law enforcement authority to conduct the autopsy?

A That's correct, ma'am. Because it is a different country and our coroner is not licensed to perform an autopsy. That's why it had to be done by the Philippine

coroner. And we went through the proper channel by going to the Interpol chief based in Manila and also the National Bureau of Investigation.

Q And as I understand your testimony, you were the one that had to brief them on the nature of this case?

A That's correct, ma'am. Because the National Bureau of Investigation head doctor asked me if I can brief him on what we are planning to do and what's our mission.

Q And what did you relate to him? What was your -- the mission that you related to him?

A I related to the doctor that we were there to obtain samples from the body of Rodolfo Meana and through their help we're going to need a Philippine coroner and also a consent from the family which was taken by the National Bureau of Investigation from the family.

Q And did you provide them with medical records?

A No, ma'am.

Q Did you bring medical records with you at all?

A No, ma'am.

Q Did Dr. Olson?

A I do not recall that, ma'am.

Q Did you, yourself review any medical records?

A No, ma'am. And even if they show me medical records, I am not an expert to make any justification on any medical records.

Q Fair enough. Fair enough. Did you see Dr. Olson with any medical records relating to Mr. Meana?

A I cannot recall, ma'am. She's bringing her personal bag, no.

Q Okay. And as I understand it, you witnessed the autopsy.

A That's correct.

Q Where did that take place?

A It was [indiscernible] in Manila.

Q Was it a government facility?

A No, it's a private funeral home.

Q So the autopsy was conducted in a private funeral home?

A Yes, ma'am.

Q And do you recall, sir, what samples were given to Dr. Olson?

A I'm not an expert of -- in that particular matter, so I cannot tell you what body part was given, but I knew there were samples that were taken and given to Dr. Olson and they were put in a specified medical container and sealed.

Q Do you know where they were stored while you were in the Philippines?

A Yes, ma'am. They were stored in a secured safe by Dr. Olson inside her hotel room.

Q Okay. So what, like her hotel room had a safe

in it?

A Yes, ma'am.

Q And so she put the samples in there?

A Yes, ma'am.

Q How long were -- how long did you -- when did you travel back to the United States with Dr. Olson?

A I believe it was approximately May 3rd. It was a Wednesday when we traveled back.

Q Did Dr. Olson maintain control -- did you ever receive the samples into evidence or did Dr. Olson take care of that?

A Dr. Olson took care of it.

Q Do you know how long or can you estimate, if you recall, how long the autopsy took?

A Approximately two hours, ma'am.

Q And did Dr. Olson, did she just observe it or did she actually participate in anything?

A She observed, she didn't participate.

MS. STANISH: Court's indulgence.

THE COURT: That's fine.

MS. STANISH: No further questions. Thank you.

THE COURT: All right. Mr. Santacroce, any questions for this witness?

MR. SANTACROCE: No, Your Honor.

THE COURT: Mr. Staudaher, any redirect?

MR. STAUDAHER: No, Your Honor.

THE COURT: Do we have any juror questions for this witness? No juror questions? Officer, thank you for your testimony. Please don't discuss your testimony with any other witnesses in this matter.

THE WITNESS: Yes, Your Honor.

THE COURT: Thank you, sir, and you are excused.

THE WITNESS: Thank you, Your Honor.

MR. STAUDAHER: Your Honor, if we could take maybe a five-minute break to make sure everything --

THE COURT: Okay. To queue up for everything?

MR. STAUDAHER: That's correct.

THE COURT: All right. Ladies and gentlemen, we'll next be playing a video deposition, so we're going to take a quick break to get everything all set up for that. We'll be in recess until 11:35.

During the recess you're reminded you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research and please don't form or express an opinion on the trial. Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 11:22 a.m.)

THE COURT: Before we take our break, what do we have for today? The Meana deposition.

MR. STAUDAHER: And then whatever, as far as the insurance --

THE COURT: This gal left and that's it. That's fine because Ms. Mayo, we told her she didn't have to come in. She set up a doctor's appointment so we need to be done by like 3:30. So that shouldn't be --

MR. STAUDAHER: Oh, I think that should be --

THE COURT: Oh, that's great. Okay. So Janie, can we interrupt the Meana deposition in the middle if we need -- want to take lunch?

MS. WECKERLY: It's, you know, it's really not as long. There's a lot of argument in it.

THE COURT: Okay.

