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 40

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observed by her fellow employees, she was observed to have been following the correct procedures.

The other reason why the saline flush, of course, was eliminated was because Mr. Ziyad, the source patient on July the 25th, didn't get a saline flush. His hep-lock was administered by R.L., Ron Lakeman, and that makes sense because he was the first procedure of the day.

He just went straight into the procedure room. He didn't go into pre-op. And so Mr. Lakeman is the one who administered the hep-lock. The CRNAs didn't really use saline, certainly not the same saline the nurses would have used. And what happens after that? Well, Mr. Washington ultimately gets hepatitis C.

What was important to both investigations ultimately was the propofol going from room to room. But the CDC and the Southern Nevada Health District actually had kind of a different way of assessing this, that, you know, the disease infection, how did it move into two rooms on -- on September the 21st? They didn't seem too tied up in that fact or too concerned about it.

They are -- they were more like of course it moved into the other room, it must have happened, it doesn't affect our analysis one way or another. We're able to reach our conclusions without knowing that because the -- they just made, I guess, a conclusion that in some way it went from room

to room and that was obvious by the perpetuation of infection in the second room.

Now, what the Las Vegas Metropolitan Police Department and Detective Whitely, that kind of conclusion, you know, there's no witness for that. You have to flush that out a little. And so you heard from people he interviewed that talked about propofol moving from room to room.

Ann Lobiondo talked about it. Linda Hubbard talked about it. Ralph McDowell talked about it. And Marion Vandruff talked about it, how propofol moved from room to room. So you actually heard from witnesses that described that phenomena, which, of course, explains how it ended up in the second room.

Now, the multi-use, multi-patient use of propofol vials, obviously that was important to both investigations and that's really not in dispute that the clinic was using maybe three to -- two or three to one ratio of vials to patients, and that was part of the problem, obviously, the first half of how the disease got perpetuated. And the CDC got that information from their visits to the clinic.

Metro went and did supply counts for the days, which are reflected showing that the number of patients versus the vials of propofol indicate certainly that there's a lot fewer vials of propofol than there are of patients on a particular day. And they did it for the year or two. And you'll have

the ability literally to count out the logs every single day if you want to when you're in the deliberation room.

So what was the last piece that caused contamination? And that was syringe reuse to redose a single patient. Now, the CDC and the Southern Nevada Health District saw this occur with Keith Mathahs on a single patient. They saw him unscrewing the needle, putting a new needle on, and re-accessing a vial of propofol that he would ultimately -- and ultimately intended to use on the next patient. So the dangerous practice they observed with one CRNA.

Now, the Metro investigation, of course, was broader. You heard from Ruta Russom. She was a GI tech. She saw syringe reuse by Mr. Lakeman within a single patient. You heard from -- statements from Linda Hubbard that talked about syringe reuse. You heard from Keith Mathahs. He talked about syringe reuse of the same syringe from -- within the same patient. Which, of course, is the first step; right?

I mean, you either -- you either need to have many, many, many vials of propofol, one for each patient, or you need to be using a whole lot of syringes in order to accomplish the administration of the anesthesia aseptically. And the endoscopy center was wrong on both ends. They didn't have enough vials of propofol, and they didn't have enough syringes. So that's why the disease occurred.

Now, both of -- as you heard the instructions read

to you by Judge Adair, both of the crimes relating to the patients deal with an aspect of recklessness. There's the crime of performance of an act in reckless disregard of persons or property, which requires the person to know a risk and -- and disregard it in an unreasonable manner.

Their conduct has to be willful and wanton or indifference, indifferent to the consequences of the risk. For the criminal neglect of patients, they have to be aware of the risk, as well, and have disregard of it, which is -- which is another way of saying that they were reckless, that they saw a risk and that they chose to disregard it.

The issue for you to decide as criminal jurors is did they see the risk? And you know from Dr. Alter and all of the nurses that testified in this case that not using -- reusing syringes is basically nursing 101. You learn that on your first day in nursing school.

And we brought in this trial a parade of nurses before you, Pauline Bailey, Janine Drury, Lynette Campbell, Jeff Krueger, Ann Lobiondo, Linda Hubbard. All of them, all of them knew that this practice of multi-use of propofol in combination with reusing a syringe on a single patient was a dangerous practice and could lead to contamination.

You had doctors testify, Dr. Carrera knew that that was dangerous. Dr. Carrol knew that that was dangerous. Dr. Herrero knew that that was dangerous. Even really early on in

this trial, Dr. Yee knew it was dangerous. Dr. Satish Sharma said it was a dangerous practice. So all of these people knew that you couldn't engage in this practice and that it was a reckless practice, but you're to assume that these two defendants were the ones that didn't know.

You all sat -- think of the -- think of the testimony alone of just Dr. Miriam Alter, which was -- it was -- it was a good chunk of the day, but not nearly as long as nursing school, right, which would be several -- several months, years, endeavor. And she talked about syringe reuse for maybe, you know, a certain amount of her testimony, a certain portion of her testimony. I bet none of you have a doubt about the danger of syringe reuse, and you've heard less than one day of testimony about it. How it escaped the knowledge of Mr. Lakeman and Dr. Desai is just not -- is just not reasonable.

The theory, though, of the defense seems to be that because when the CDC contacted Keith Mathahs and they saw him changing the needle on the syringe and he responded, oh, I didn't know you couldn't do that, that somehow that means that there really wasn't an understanding of a risk because he said he didn't know.

And this is a man who, at that time, had been working in anesthesia for 30 years and he hadn't reused syringes before, but because he comments to -- makes an

offhand comment of, oh, I didn't know, you're to assume that no one has any knowledge about the danger of syringe reuse, even though it's taught throughout nursing school and medical school. And that's kind of the -- one of the fundamental questions in civil versus criminal. Because to be criminal, this has to be a reckless act. To be criminal, they have to have known of the risk and disregarded it.

So the question is, is it plausible that they wouldn't have known the risk? I mean, in Keith Mathahs's case, if that had really been accurate that he just didn't know up until that 30 year point in his career, that should have been a pretty seminal moment in his working life. But when he testified on the stand, he barely remembered the conversation. More than that, he indicated that prior to that conversation he had a discussion with Dr. Desai about the risk of reusing syringes, indicating that he was aware of it.

So, you know, I didn't know is sort of a way of avoiding responsibility. It's like saying there's a lot of people that continue to have unsafe sex with -- with strangers. They must not know that there's a danger of disease transmission, or I didn't -- I'm sorry, officer, I didn't know I was in a school zone. That's why I wasn't driving slower. Or I didn't know I couldn't write that expense off on my taxes. Sometimes I didn't know isn't an excuse to lower your own responsibilities. And more

accurately in this case, the I don't know could be something like I didn't know that my anesthesia time related to insurance billing.

Now, Miriam Alter also testified about the history of hepatitis C, which medical providers would be aware of. There was the identification of it, which these defendants were alive for. There was the outbreak in New York City, which got a lot of public attention. There was the outbreak in Oklahoma after that which got a lot of media attention, and another after that, and another after that.