MR. STAUDAHER: We're trying to cut out as best we can. I talked to counsel about that. We're eliminating all the beginning stuff, all the end stuff and there's a big section in between that where he had to be medicated, I guess. We're eliminating that. So we're going to start off with the questioning of Ms. Weckerly going through questioning with Mr. Wright. Then it stopped, then there was the break and then we pick back up with Mr. Wright's questioning until the Court stops it and that's -- whatever happens in between we can't really take out.

THE COURT: Okay. That's fine. And then we'll --

MR. WRIGHT: What do you mean in between?

MR. STAUDAHER: When you're questioning. During your -- if there was an objection.

THE COURT: You know, if somebody came in or said something, then that's going to be on there. Okay. And then we'll take lunch after that and then you guys can get with the witness on the documents.

MR. STAUDAHER: Right. I've given them one document. The other one I guess is still on it's way. I haven't checked.

THE COURT: And then we'll figure that out and that will be after lunch and then we'll take our recess for the day. Sounds good? Okay.

(Court recessed at 11:24 a.m. until 11:36 a.m.)

(Outside the presence of the jury.)

THE COURT: Bring them in. Are we all queued up?

MR. STAUDAHER: We believe so, yes.

THE COURT: Okay.

MR. STAUDAHER: As soon as we get to the -- just so the Court knows. In order to remove all of this -- the in between medication thing, when we get to the end of this segment there's another segment I have to go to. And I will play the entirety of that segment because we just pick back up with Mr. Wright speaking or asking questions up until the

point where the Court starts talking about being done. And then there's some stuff that comes after that, so I'm going to end it at that point. There's nothing -- there's no more questioning that happens after that particular point.

(Pause in proceedings)

(Jury reconvened at 11:39 a.m.)

THE COURT: All right. Court is now back in session. Ladies and gentlemen, in a moment we will be playing for you a video deposition that was taken of Mr. Meana. That is questioning that is done under oath when the trial is actually not in session. We will see, I believe, in the video deposition that the questioning of Mr. Meana was cut short due to concerns that were expressed regarding his physical state. So for that reason, you will see that both the defense side did not have an opportunity to thoroughly question Mr. Meana. The deposition was not concluded, meaning it was not completed. But we are showing you the portion of the deposition that we were able to complete.

Having said that, Ms. Olson, will you queue that up. Can everyone see this monitor? Is this is a good location or would it be better if the bailiff moved it more centrally into the courtroom? Yeah, why don't you move it so they're not all -- whatever you do, don't unplug it. Can everyone see that all right? Everyone good. Okay. Very good. Janie.

(Rodolfo Meana testimony previously transcribed.)

THE COURT: All right. Ladies and gentlemen, that concludes the deposition. Kenny, you can move the screen back. And then I believe next up is the witness from yesterday; is that correct, Mr. Staudaher?

MR. STAUDAHER: Yes.

THE COURT: So while Kenny's moving the screen back and the easel so the jurors can see, can you just get the next witness?

MR. STAUDAHER: Certainly.

THE COURT: Help us out here. Ma'am, just come on up here, back to the witness stand, please. Then just go ahead and have a seat. And you are still under oath. Do you understand that?

THE WITNESS: Yes.

THE COURT: All right. Thank you. Mr. Staudaher, did you have anymore direct examination?

MR. STAUDAHER: I just have [indiscernible] document.

DIRECT EXAMINATION (Continued)

BY MR. STAUDAHER:

Q At the end of the testimony last time there were some discussions about a particular document that you had that at least was part of your company as far as what the policy was in place at the time with the endoscopy center. Do you recall that?

A Yes.

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: You may.

BY MR. STAUDAHER:

Q I'm showing you two documents. One is marked proposed State's 240 and the other one is marked 241. Can you tell us if you've been able to obtain these documents, if you're familiar with them and what they are?

A Yes.

Q Start with 240.

A 240 is the Medical Group Participation Agreement which is the contract between the providers and United Healthcare.

Q And what does that mean exactly?

A This is a contract which was signed that they will provide care and follow terms of billing and such for -- to become a participating provider with the network.

Q Now there are two separate contracts. This is the second one; is that correct?

A Correct.

Q Do you know what the difference is between the two?

A The contract that we discussed previously was for the facility itself. This one covers the providers within the facility.

Q Okay. So this is the one that was used to -- as

a guideline for billing purposes for the providers?

A Correct.

Q Does that include CRNAs?

A Yes.

Q Now Exhibit Number, proposed 241, what is that?

A This is a Market Standard Specifications. This would be what we would consider the fee schedule.

Q So the fee schedule for what, for various procedures and things?

A Yes, for various procedures.

Q Now I note on that document that at least the procedures themselves have been, looks like redacted out; is that correct?

A Correct.

Q Is there anything on there related to anesthesia?

A Yes.

Q And is there anything on there that relates to what the actual unit value reimbursement was for anesthesia at the time?

A Yes.

Q At this point, there is, and I just want to go through one thing on 240, getting to the back of this document. I believe it is the second page, actually second to the last page, refers to Appendix Three.

A Yes.

Q Now, there's nothing -- there's just some verbiage there on Appendix Three, but does it refer to yet another document?

A It refers to the fee schedule.

Q Okay. And then the fee schedule that's 241 is listed as Appendix Three?

A Yes.

Q Is that the document that it refers to?

A Yes.

Q Okay. To your knowledge, does this all go together?

A Yes.

Q For the Endoscopy Center of Southern Nevada?

A Yes.

MR. STAUDAHER: At this time I'd move for admission of State's proposed 240 and 241, Your Honor.

THE COURT: Any objection?

MS. STANISH: May I voir dire, Your Honor?

THE COURT: Sure.

MS. STANISH: Thank you.

BY MS. STANISH:

Q After your testimony yesterday, did you have any discussions with anybody regarding these two documents that you just spoke of?

A No. I had not seen either one of these documents until I got here this morning.

Q And who showed them to you?

A They were shown to me by United Healthcare's counsel once we were here in the witness room.

Q And then, did you discuss the context -- contents of these documents?

A No, I just reviewed them.

Q Okay. And do you, referring to -- referring to State Exhibit, proposed Exhibit 241, do you see a date on that?

A No, I do not.

Q In your experience, if you know, do the fee schedules change periodically?

A In my experience, yes.

Q And can you tell us how often the fee schedules normally change?

A I cannot tell you that, no.

Q Is it annually?

A I do not know.

Q You don't know?

A No.

Q And do you have any way of -- well, let me ask you this. The date on this contract, this provider contract that's marked as proposed Exhibit 240, what's the date of that

document?

A It says May, 2003.

Q And in your experience, do these contracts normally get amended over time?

A At times there is a possibility of it being amended.

Q As you sit here today as the custodian of record, do you know if this contract that's dated October, 2003 -- is that the date you said?

A This is October. Down here it says May, 2003, so that must have been when it, when the format was created.

Q Oh, I see.

A So, I'm sorry. October, 2003.

Q So it was signed in October, 2003.

A Correct.

Q So as you sit here today as custodian of record, do you know if there -- this contract was amended between October, 2003 and July of 2007?

A Not that I'm aware of. I do not know.

Q What would you do to figure that out?

A There would have been another agreement on file which would have then been sent to us if it had been updated.

Q Did you personally look for this document?

A No, I did not.

Q And with respect to the rate schedule, what

would you, as custodian of record, have done to determine whether that was the rate schedule in effect in July of 2007?

A As custodian of records, I count on our network management to provide me with the accurate documents that I request, as they are requested from me.

Q Who's that person?

A It varies depending upon who's available to pull the documents.

MS. STANISH: Your Honor, may we approach?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: Mr. Staudaher, you may proceed. Did you have any additional questions regarding that document?

MR. STAUDAHER: No, Your Honor.

THE COURT: And that's Exhibit Number what?

MR. STAUDAHER: Exhibits Number -- actually, I think they're up there. 241 and 240.

THE COURT: All right. Those will be admitted.

(State's Exhibit 240 and 241 admitted.)

THE COURT: Pass the witness? Mr. Staudaher, that concludes your direct?

MR. STAUDAHER: Yes, Your Honor.

THE COURT: All right. Ms. Stanish.

CROSS-EXAMINATION

BY MS. STANISH:

Q Do you know what the base value -- do you know -- explain to us what formula the insurance company used to calculate the payment to the gastro center for Ms. Aspinwall?

A The formula was listed in the reimbursement policy. I do not have the formula memorized.

THE COURT: Is that in one of the exhibits that you testified about --

THE WITNESS: Yes.