And all of this is telling people to not engage in unsafe injection practices, not to reuse needles, not to use the combination of using the same needle on a patient, and then a multi-use vial on the next patient. All of that was in the media, according to Dr. Alter. So is "I don't know" even possible after that?

Moreover, there was the mailing that you saw from the CRNA professional association which was the warning, don't engage in this practice, do not do this, this is a dangerous practice that Mr. Lakeman should have gotten. That was in 2002 that that came out. These individuals also historically lived through the identification of hepatitis C scientifically.

They certainly were around when AIDS came to light and all the precautions that were necessary in association

with that disease. General knowledge that everyone seems to have about the dangers of blood-borne pathogens and how they could be transmitted. So "I don't know" sort of becomes less plausible.

On top of that, you heard from the CDC representatives about the campaigns that they have done over the years to alert healthcare providers of these dangers. And "I don't know" seems less plausible after that. Under the defense standard, five years from now, after all this, if a healthcare provider would say, gosh, I didn't know, I didn't know that was a danger, that would be sufficient. You have to look deeper. Is this plausible that they didn't know?

And the real distinction with Ronald Lakeman is he did know. He had the conversation with Dr. Schaefer where he explained the practice that he engaged in. He said two things about it. One, he would deny the conversation if it was ever brought up, indicating he had said something about an unsafe practice.

Secondly, he said that he used negative pressure on the syringe to make sure there was no -- there was no mix or contamination that occurred. The very act of using the negative pressure indicates that he was trying to accommodate or address a risk. He was aware of the risk; he tried to address. He just -- it just didn't work.

Now, as to Dr. Desai, he would have had knowledge,

as well. He had every bit of knowledge all of the other doctors had, and they certainly knew of the dangers of this. And remember, Dr. Desai is a gastroenterologist. He treats people with hepatitis C regularly. Surely, someone who does that would be familiar with the risk factors associated with hepatitis C transmission, and he certainly didn't need to ask his boss, Dr. Carrcl, about any sort of facts about transmission. Desai also had conversations with Keith Mathahs and Linda Hubbard, which indicated a knowledge of the risk, but he went forward anyway.

Now, the crimes themselves of -- in terms of the patient crimes have an element of substantial bodily harm, which is defined as bodily injury, which creates a substantial risk of death, or which causes serious permanent disfigurement or protracted loss or impairment of the function of any bodily member or organ, prolonged physical pain. And then you also have to determine whether the criminal act was the proximate cause of the substantial bodily harm.

And let's look at our victims in this case. We know that Michael Washington came into the clinic with some stomach upset and diarrhea, and he left with hepatitis C. Rodolfo Meana, he came in with constipation; he left with hepatitis C. Stacy Hutchison came in with some bleeding, and she left with hepatitis C. Sonia Orellono, whose is pictured there came in with constipation, and she left with hepatitis C. Patty

Aspinwall came in for a diagnostic test and left with hepatitis C. Gwendolyn Martin, she came in for heartburn; left with hepatitis C. And Carole Grueskin came in with some slight bleeding and left with hepatitis C. So the all came in with minor problems, and they left unknowingly with bigger ones.

Now, Sonia Orellono Rivera may be the patient that overall did the best. She's the youngest. She didn't have severe acute symptoms. She felt ill, she felt tired, and she says she still feels that to this day. But it was -- you know, it's taken a toll that she hasn't undergone Interferon treatment. So maybe she did the best, but she still had to change her life, and you saw her testify. This isn't an easy thing for her. She still had to take precautions. She still had the stress of wondering if the disease was going to surface, and she certainly suffered.

Now, Patty Aspinwall, maybe she did the second best of the seven we have, although she was hospitalized because of her acute systems, which certainly would constitute substantial bodily harm, and she also had to deal with the stress of wondering if the disease was going to come back or the steps that she had to take to protect her husband. She had -- she had substantial bodily harm.

Now, Stacy Hutchison and Gwendolyn Martin, they went a different path. These women actually underwent the

Interferon treatment. This was the treatment that lasted like for almost a year with the shots and the pills and feeling depressed and feeling crazy and tired and fatigued, all of which constitutes substantial bodily harm.

But they ended up with a good outcome relatively speaking, in that they don't seem to be suffering from those symptoms now and there's no indication of disease in their system. But there's no requirement that hepatitis -- or that substantial bodily harm be permanent. They certainly went through a long phase of pain and suffering.

And maybe sadly, predictably, the three people that have done the worst since their infection are the oldest ones. You saw Michael Washington testify. He is hoping, according to his wife, for a transplant, a liver transplant. She also described him as being mentally different and physically different, and you can make your own assessment based on your recollection of his testimony.

Carole Grueskin didn't seem to ever recover from the stress of learning what -- learning that she actually had been infected by -- infected with hepatitis C at the clinic. You heard from Dr. Lewis that there was no sign of dementia. There was no sign of her loss of competency prior to her going to the clinic and learning of the diagnosis. And now she -- she doesn't know where she is, she doesn't know what her name is, she doesn't know any of her history.

Rodolfo Meana, he obviously had the -- you know, the worst outcome. He -- he ultimately died from this. And before he died, he suffered the symptoms of feeling ill and feeling fatigued.

So let's talk about the crimes, the first crimes that are -- that are relating to patient care, and this is performance of an act and reckless disregard of persons or property. And the elements of this crime, essentially, a reckless act sort of disregarding the safety of another, but it doesn't have to be by a healthcare provider. It's just a reckless act that unreasonably risks the safety of another individual. And this is where direct liability and conspiracy liability and aiding and abetting kind of come into play.

On July the 25th it's Ronald Lakeman who is treating both the source patient and Mr. Washington. He is the direct actor. He is the one that did the injections on both of those people. So his actions, he is the direct actor for that -- that act.

Now, on September the 21st Mr. Lakeman was working with Keith Mathahs, and you know Lakeman treated some of his own patients directly, and then there's kind of an interplay between the two with supplies and also Mathahs's patients. And there has been some talk in the -- in the courtroom about how these -- these patients must have been treated -- must have been treated at the same time.

If you look at the 21st, it's clear that the day starts off with Clifford Carrol covering both rooms. And he's clearly not in, you know, two places at once, so these -- these room times, as we've talked about it again and again, they don't -- they don't represent real time because otherwise he would be in two places. But Dr. Carrol does this procedure, this prccedure, this one, this one, and he kind of goes back and forth as they testify between the rooms.

We get to Kenneth Rubino, and that -- that's sort of the last one he does, and then Carrol testified that Dr. Desai comes in. And this is Lakota Quannah. And if you look down here, Stacy Hutchison has Dr. Desai, too, as her doctor. So somehow Desai is going back and forth between the two, and there's no -- there's no suggestion that he's in two places at once. It's just the timing is off. But there's really no question that Stacy Hutchison is treated after Kenneth Rubino. There's no mystery about that.