THE COURT: -- yesterday?

THE WITNESS: Yes.

THE COURT: All right.

BY MS. STANISH:

Q I'm just going to give you all the documents and you can plow through them and find whatever helps you. Okay? You got it?

A Yes.

Q What is it?

A The standard formula for the anesthesia maximum is the base value plus the time increments plus the modifying units times the conversion factor times the modifier percentage.

Q All right. And do you know what the base value was assigned to Ms. Aspinwall's case?

A The base value was five.

Q I want to display this chart which I will note

is not handwritten but made with high technology just like the State. I'm hoping that you can help us understand the value of anesthesia services that were provided. I understand you to say that the base value was five, right? And it might be helpful if you could pull out Ms. Aspinwall's 1500 form.

A That's what I'm doing right now.

Q Now when I ask you these questions, please, if you don't have knowledge on how to do this, tell me because I understand you're a fraud investigator and not a billing expert.

A Okay.

Q So I want this to be precise, if we can do that. So turning to Ms. Aspinwall's claim, there were no modifying units; is that correct?

A Correct.

Q So we can just put zero there. So with respect to the amount of time for Ms. Aspinwall, that was how much time? How many units billed?

A Three.

Q So this is what's actually paid to Ms. -- for Ms. Aspinwall's anesthesia service, correct?

A That is what the insurance company paid.

Q And you're suggesting that there -- Ms. Aspinwall had another insurance, a secondary insurance policy, correct?

A No. What I'm saying is that based on the explanation of benefits, Ms. Aspinwall had a patient responsibility of a certain amount of money.

Q All right. Now, can you tell us based on this new document that we got today regarding the conversion rate, on this document what is the conversion rate for anesthesia?

A Forty-four dollars.

Q And so each unit is $44?

A Correct.

Q And as I understand it, if we take $44 and multiply it by eight units?

A Correct.

Q We're going to get the gross amount of compensation to the clinic; is that correct?

A Correct.

Q That amount still has to be reduced somehow based on the member's what?

A Member's responsibility.

Q Is that the term?

THE COURT: Is that like a co-pay?

THE WITNESS: Like a co-pay or co-insurance.

THE COURT: And us regular folk would call it co-pay.

THE WITNESS: Right. Yes.

BY MS. STANISH:

Q But now, and I want to -- if you would turn to

Ms. -- the EOB, the explanation of benefits, doesn't part of the equation also factor in the plan that Ms. Aspinwall's on as far as what percentage the business or the insurance company's going to pay?

A Correct.

Q So can you explain to me how we get to this figure? I mean, the conversion factor we now know is $44 if that document you have there was the one that applied during calendar year 2007, correct?

A Correct.

Q So let's pretend for a moment that that's the case. All right? So we multiply eight by $44 and we come up with $252. We don't have any modifier percentage on Ms. Aspinwall?

A The modifier percentage was 100 percent.

Q Okay. So we don't have to worry about that math, right?

A Right.

Q We'll leave that blank. Can you tell me how we get to this figure?

A According to the explanation of benefits, the allowed amount or the approved amount, the total amount paid -- that was approved to be paid was $312.40. So there was the provider, participating provider discount was $247.60.

Q So I got this figure of 352. Let me just do

this and I'll subtract the 249 and maybe you can -- will that help us?

A Actually, what would help us is to subtract the 312.40.

Q Okay, 312.40 equals $39.60. What do I do now?

A I don't know.

Q Yeah, me neither. Who would know in your organization about this?

A It would have to be a claims processor that would know why there's a difference.

Q And you know what I was hoping we could accomplish and tell me how we have to do this. If we wanted to know what the value of service was that Ms. Aspinwall received and we want to fill in the blanks on this chart, assuming she -- we know what the figure is but we're not quite sure how we got there with respect to a procedure between 31 and 32 minutes. But if I wanted to know what the compensation would have been had the anesthesia service lasted 16 to 30 minutes, how would we do that?

A Well, based on the fee schedule provided here today, it would have been $44 less.

Q So the -- assuming Ms. Aspinwall had anesthesia service that lasted between 16 and 30 minutes, it would be $44 less than the $249.92?

A No. It would be $44 less than the $312.40,

because the allowed amount.

Q Let's try that. The allowed -- tell me what to do.

A Okay. The allowed amount was $314 --

Q Let me stop you right there just to go through this. We would be talking about seven base units if the service lasted between 16 and 30 minutes.