Now, we know that there were also skips along the way, some people who didn't get infected. And we heard from some experts about that, that sometimes people can be exposed to the virus and they might be a lucky person who doesn't -- who is able to clear it on their own and doesn't have the virus. Or Dr. Alter said that maybe they wouldn't have enough of a viral load to actually contract the disease. Or, you know, there's a lot of happenstance into how the -- the clinic

did it's practices. Maybe they actually got a prefilled syringe and that's why they got skipped along the way.

But the question is were the practices unreasonable? Were the practices ones where there was a risk associated -- associated and that was disregarded by Ronald Lakeman? And obviously that was the case. Every -- every medical provider you heard from talked about how unreasonable it would be to engage in that type of administration of propofol.

You cannot reuse syringes and reuse vials. The combination of the two spreads infection. And you can't really say that it was just one bad day for Lakeman anyway, because he's there on July the 25th, and he's also there on the 21st. Actually, only he and Desai are there on both days.

Now, with regard to the patients that Lakeman didn't treat, meaning Mathahs's patients on the 21st. Lakeman has what we call aider and abettor in conspiracy liability for those patients. As the Judge instructed you, conspiracy liability occurs when there's an agreement to do something illegal. And if you agree with another person to engage in an illegal act, you're responsible for the foreseeable consequences of that act.

Similarly, if you aid and abet in a legal act with the intent to -- to commit a crime, which is in this case employ dangerous practices or perform this -- this act in reckless disregard for patients, you're responsible for what

your cohort does. So the agreement, of course, between these two CRNAs was not to infect everybody with hepatitis C, but the agreement was, look, we're going to engage in these injection practices. That's a dangerous practice. We understand the risk, but we're going to take the risk and go along.

And they worked together doing it because we know they shared their supplies against all their training. We know that propofol now went back and forth. And there really is no tie of one patient to another in terms of the care. There were -- the way the infection perpetuated, it was possible to infect this many people because both of them were willing to engage in these dangerous practices. And once they violated the standards, it was sort of up to fate as to who was going to get infected and who wasn't. It wasn't tied to a particular CRNA. So Ronald Lakeman has liability for Keith Mathahs's patients, as well.

Now, Dr. Desai, although he's there on July the 25th and September the 21st, he doesn't do any of the injecting, so he's never the direct actor. He is what's -- he's what's called an aider and abettor or in the conspiracy. And aiding abetting -- aiding and abetting is simply encouraging someone to commit a crime. And in this case, it's that performance of an act in reckless disregard of persons or property.

And Dr. Desai we all know is many things, but one of

those is he's very intelligent. He's had training, the same training as all the other doctors who testified in this case and knew of a risk associated with this type of injection practices. We know that from Keith Mathahs that there was a discussion with himself and Dr. Desai about the dangers of reusing syringes.

And you also know about the conversation that Linda Hubbard related to the police about Desai instructing her to do anesthesia Ron's way, which means with the reuse of syringes. That is aiding and abetting. Now, there's been some suggestion that the statement that Linda Hubbard made was coerced or that she was lying about it.

You heard from Detective Whitely that there was no coercion with that statement. He was present in the interview. And think about what the -- the statement was. I mean, Linda Hubbard in 2008 is able to recall a pretty subtle conversation that she had back in 2005 with pretty good accuracy.

Now, there was the -- the point that, well, look, you know, she started in August 2005 and they didn't order those 50 milliliter vials until October. So -- so there was like a six-week gap there. Her conversation didn't say it was the day I started. And the other thing I would point out is people are kind of, you know, bad about time.

I mean, Ralph McDowell testified that in 2008 it was

six months earlier that there was the discussion about using saline with propofol, which would have put the time at the -- at the end of 2007. And he was clearly wrong about that because Ann Lobiondo said she was at that meeting, and she had left the clinic by the spring of 2007.

And Vince Sagendorf hadn't even heard about the meeting and he was there at that time period. So just -- just because the time period is off isn't really suggestive of deception. It's just how people, when they're working in the same place every day and they have discussions, it's hard to pinpoint an amount of time.

You also saw Linda Hubbard, okay. You saw Linda Hubbard testify I don't remember, I don't remember. And you know Linda Hubbard is the person who never seems to have the glove on, who is capping needles, who is pulling off needle caps with her -- with her mouth, who is still pulling propofol after the CDC comes, who is still willing to use the 50s even when there is a memo or an edict that she's not supposed to do that. Now, do you really think that woman is capable of conjuring up this subtle conversation just -- just to benefit the police, or is she actually recalling something that was actually said?

Now, Desai, you know, he had a policy about everything. He told Vince Sagendorf, don't use more than 200 milligrams of propofol on a single patient. Don't use a lot

of tape to the nurses. Don't use too many gowns to the doctors and the techs. Don't use too much jelly to the techs. He tells Ralph McDowell, you're the most expensive CRNA, you use the most propofol.

There was nothing that wasn't controlled by him. He was focused on saving money at every turn. And it wasn't like some eccentric personality that you have with like a paternal relative that, well, he just doesn't like lollygagging and, oh, he just doesn't like waste or people standing around. That's not what this is.

This is a willingness to compromise patient care to collect a couple cents on each procedure. He was willing to do that. And what's sobering, actually, in this case is that it wasn't that hard for him to get other people to compromise, as well. The ones who didn't left quick, and that was Anne Yost, Jean Scambio, and Karen Peterson who all left like within days or weeks of being employed there.

Now, the second -- the second crime that deals with the care of the patients is the criminal neglect of patients. This one is a little different in the sense that it -- you have to be a professional caregiver for the crime to apply to you. There's a recklessness aspect to it to where you have to have engaged in reckless behavior and it has to be a departure from the standards of an ordinary prudent person, and the harm has to be foreseeable.

And we know that -- that the behavior itself was certainly reckless, and we know that Ron Lakeman had an awareness of it and that it was just not a practice that people engaged in. It was a departure from what an ordinary person would do. And was the consequences, you know, was it foreseeable?

Well, they're injecting people into their blood stream. It is foreseeable that they would get a blood-borne disease if they're cross contaminating their vials of propofol. This wasn't a mistake, it wasn't misjudgment, it wasn't a misunderstanding. It was a calculated risk that something probably wouldn't happen, and they were wrong in the calculation.

In terms of the criminal neglect charges, Lakeman has, of course, liability for the patients he treated himself, meaning Mr. Washington on July the 25th, his own patients on September the 21st, and through conspiracy and aiding and abetting liability for Mathahs's patients on -- on the 21st, as well.

Now, Desai, once again, isn't the person injecting the propofol, so his liability is solely as to being an aider and abettor or in the conspiracy. And we know that Desai was aware of the risk because he had those discussions with Linda Hubbard and Keith Mathahs.

It's also a fair bet that the harm would be

foreseeable for him as a gastroenterologist who treats people with hepatitis C. He might be aware that if you contaminate vials that you're injecting in people's blood, that hepatitis C might be spread. And it wasn't the result of misadventure or a problem or a misunderstanding. It was a calculation made to cut costs.