A Correct.

Q And so you're not able to do -- you're not going to multiply that figure, you're just going to somehow work your way backwards?

A Well, no. I mean, I'm assuming that this $44 is correct. If it was one unit less, one unit equals $44, it would have been $44 less than the total allowed amount.

Q Okay. And you're saying the -- and that amount is the 312.40?

A Correct.

Q 312.40 minus $44 equals $268.40?

A Correct. And then the plan would have paid 80 percent of that.

Q So I have to do more math. I have to multiply this by.80?

A Correct.

Q So I'm taking 268.40 and multiplying it by.80 and I get $214.76.

A And that's what the plan would have paid then.

Q $214.76. And what would you do here if the time frame was between zero and 15?

A Again, we would follow the same process.

Q Would we be still subtracting $44 or $88?

A No. What we would do is if you go back to what the allowed amount was on that 214.72.

Q Take this and subtract $44?

A No.

Q What? What do you want me to do next?

A Okay. Take the $214.72, so that's 80 percent of the allowed amount. We need to get back up to 100 percent of the allowed amount. Okay? So we're going to multiply --

Q Are you sure?

A Yes.

Q Okay. Go ahead. What do you want me to do?

A Okay. Let's scratch this for a minute. The easiest way to do this is let's go back to the original. The original allowed amount was $312.40.

Q Okay. The amount approved.

A Correct.

Q And that amount approved comes from what figures, by the by?

A That comes from the claims processor's dealing with the contract and the plan that the member's under. I do

not -- don't have specifics.

Q Doesn't it also have to factor in all the co-pays and all that?

A That's what the 80 percent factors in at the end.

Q Does this $312.40 even have anything to do with the conversion factor of $44?

A I do not know.

Q Are you certain what you're explaining to us is accurate then?

A What I'm saying is that if the allowed amount or approved amount is $312.40 and each unit is $44, we subtracted $44 for the down step from one unit. Now if you subtract $88, subtracts two units. And that's going to be the approved amount or the allowed amount. And then the amount the insurance company would pay is 80 percent of that.

Q So 80 percent of 224.40 is $179.52 for anesthesia time between zero and 15 minutes.

A That's the way the formulas read.

Q All right. Do you know, if you know, does the insurance company as part of the contracting process inspect the facility, the clinic?

A I do not know.

Q Do you know if it requires certain credentialing?

A I do not know.

MS. STANISH: Court's indulgence.

THE COURT: That's fine.

MS. STANISH: No further questions.

THE COURT: All right. Mr. Santacroce.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Ms. Kalka, who figures out how much is going to be paid on a claim?

A That's one with claim processors.

Q So tell me how that process works.

A I do not know. I don't work in claims processing. I never have.

Q Do you know what kind of training these people have?

A No, I do not.

Q Well, can you tell me two things? How much was paid for Patty Aspinwall's anesthesia service on September 21st of 2007?

A The insurance company paid the $249.92.

Q And can you tell me who that money was paid to?

A It was paid to the Nevada Gastroenterology Center.

Q So it wasn't paid to the CRNA, correct?

A Correct.

MR. SANTACROCE: Nothing further.

THE COURT: All right. Mr. Staudaher, redirect.

MR. STAUDAHER: Just one series of questions.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q Do you know what the term prorated means?

A Yes.

Q On State's 241, $44 figure per unit.

A Yes.

Q See where it says partial units priced on a prorated basis?

A Yes.

Q Do you know what the prorated basis was for an individual unit within a unit [indiscernible]?

A No.

Q At least that was part of the fee schedule.

A Correct.

MR. STAUDAHER: Nothing further.

THE COURT: Anything else, Ms. Stanish?

RECROSS-EXAMINATION

BY MS. STANISH:

Q What does that mean, what you just said?

A Prorated?

Q No. Yeah. Prorated to what?

A I don't know what it was prorated to.

Q You know the time units that you talked about?

A Yes.

Q We heard testimony from a billing code expert about the CMS way of measuring time with decimal points. So 18 minutes would be different than 12 minutes. Do you know how your insurance company delineated time?

A No.

Q Time is relative and we don't know what the time is.

A I do not know.

MS. STANISH: Okay.

THE COURT: Mr. Santacroce, anything?

MR. SANTACROCE: That wasn't me whistling.