Now, the -- the sort of second part of this case is about financial crimes or insurance fraud, essentially. And the -- the way they -- the way they committed the insurance fraud was sort of via a group effort, and that's what made it impossible, really. Because if you have one CRNA that is actually putting in the correct times, that would have been kind of something that would stick out to the insurance companies as they process the claim.

So this certainly was a practice that all the CRNAs were involved with and all, you know, could have been charged for their part in committing the insurance fraud. It was a group effort. I mean, remember the testimony of Rode Chaffee where the CRNAs would be talking to each other that I can't take another PacifiCare patient. I just had one. And so they'd switch the order so the PacifiCare wouldn't have the times overlapping on the insurance claims.

That kind of thing, that sort of behavior is evidence of a conspiracy. On the two days in question, Mr. Lakeman himself worked about ten hours. Maybe a little --

give or take ten hours on the -- on July the 25th and on September the 21st. He actually billed a little over 14 hours in his anesthesia time.

So you can go back and you can compare the tape reads versus the anesthesia time -- anesthesia time recorded and see if you see the discrepancy. And you now from Joan Syler that they're not allowed to overlap, they're not allowed to bill more hours than there are in the day, and they're not allowed to count recovery time because they're no longer caring for the patient at that point.

Now, a couple things are unusual with the insurance counts. One of them concerns Sharrieff Ziyad. His claim, when you look at his 1500 claim, it actually -- they made a mistake, the clinic made a mistake. They put eight, meaning eight units, but that insurer wanted time, like minutes. And so that insurer on his claim actually only pays for the eight units.

There was an attempt to defraud there, but it really didn't work out because they -- they submitted the information in unit form versus minute form and the insurance company paid according to the minute form. So the endoscopy center didn't really make extra money on Sharrieff Ziyad's claim.

With some of the other patients, with Carole Grueskin, with Stacy Hutchison, and with one of Patty Aspinwall's insurance claims there was just sort of a flat

rate pay. So although they certainly -- they -- they put in the false numbers and they got up to the 33 minutes, there was no net gain to the clinic as to those claims.

The State's perspective is, though, and you can evaluate the testimony how you see fit, is that the insurers testified that if there was false information on those claims, they wouldn't have paid them at all. And so ultimately they got money that they shouldn't have been entitled to. And you -- you can recall the testimony and -- and make your own assessment of it.

The other people where there was a clear gain, that occurred with Sonia Orellono. There was extra units paid. There were extra units paid on Patty Aspinwall's claim to United Healthcare Partners, and there was extra money paid on Gwendolyn Martin to PacifiCare. The insurance fraud is pretty clearly established in this case.

Now, Desai's participation is also established. Remember that memo, the PacifiCare memo? You can look at that in the deliberation room where he is actually instructing the staff not to put PacifiCare members in -- in close succession with each other. And you also know that he told Ann Lobiondo, hey, remember to make your time 31 minutes. And he told her that more than once, and that was for the insurance claims as well.

And you also know from his conversations with Tonya

Rushing that as this is all crashing down and she's crying and talking about insurance fraud and that this -- you know, she's worried about what's going to happen to her, he doesn't really have much of an answer for her. His involvement in that, it was his design.

Now, there are other crimes sort of associated with -- with the insurance themselves. There's a count of theft which has a threshold value of $250. And as you look at all the people that -- that are charged or that consist in that count, you may be adding up in your head like, well, is that -- you know, did they get 30 extra dollars there, did they get ten? And it's kind of a tedious prccess.

Just so you understand, the State's theory on the theft count is based on what the insurance representative said, none of these claims would have been paid if there -- if they had known there was false information on them and that would add up to $250. And that same analysis applies for the obtaining money under false pretenses, as well.

The last charge that I'd like to talk about is the death of Rodolfo Meana, which is a murder count. Now, normally, we all think of murder as the intentional killing of a human being, and certainly that is the form of murder. But under the laws of Nevada there is a lesser form or a less severe form of murder, and that is second degree murder. That occurs when someone engages in an inherently dangerous

unlawful act and there's a death resulting from it. And there's other requirements to the crime. Or they engage in an inherently dangerous felony and death is what results.

In order for you to find the defendants guilty under this theory of murder, you'd have to find that the death was foreseeable. And that is -- I mean, that is what happened in this case. Is it foreseeable that Rodolfo Meana would contract this disease, and is it foreseeable that someone would ultimately die from that disease.

Now, you heard that he was in sort of a weekend state, that he had a lot of health problems, and that he also had problems with his kidneys and so there may be some issue regarding what the ultimate cause of death was. And I'd ask you to consider the testimony of Alane Olson who observed the autopsy, actually saw the organs and actually made an onsite assessment of the cause of death. And she said that the death was caused by complications from hepatitis C. She saw literally the toxin spill out of his body when he was taken to autopsy.

The other aspect I'd like to remind you of is this. As to the element of the cause of death, it is sufficient if from the evidence it is proven beyond a reasonable doubt that Rodolfo Meana's hepatitis C was of such nature that in its natural and probable consequence it produced death or at least materially contributed and accelerated death. So you can

consider that instructions -- that instruction in your evaluation of the murder count as well.

Now, again, because neither Lakeman or Dr. Desai was the person who administered the propofol to Rodolfo Meana, their liability is premised on conspiracy and aiding and abetting. But it was just by happenstance that Mathahs would have ended up treating Meana.

I mean, there was no rhyme or reason as to why Mathahs got him as a patient rather than Lakeman. So Lakeman has -- has responsibility. And in terms of, you know, Dr. Desai, was this something that was foreseeable given his knowledge and his expertise and the nature of the disease, you know, it certainly was.

In the end you'll have a duty to sort through, you know, literally all the facts and the evidence in this case and make an assessment. And, you know, people in their 50s and 60s and 70s shouldn't be going in for routine colonoscopies and coming out with communicable diseases. It was 2007 when this happened. It was at a time when the nature of this disease was understood and the precautions that needed to be taken to administer medication were well known.

Their infection was the result of laziness, sloppiness, and arrogance. It wasn't the result of a lack of knowledge. They took -- I mean, they ended up taking chances with other people's health and well-being, not their own, and

those people dealt with the consequences. And the really ironic part, or ridiculous part, I guess, is that it was all so avoidable. I mean, none of this needed to happen. None of these people needed to get sick. None of the people at the clinic needed to have trouble finding a job. No one needed to lose their license.

But it did happen and it did occur and it was the result of reckless behavior. And in the end, your collective verdict is going to write sort of the ending to this story. And part of -- part of that will be your -- your assessment of the evidence. You will write the end of the story.

And unlike the civil cases and civil judgments that you've heard about in this case, this is in criminal court, and this case, the criminal case, it's about pennies. This case is about pennies because the only thing that caused those people to get infected was the decision not to spend a couple more dollars on supplies per procedure. It's pennies that were saved on these practices. And it wasn't worth it and they knew better and they should be held accountable.