THE COURT: Can I blame you anyway?

MR. SANTACROCE: Sure. You usually do.

THE COURT: I'll see counsel at the bench.

(Off-record bench conference.)

THE COURT: We have a juror question. A juror would like to know do you know if the fees for 2003 through currently 2013 have changed when it comes to the CRNA charges for anesthesia?

THE WITNESS: That I do not know.

THE COURT: Okay. So you don't know if there's been a change over time?

THE WITNESS: No, I don't.

THE COURT: All right. Mr. Staudaher?

BY MR. STAUDAHER:

Q If the anesthesia units were actually lower than the $44, would less have been paid on the claim?

A Yes.

Q Okay.

MR. STAUDAHER: Nothing further, Your Honor.

THE COURT: Ms. Stanish.

MS. STANISH: No further questions.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: No, Your Honor.

THE COURT: Any additional juror questions before we excuse the witness? All right, ma'am. Thank you for your testimony. Please don't discuss your testimony with anyone else who may be a witness in this matter.

THE WITNESS: Yes, ma'am.

THE COURT: Thank you and you are excused.

THE WITNESS: Thank you.

THE COURT: All right, ladies and gentlemen, I believe that that's all the State had lined up for us today. We will reconvene tomorrow morning at 9:15.

During the evening recess you're reminded that you're not to discuss this case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any

person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium and please do not form or express an opinion on the trial. Notepads in your chairs and just follow the bailiff through the rear door.

(Jury recessed at 2:46 p.m.)

MR. SANTACROCE: Your Honor, I'm going to make a motion to strike her testimony. She certainly didn't have information enough for us to cross-examine her on and she had no idea, no experience in billing, processing claims. So for those reasons we're going to move to strike her entire testimony.

MS. STANISH: We would join that.

MR. STAUDAHER: She testified to what she testified to. The fact that she said she didn't know something doesn't mean that her whole testimony goes away. That was ferreted out on cross-examination. The documents that were provided were provided at the defense request. She certainly testified about the records that were a part of the actual original complaint -- claim that she certainly had knowledge of and testified about. So we believe there's no basis to strike her testimony. The jury can weigh it as they will and they can certainly argue the things that they brought out on cross-examination.

THE COURT: Anything else, Mr. Santacroce?

MR. SANTACROCE: No, that's all.

MR. WRIGHT: Yeah. At the defense request, because the Government never investigated it to begin with. I mean, that's what's so irritating in all this. Yeah, we do things like object to hearsay and want the documents presented that should have been gathered five years ago. And it makes us look obstructionist in front of the jury and like we're trying to hide or confuse things. And it's all because the Government didn't prepare their case. And it is -- remains unprepared. We don't know if the units here are incremental to 31 minutes, 16 minutes. We don't even know if the rates have changed out of this witness. Absent more coming in, I think it should be stricken. It's incomplete and she didn't bring necessary records and the necessary witness to present it properly.

THE COURT: Anything else, Mr. Santacroce?

MR. SANTACROCE: No, Your Honor.

THE COURT: Anything else, Mr. Staudaher?

MR. STAUDAHER: Just if the Court entertains that at all, we would like to at least have the opportunity to potentially cure that. I don't think that that's --

THE COURT: Yeah. I mean, here's the thing. I mean, generally, of course, you know, if a witness's testimony is incomplete or they didn't have a real basis of knowledge for everything, of course you wouldn't strike their testimony. It

would just be well then, the jury can consider that they really didn't know what they were talking about or their testimony was incomplete or something like that.

The issue here is a little bit bigger than that because the issue here is, you know, it's the State's burden to prove these things. And what Mr. Wright is really is, you know, a jury doesn't know what they're supposed to be looking for. So a jury doesn't know that there's supposed to be backup documentation for all of these things. I mean, basically, this is a fraud case and it's numbers. Numbers matter. Mr. Wright is saying look, you know, it's their right to demand the backup and the explanation. And when that's not forthcoming or that wasn't part of the State's presentation, then it makes it look like the defense is somehow nitpicking or hiding the ball or trying to confuse the jury or whatever and that that's unfair because that should have been put out on direct and made a part of the case, the State's case in chief.

You know, a criminal case is a little different. In a civil case they could, you know, make a Rule 50A motion at the end of the State's case and say the State didn't prove it, they didn't prove the numbers, they didn't prove the loss. You know, a criminal case is different. So really, I think what the issue is is what's the remedy here for this sort of incomplete testimony. Because at the end of the day, I don't

know, maybe you guys figured it all out -- I mean, I'm still not sure her calculation -- we never figured out how it got to that number. And then when it says well this is prorated, well to me that suggests now you're prorating based on the increments, meaning like 17 minutes is different than 15 minutes and 21 minutes is different than 15 minutes is different than 30 minutes. So what does that even mean? We're left -- I don't know.

And I think what they're saying is it's the State's obligation to put that forward. So what's really the remedy in this matter. Like I said, normally, if a witness's testimony is incomplete or incomprehensible or something like that, assuming they've been qualified, that just goes to the weight. And you tell the jury, you know, in argument, that witness wasn't making any sense. But you don't strike it. This is kind of a little bit different because, you know, she's supposed to be here as the person most knowledgeable or whatever, which to me really should have been a billing person to explain all of this.

It's not the defense's obligation -- it's not the defense's obligation to try to calculate your damages. When I say damages, to try to calculate the amount of the theft. That's what's happened here. I mean, this is the most bizarre thing. You don't prove up the amount of the theft -- I mean, I get your theory is well, it's any amount because it was a

fraudulent charge and therefore, they didn't have to pay anything. But they could argue look, they were entitled to -- I'm just going to use easy numbers.

The defense would have a right to argue look, we know anesthesia was performed, they're entitled to $100. By virtue of the fact that they billed for 33 minutes, they got paid $175. And so the amount of this is $75. That's the amount they ripped the insurer off for. That's a misdemeanor. I mean, they should be able to argue that. And then if the jury accepts that, then the jury accepts that and you can argue your theory that it's any amount because they made a fraudulent statement in their thing and it should have been zero. I guess that's what your argument is going to be.

It's the State's obligation to prove this, not the defense's obligation to try to prove -- I mean, that's the weird situation I think we're in. The defense is trying to prove the amount of the damage which should have been the State's amount -- obligation. And then you can argue it and spin it however you want. That's argument and that's entirely up to you however you would want to spin it. I'm not saying that and they can't tell you how to do it. But I understand that that's your theory --

MR. STAUDAHER: May I weigh in on two points?

THE COURT: Okay.

MR. STAUDAHER: First of all, that is one part of our

theory. The other part and the statute is on point. Under NRS 205.265, if we can prove that any portion of the amount of money that was taken in this particular case was taken in a death-related manner, fraudulently in this case, we get to count the entire amount. We also get to aggregate under --

THE COURT: You can aggregate various patients together. No one has a problem with you doing that.

MR. STAUDAHER: But with regard --

THE COURT: But then you still, if you're aggregating you still -- and you're trying to get above a threshold, again, numbers matters. What was that statute? I got to look at it.

MR. STAUDAHER: NRS 205.265. It's commission or part -- excuse me. Commission or part ownership is no defense to larceny. There's a case on point, it's a 1975 case, Babcock v. State. The cite is 91 Nevada 312. In that case it says that it shall be no defense to a prosecution -- and this was an embezzlement case, but a theft-related case -- that property appropriated was partially the property of the accused and partially the property of another. The accused is still guilty of taking for his own monies that belonging to someone else. His portion is disregarded for this determination.

So under NRS 205.265, we get to count the entire amount if we can show that any portion of that is taken. It's

the -- this is a case where it's a tip jar, essentially, where the person was entitled to the money --

THE COURT: Right. They took the tip jar and it was a tip pooling situation.

MR. STAUDAHER: Correct.

THE COURT: And they said well, we're entitled to part of the tips. And that's the analogy -- did the defense know that that was the basis of the State's theory of the case?

MR. STAUDAHER: That's one.

THE COURT: Okay. Well --

MR. STAUDAHER: The other one the Court has said, articulated --

THE COURT: Well, I'm asking you about the numbers. And then I heard this theory yesterday or the day before, so I'm just saying, is that how I -- I said you spin it however you want. I'm not going to --

MR. STAUDAHER: There are two theories, Your Honor.

THE COURT: You spin it however you want, but numbers matter. This is a fraud case and however you want to spin it or whatever theory you want or however you want to compare this to the pooling of tips in a jar on a bar, that's fine. But they're still entitled to numbers. Numbers matter.