THE COURT: All right. Thank you, Ms. Weckerly.

Ladies and gentlemen, before we move into the closing arguments for the defense we're going to take a brief recess. Obviously, the case is not over so I must, again, remind you of the admonition 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 the case, person or subject matter relating to the case. And do not form or express an opinion on the trial.

Notepads in your chairs, and please follow the bailiff through the rear door. We'll take about ten minutes.

(Court recessed at 11:23 a.m., until 11:36 a.m.)

(Inside the presence of the jury.)

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

And, Mr. Wright, are you ready to proceed with your closing argument?

MR. WRIGHT: Yes.

THE COURT: All right. Thank you.

DEFENDANT DESAI'S CLOSING ARGUMENT

MR. WRIGHT: My name is Richard Wright, as I start with every witness. You all know by now that's Margaret Stanish. We represent Dr. Desai. And first of all, myself and the Desai family want to thank you for your terrific effort. We understand.

I stood here two months ago and talked to you about this case and we do know the -- the individual efforts in that which you have given up to be here to participate in this. It is an awesome undertaking when you're talking about like ten weeks of being here, all to help the State and the defense try

to achieve justice in this case, which is what this is about.

I started off talking to you in my opening statement about the fundamental principles that would be guiding us, you all, as you decide this case. And I talked about it because now you've heard it all, the civil cases, some of the civil witnesses, some of the evidence about it's this is a likely cause. But we're in a criminal case, so I'm going to once again go over those fundamental bedrock principles which makes this different than the civil litigation which has already all taken place.

First of all, criminal case indictment. Both defendants are indicted. You have the indictment. We're not going to read it because it's so long and so confusing. But it's Instruction No. 3, and that indictment is an accusation and it's not any evidence. And as we stand here even today, the defendants are still presumed innocent.

When you go in and deliberate and review all the evidence, then you'll make a determination whether the case has been sufficiently proven. But I talked about this with you all at the inception because the presumption of innocence is almost counter intuitive that I must presume, that is I have to say the man is innocent as the trial starts and progresses.

And then the question becomes in our criminal justice system, okay, he's innocent right now, he's accused of

very serious felonies, billing, murder, medical negligence, reckless disregard. Who has to prove it and what do we have to do? But who has to prove it? The burden of proof is solely on the State. That means they have to prove every element, everything to your satisfaction, and we don't have to bring in any evidence whatsoever.

We don't have to bring in a single witness. All -- all we will do is cross-examine witnesses. We can bring in witnesses if we want to. You saw by the end of the case we brought in Dorothy Sims and we brought in Dr. Howard Worman from Columbia University. Other than that, the defense rested.

So the State has to bring all of the evidence that you need to make the determination. Okay. So now making the determination, how -- how certain, how conclusive do you have to be before you convict a fellow citizen? And that's what we call the quantum of proof, the amount of proof.

Now, you now from -- we've heard about civil cases. In a civil case it's simply like 51 percent of the evidence is all that matters in a civil case. Whoever makes it more likely than not. Just push the ball over the 50 yard line, and that's good enough for one side to win.

In a criminal case, it's proof beyond reasonable doubt. That means excluding all of the other alternatives to your satisfaction so that you have an abiding conviction,

that's the definition that's in your instructions, that on the most important affairs in our own individual life, you would act absolutely like that without hesitation because you're so firmly convinced that the evidence comes only to that one absolute conclusion. That's what has to be shown in a criminal case.

And this testimony we've heard from Brian Labus, from Miriam Alter, from various CDC representatives about the causation and it's the most likely cause is this or that. That's simple stuff. You didn't hear a single expert or witness come into this courtroom and say I have ruled out every other method of causation and I will tell you beyond reasonable doubt to a certainty this is how it happened on that day.

And a witness came in here and said that. All you heard was the civil standards about most likely. So that's the amount of evidence that has to -- or that's how convinced you have to be. And the State has to present it all.

Obviously, my client didn't testify, nor did Mr. Lakeman. And there's an instruction in there, once again, this is counterintuitive, but the instruction tells you it's their constitutional right, the same right you would have if you're ever sitting over there and I'm representing you, that's the right that you do not have to testify and you don't have to say a single word, and that the jury will absolutely

not hold that against you if you were the defendant or against my client.

So once again, you have to work on that. You can't think, well, gee, I'd like to know what he has to say about this, or I'd like to have an explanation or answer for that. If you even speculate along those lines, you're violating the instructions which you've agreed to abide by.

You just have to accept it that they are relying upon, as the instruction says, the advice of their counsel, and their counsel has made the determination the case has not been proven, there isn't proof beyond a reasonable doubt, so we don't have to do anything other than rest and argue the case based on the evidence or lack of evidence that the State didn't bring into those courtroom.

So with those -- with those guidelines, I'm going to first talk about the billing, theft, obtaining money under false pretenses, and false medical billing counts. As -- as you know, there's two components to the case, what happened on the healthcare and whether that was reckless and how the transmission of hepatitis C occurred, and then the second part, just like a second, separate trial, is the billing fraud component of the case.

And, of course, the billing fraud, as I just call it, I love the three different charges all into one thing, because factually it all has to do with the same thing, with

the anesthesia time, unlawfully, knowingly, intentionally inflated. In other words, too much anesthesia time means higher billings and did that get the clinic, the defendants, money they weren't entitled to.

And it's -- even though we've talked about it generically and generally, clinic practices and everything else, we are dealing with discrete individual counts, crimes in the indictment. There's like 27 separate crimes in there and nine, ten, eleven, twelve of them, twelve deal with the false billing.

And so what you've had to do and why -- why we dragged in all of these insurance company witnesses, Veterans, Blue Cross Blue Shield, Health Plan of Nevada, because every one of them had to deal with one count, one bill, and how much was paid, how much should have been paid so we can come up with a number and see if there was a loss, because that matters. Because is it over 250, under 250?

And so that's why a lot of what was boring and methodical, but you have to count by count because you're going to see that -- and I will -- I will put up a chart for you all and you can go through the calculations. You're going to see that the grand total, the grand total in the case of the total false billing if we just use absolutely the doctor's note times, in other words, the time when the doctor started his procedure until the time he ended his procedure.

If we use that as the anesthesia time and ignore pre-op interview and ignore taking them out to the recovery room, we come up with a grand total overpayment, total of all counts of $219.40. And if we do the amount of overpayment by Lawrence Preston's method, he was the witness who came in, Larry Preston, I'll go through his testimony. But he was the one who initially set up anesthesia billing, started the CRNA program when Dr. Desai went from anesthesiologists to CRNAs.

And Lawrence Preston is the fellow who testified that from his years of experience and him owning a billing company and starting the billing practices for Dr. Desai, that the anesthesiologist time is from the -- when he starts history and physical, starts interviewing the patient, did you -- do you drink milk, are you allergic to milk, all of the questions they ask on that form, from then until they leave the recovery room. Leave the recovery room.