MR. STAUDAHER: Correct. But that's one of the reasons why we never -- we're getting the documents to try and

parse out exactly what portion is related to the fraudulent theft and what's not. The reason that this statute is in place, the reason that the case law shows that we don't get to count or that we get to count the entire amount is it's not the obligation of the State to try and figure out what portion of the theft was theirs and which was not. That's the state of the --

THE COURT: Except that's a tip jar where they're pooling tips. I mean, I guess you could have done it in that case. This is a little different. This is like they -- the surgery took seven and a half minutes so they'd be entitled to seven and a half and they bill for 33. So what number is that? I mean, to me -- first of all, I don't know that this is -- I mean, assuming you get convicted and this is your theory, I mean, I see a great appellate argument here and I'm not sure how the Nevada Supreme Court is going to look at the applicability of your tip case in this statute to the facts here.

It should would be nice if you had some numbers to back up your theory. I'm not telling you how to do it. But, you know, that's -- I think that they're entitled to know, first of all, where you're going with this and what numbers. Because they're going to spin it how they're going to spin it and we'll deal with instructions. I'm assuming you're going to ask for this kind of an instruction and I suggest you

provide the cites and I'm glad you brought it up now because I don't know if they were aware that this is what you were going to do, even though you sent the instructions over already because I'm sure they're going to want to do that.

Just right now, based on what I've heard, I'm not real comfortable with giving that, but I might. But I'm going to have to research it.

MR. STAUDAHER: This has been in the case since the writ in this particular matter.

THE COURT: Okay. Well, I mean, again, you start all over with the jury instructions. I didn't rule on the writ.

MR. STAUDAHER: I know. I'm just saying that it's not like it's brand new news to the defense.

THE COURT: Okay. And maybe it's not. I mean, I haven't had an opportunity sitting in here all day, every day, haven't had an opportunity to consider what instructions I'm going to be giving. I'm assuming, anticipating that you're going to want this as an instruction and I'm anticipating they might oppose it. I'm glad now I have a heads up so I can start considering it. I certainly am going to read the case that you just alluded to and if there's any other cases out there, I'm going to read them.

This is, you know, an unusual theory, maybe not --

MR. STAUDAHER: And I want to be clear with the Court. It's two theories, Your Honor, it's two theories.

THE COURT: Okay. So there's that.

MR. STAUDAHER: The first theory is the one -- or the second theory is the one I just articulated to the Court. The first was the one that the Court articulated, which is if they do what they did with the insurance fraud, that they weren't entitled to any of the money because they wouldn't have had to process the claim, the company would not have had to pay any money for the claim.

THE COURT: Here's the problem --

MR. STAUDAHER: So those are the two theories, Your Honor.

THE COURT: I was looking at this yesterday, your insurance fraud on page five, line 25. The way you've pled it, which exceeded that which would have normally been allowed for said procedure. You pled it, you prove it. That means you're stuck with what you pled. You pled or you or Scott Mitchell, whoever wrote this, which exceeded that which would have normally been allowed for said procedure. That's the pleading in the indictment, so that's what you have to prove.

Again, how you choose to prove that, as long as it's admissible, is entirely up to you. But, you know, there's been a lot of litigation on the sufficiency of this indictment. I upheld the indictment. The Nevada Supreme Court, with the exception of the RICO parts, as you know, upheld the indictment. The whole big issue was notice of what

they should have known and everything like that. So you put them on notice this is what you're going to be proving. So that's what you're going to have to be proving, in my view.

So that's one issue. How you choose to go about that -- Ms. Weckerly made it known yesterday that there's other witnesses on the list. So as long as you notice a witness, you can call them, as long as they're noticed. So how you choose to proceed is up to you.

On the other issue, you know, again, I'm happy to have a little heads up. I'm certainly going to read that case.

MR. SANTACROCE: Wasn't that an embezzlement case?

MR. STAUDAHER: That was an embezzlement case, but it's a theft case.

THE COURT: It was the tip jar.

MR. SANTACROCE: Yeah, it was embezzlement. We're charged with insurance fraud.

THE COURT: And theft.

MR. STAUDAHER: No, you're charged with theft.

MR. SANTACROCE: And theft.

MR. STAUDAHER: And that's why it's applicable to the theft --

THE COURT: So even for your insurance fraud, which doesn't have the dollar threshold, you still -- you know, again, you pled it.