Now, that's what Lawrence Preston testified. And he explained because the recovery room -- it isn't like a hospital. It's an ASC. The recovery room is right -- the CRNAs are over there, the recovery room bays are right here. They are responsible for the patients, and his words is the billing time follows the responsibility for the patient.

And until the blood pressure, that last check is taken and they are unhooked in the recovery room, Lawrence Preston says that is the anesthesia time. And so if you view

that as the anesthesia time, you will see that the total overpayment for all counts is $54.70.

Now, to be certain so that we focus solely on what we are talking about, which is was the amount of time overstated on the bill, and you can go through and look at all of the bills, but that was at 1500. And so a bill went in with an amount of time on it saying it's 33 minutes and that's why Margaret sat there and worked through all these different calculations which end up on my chart.

She would say each of them, if it was eight units, if there was a base units of five for payment, and then the first 15 minutes got you one unit, second 15 minutes got you a second unit, five, six, seven. And then if you went over 30 minutes you got a third unit you add, so that's eight. And Margaret would say, what if it's eight, how much do you get? What if it's seven, how much do you get? What if it's six?

Because what the charge is in the indictment is the accusation that they got paid too much, more than they were entitled to because of the excessive time. The charge is not they were entitled to nothing. You can read every single insurance fraud billing count. I will just use one as an example, which is Count 14, insurance fraud. And the -- the theft counts and insurance counts, the theft counts, fraudulent billing counts, and obtaining money under false pretenses counts all use the same factual allegation of

wrongdoing.

And the factual allegation on this is that they falsely represented, in other words the bill falsely stated that Anthem Blue Cross Blue Shield, that the billed anesthesia time and/or charges for the procedure performed on Patty Aspinwall was -- were more than the actual anesthetic time and/or charges.

Said false representation resulting in the payment of money to the defendants, which exceeded that which would have normally been under a -- which would have normally been allowed for said procedure. So what -- what we're talking about as the fraudulent allegations is how much more did they get? Because they're entitled to some amount, and that's what I worked out on the charts, if you accept the State's version of the evidence.

And so the sole dispute of every one of them is the billed anesthesia time was more than the actual anesthesia time. In other words, they padded it by minutes, and by how many and how much of those padded minutes were. That's ever single count.

Now, how did we get to the billing practices and where we were? Because a false bill is one half -- is one component of the criminal charge. The second component -- they first have to prove, the State, that the bill is wrong. That when that says 34 minutes, it -- it truly should say 17

minutes.

That would be a one-unit difference, and that would translate in some counts into like 38 bucks. In some counts it made no difference. There are counts in here in this indictment that were flat fee payment whether you put down 280 minutes or 1 minute, you got 90 bucks. So there was absolutely no loss, and that's why the number comes out so low.

But how did we get there? Dr. Desai has got his clinic. He was using anesthesiologists, as you know. One of them was Dr. Yee, a fellow who came in and testified. He's using MD anesthesiologists. He's got one procedure room over on Shadow Lane. And then in about 2001/2002, the determination was made to go to CRNAs rather than anesthesiologists. And Lawrence Preston testified to this.

And the decision -- there were several decisions that had to be made. And he testified -- he told them contact the nursing board, contact the State, because one thing you have to figure out is can a CRNA work in Nevada without a MD anesthesiologist supervising him. And for the first year or two at the clinic there was confusion about this.

And they even set up, Mr. Yee testified about it and Mr. Satish Sharma came in and testified about it, entering into an oversight agreement by MD anesthesiologists, which they signed but never was implemented and never went into

effect. Because it turns out in Nevada you don't need an MD anesthesiologist. All you need is a CRNA working for a podiatrist, a dentist, or an MD, and then that person is the responsible supervisor for the CRNA.

So Lawrence Preston testified the question was what should they have done? Dr. Desai was having problems scheduling anesthesiologists to come in for all of the procedures. And so should he hire anesthesiologists to work for the clinic, or hire CRNAs?

And Lawrence Preston testified that if you hired anesthesiologists, if you can get some that would come to work there like for a salary, anesthesiologists get to bill more. CRNAs have a reduced factor. I think he testified it was like 85 percent. So if you hired anesthesiologists, their bills get paid higher. The question would be would they work independently and put in their own bills and keep the money, or should the clinic hire them and bill them out and just pay them a salary?

The way they -- the determination was made, Lawrence Preston testified to, to go with the CRNAs because you can get more of them, ending up hiring five or six, including part time. So CRNAs were hired. The first CRNA was Ms. Lobiondo. And she testified that she brought some of her forms with her because CRNAs had never been used in the clinic, had not been used anywhere in this fashion. She had been working at North

Vista North Las Vegas Hospital, other places, came, brought her forms.

Lawrence Preston started the billing practice for it. At the time, Lawrence Preston, Tonya Rushing, the chief executive officer or whatever she was of the clinics who testified in here, for the first two years she worked at the clinic she was working for Lawrence and his company basically on contract to the clinics. And she left.

Lawrence Preston sold his billing business because he didn't want to deal with the federal government was his testimony, and the -- but he testified that at the inception he started the billing, the billing method and practices. And his testimony is at the inception, anesthesia time starts first time you start dealing with the patient, ends when the cuff comes off in the recovery room.

And this was a witness not called by the defense. This is a witness called by the State and then testified for the State. And he testified that that is the correct billing method and practice in his judgment and he so advises his clients. And the questions were asked by the State, you mean to tell me someone like an anesthesiologist could be billing for more than one patient at the same time?

And his answer was absolutely correct. You've got that right. I can -- I can have like three patients I am responsible for. I can have two in the waiting room. When

they stop, the clock goes off, they're not my responsibility. I can be doing a procedure on one, and, yes, the answer is, like any other physician or practice, there can be times where I have multiple billing and it's legal.

And he testified that he has gone to conferences, he has talked to insurance companies, and that is what he believes and so advises clients. And so this billing practice started. He sold his business. It went to a lady. I don't remember her name, but went into partnership with Tonya Rushing. She was the -- doing the billing for Dr. Frank Nemec.

And so Tonya Rushing set up the billing company, taking over for Lawrence Preston. And Tonya Rushing was like 90 percent owner, and this lady did it for 18 months and then she said this is -- I'm not doing it anymore. And Tonya took it over and said I will do it all myself, and she hired individuals and the billing company continued as it had -- as it had been doing on their merry way.

And it -- and it continued on their merry way up until what we've heard was the Rexford case, and that's the testimony of Dr. Clifford Carrol. Because what happened in 2007 was there was civil litigation. A patient named Rexford sued Dr. Carrol because of whatever happened on the procedure. And during the discovery, in the fall of 2007, in January/February of 2008, and it just so happened to coincide

with the investigation of CDC and the notice and closure of the clinics.

But Dr. Carrol explained and testified that he's got this litigation going on, and all of the sudden his lawyer is telling him the plaintiff's lawyers, the lawyers for the patient are raising questions about our billing and anesthesia times. And Clifford Carrol testified that he goes and talks to my client, Dr. Desai about it. And says in the -- in this Rexford litigation they were subpoenaing, the plaintiff's lawyers are subpoenaing our anesthesia records, all of the records for the date of the procedure. Is there anything wrong? Are our records right on this? And he said Dr. Desai said there is no problem. Our records and billing is correct.

And so at first Dr. Carrol testified he was a little concerned, sloughed it off, but then additional, I can't remember, someone else was deposed in this civil litigation. And, again, it came up as an accusation of false billing. And then Dr. Clifford Carrol testified that he has this in his mind and he's concerned about it because these lawyers are making accusations of false billing and he sees a CRNA, I think it was Sagendorf, rely on your own memories, but Cliff Carrol says he sees a CRNA putting down like 31 minutes on -- on his timesheet on his anesthesia record.

And Cliff Carrol sees this and this is in January or February or 2008. And he says what is this? And Sagendorf

says that's the way we've been billing. And Cliff Carrol says he goes to Dr. Desai and they have a conversation again and -- and he says is there billing fraud going on here? And Cliff Carrol says Dr. Desai said there is not any billing fraud going on here. So we've had two conversations of Clifford Carrol and Dr. Desai.

And then the third and final conversation Clifford Carrol testified to with Dr. Desai was in June 2008, Summerlin Starbucks right before his second stroke. He goes, and this is at a time when Cliff Carrol said he was very emotional and he needed help and was crying because the clinics had closed. Their -- their -- their business was wiped out, their licenses were suspended, and Cliff Carrol said he was almost suicidal at the time.

And he talks to Dr. Desai and holds his hand and he said is there -- on this billing, how -- how did this happen and how did we get started into this? And the answer was from Cliff Carrol's mouth, relating what Dr. Desai said, was this all started back the way we did it when we had one room, maybe one procedure room at the clinic years ago and it didn't change. But, of course, it had changed in like January or February 2008.

You can look at all the records because the second meeting of Dr. Carrol with Dr. Desai when he saw Vinnie Sagendorf, 31 minutes, that's what, I think, Tonya Rushing

testified about this also, all of the sudden it came to a head. Wait a minute, let's get straight on this, and on the billing. And that's when the edict was put out that no more pre-op times, no more post-op recovery room times. Make those bills precisely doctor times.

Because at that point Tonya Rushing said she researched it and looked into it. Whether she called the insurance companies or who, I don't know. But from that day forward, the billings changed. And this is like in February 2008 is the testimony of, I think, Dr. Carrol and Tonya Rushing. However you recall it, it is.

But at that point forward -- and of course one of the billers came in that worked for Tonya Rushing's company. They saw that all of the sudden the times had dramatically dropped on the anesthesia billings. And of course they dropped. That coincided exactly with Cliff Carrol, Dr. Desai saying from now on do it exactly like this. And so that's the evolution of this billing and it's carrying on. And so you -- you all make the determination.

I mean, if it is mistaken billing or misinterpretation because Larry -- Lawrence Preston is wrong, then it's not a crime. If -- if it is a justified billing that's arguably correct and you have your biller saying that's how it's done, then it's not a crime. That is a civil argument with the insurance company. We say it's that, you

say it's that. The insurance company will pay what they want. You can put in a bill for $8,000 and they'll pay what they want.

But you -- you make the determination. Is it false, incorrect? And then if it is, to make it a crime, I have to have intentionally known it and have no basis for what I did. Just like when you file your tax returns. These are specific intent crimes. You file your tax returns this year and there's a mistake on it. You forgot you got some dividends or you got a bonus or you won the NFL prize at the sports book and you didn't put it on your tax return.

Well, you tax return is false and that's what's called a false tax return. That's not a crime. It's simply an incorrect tax return. You will -- when it's found out, you will owe, pay fees and interest up the gazoo, but it's not a crime. If you know it, if you're sitting there and you're conscience is saying to you, ha ha ha, I'm leaving off those tips or I'm leaving off that parlay card I won, you're committing a crime because that's -- that's the mental component that criminalizes false tax returns and false billing case.

The actual computations here were pulled together. This -- this exhibit you don't have. This is called a demonstrative exhibit. And I'll file a copy with the Court and give the State a copy. The demonstrative exhibit means I

get to use it and show it to you, but it doesn't go into the jury room. The exhibit that's in evidence is Z1, and that has the times I'm talking about. This was a chart that Margaret put together and was introduced thrcugh, I think, Whitely or by stipulation.

But it essentially pulled all of the times out of the records for the patients to figure it out. And you will have this exhibit with you. And you will see it has the patient name. And actually you can go through. We didn't do this, but you can take the exhibit and you can put the actual counts on here because each of these is alleged as a separate crime.

And you have the patient name, patient date, who the physician is, who the CRNA is, time of procedure, colonoscopy or endoscopy, doctor's note start time. Lord knows we've heard a lot about times in here about which ones are correct, which ones aren't correct. This -- the -- this doctor start time, report process start time from the doctor's note. This -- this, I believe -- recall your own recollection, but I believe the -- the evidence has been that like the -- the best, most reliable, consistent time between nurses times, computer times, rhythm strip times, because all clocks are a little different.

Let's just use one time and make it consistent. And this is the doctor's note start time. In other words,

patients enter the room, equipment scope being hooked up, patients log onto the computer. And so this -- this is like the logon start time which is designated. So that's why we did this doctor's note procedure start time.

Next we have the doctor's note procedure end time. And, of course, once again you heard testimony as to that. Doctor finishes the procedure, patient is being tended to by CRNA, doctor goes to the computer, all the photographs have been taken of the internal testing, and then he puts the findings, conclusions, whatever it is, all of the notes that he puts on there, and then he punches the signature button and that produces to the second and end time.

So this is the total time of the procedure that the doctor was working on him. So if we were to use that conservatively as anesthesia time, because we know the anesthesia time, the evidence has been the CRNA starts with the patient interview, hooking up before the doctor comes in, and also tends to the patient who is still presumably asleep when it's over for awhile before then moving him out to -- or she out to recovery.

So if we use this as the conservative amount, let's say -- let's bend over backwards and call that anesthesia time, this doctor's note total time, that's -- from these, that's where we get the 10 minutes, 14 minutes, 8 minutes, 18 minutes, total minutes.

Now, if we use the last recovery room vital sign, this -- this would be the procedure end time out in the end room. Because you know they unhook the patient in the procedure room, roll them out, hook them up again to new rhythm strips, blood pressure, heart monitoring, and they're out in the recovery room, and that like takes 10 to 15 to 25 minutes, whatever your recollection is of it, and then they unhook them out there, which is at the time they're going to take them over, get them dressed, see the discharge nurse.

If we use that, I would call this the Lawrence Preston end time because that's what he says is the correct end time for anesthesia. And so those times all come out of the patients' records as to when they were -- their last reading was in the recovery room.

If we use those times in brown, brown would be Lawrence Preston, yellow would be ultra conservative billing purposes, like face to face time, ignoring everything else, if we use Lawrence Preston time, you can see it's 26, 29, 20, 34, 32, 45, 41, 39, and 36 minutes. Those are the actual times.

And so then, for my demonstrative exhibit, I took Exhibit Z1 and this -- I added -- I converted the minutes to money. And this -- this couldn't be done until we were complete and heard the last witness testify for the insurance company. And when we convert -- convert it to money, we convert it giving you alternative ways to do it on -- on what

should be the correct way.

And if we do it by using the most conservative, just plain doctor's time, the first one, Rubino, 10 minutes. The -- from the witness who testified or the insurance company for Mr. Rubino, five units -- the -- the over -- the overpayment is five plus one, so there would be -- would have been two units of overpayment. That comes to $76.60 for Mr. Rubino if we use that method. If we do the overpayment by Lawrence Preston, it would be one unit overpaid because it was 26 minutes for Rubino, and that would be $38.30.

Doing the same for each of these, Mr. Meana, one, $32.80, or $16.40. These will be the amounts that go right to a specific count in the indictment alleging a false fraudulent overbilling.

Now, if we go to Orellono, eight minutes, $34 if we do it most conservatively. If we do it Lawrence Preston's method, there is no overcharge at all. Going to Hutchison, 14 minutes, it's a flat fee. So either way it's irrelevant. Same with Grueskin, flat fee.

Ziyad, source patient, his -- there was none because they underpaid. The insurance -- the insurance company underpaid the clinic. There was actually a credit, so they owe the clinic on that one because it was an underpayment. Either way, underpayment.

So what -- what do the totals come out to? $219.40

total of every single count, or if it's done Lawrence Preston's way, $54.70. Now, where do these numbers matter? If you find that this was a crime, knowing intentionally they're wrong, and you -- and you just -- if you -- if you think this was incorrect billing based upon Lawrence Preston or if you have a reasonable doubt about it, if you just simply don't know, then there's no crime at all.

But if you're firmly convinced beyond a reasonable doubt, ah-ha, they conspired to do this and they knew what they were doing, then when you got through it you'd say, okay, I'm firmly convinced they knew what they were doing and their conscience said ha ha ha, I'm cheating, if that's your finding, then you have to figure it out and plug it in.

Because in the theft count, the theft count which is simply one count of theft, it has to be either over $250 or under $250. And there's a verdict and you would either check -- if you think it's a crime, you either say over 250 or under 250. And, of course, it matters. Under this it makes no difference either way because both of them are under $250.

When you go to the obtaining money under false pretenses, it is also a dollar amount driven two charges, and it has to be over $250. I can't remember which patients are under -- on the false -- obtaining money under false pretenses. You'll see them in the indictment. But for each of those, it has to be that the inflated time resulted in more

than $250. And if it -- and if it doesn't, then all no's. It's simply not guilty.

Pardon me, it's -- it's under $250; right?

MR. STAUDAHER: That's what it would be.

MR. WRIGHT: Under 250 for those. And for no matter which patient it was, none of these -- 76 bucks is the highest one. So for obtaining money under false pretenses, it would be under $250, whichever patient it is. It may be one of the none ones. I don't remember. And then when you get to the false medical billing case, the amount of money doesn't matter. Okay? It has to be a false billing and some money.

If it's none, there isn't any because they've alleged an overpayment. But if there is $16.40 and you believe that that was done intentionally and willfully, then on that the answer would be guilty. On the -- there are nine counts, nine different patient charges. So you go through them on each and figure it out. Now, that -- that's essentially the billing fraud component of the case.

And if we could take a lunch break, Your Honor.

THE COURT: All right.

MR. WRIGHT: We're not -- I'm going to argue some more. I'm done with the billing. You're going to have lunch, and then I'm going to come back and talk about the other half of the case.

THE COURT: Can I see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our lunch break now. We'll be in recess for the lunch break until 1:30. Obviously the case has not been submitted to you. The case is not over yet. So please be aware and mindful of the admonition, which I am about to give you.

Do not discuss this case or anything relating to the case with each other or with anyone else. Do not 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 by way of the internet or any other medium. And do not form or express an opinion on the trial.

Please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 12:28 p.m.)

THE COURT: All right. I'll see counsel at the bench regarding scheduling.

(Off-record bench conference.)

(Court recessed at 12:32 p.m., until 1:40 p.m.)

(Outside the presence of the jury.)

MS. STANISH: Judge, is the jury instruction on the petty larceny --

THE COURT: It was wrong.

MS. STANISH: Yours was changed.

THE COURT: So I adlibbed it, and then I had my JEA type it to be correct because I caught it. And that is Instruction No. 21. And so these are the originals and if you want to look and make sure you're --

MS. STANISH: No, I trust you did it.

THE COURT: -- fine with the change.

MS. STANISH: I just wanted to make sure.

THE COURT: But, right, I saw that it was wrong and so then I just --

MS. STANISH: Good cover.

THE COURT: -- corrected it and -- and then she's changed it. And so the packets are all correct. We made 12 copies so that all of the jurors will have their own copies of the instructions.

(Pause in the proceedings.)

(Inside the presence of the jury.)

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

And, Mr. Wright, you may resume your closing argument.

MR. WRIGHT: Thank you.

DEFENDANT DESAI'S CLOSING ARGUMENT (Continued)

MR. WRIGHT: Ladies and gentlemen, now to the medical criminal neglect, reckless disregard portion of the case on the hepatitis C, the causation, and what the conduct

was and whether criminal acts were committed by Mr. Lakeman, Mr. Mathahs, and my client Dr. Desai as an aider and abettor.

Now, remember, again, two months ago at the beginning of the case when I talked about negligence, auto accidents, reckless disregard, driving the wrong way down the street, and tried to give you a little example by drawing it on the paper. And it drew some objections, and I told you by the time we get to the end of the case I will show you the elements of the crimes charged, and I will show you that it has to be the equivalent of someone not just driving the wrong way on the freeway, but knowing they're going the wrong way on the freeway and intentionally going the wrong way, as opposed to accidentally or mistakenly doing something.

And the example I gave you I'm going to talk about because it fits right with the jury instructions. Because in any ordinary negligence case, I think I gave you the example of someone turns the wrong way out here on Fourth Street. That's a one-way street downtown here. And all the time I drive on it carefully because tourists and other people invariably don't know it and turn the wrong way and are driving the wrong way on a one-way street, and it can cause an accident.

And if they do cause an accident, they're certainly liable. Their negligent act caused someone else to be harmed. But they aren't criminally prosecuted for it because it's a

negligent act. It's an accident, a mistake. I didn't know what I was doing when I was driving the wrong way.

The other example I gave you, which is where we get to recklessness, conscious disregard of a dangerous situation. I said what if you're out on the freeway? You're out here and you come up on a traffic jam, there's an accident up ahead and traffic is stopped dead and you're sitting there and you look over and there is an onramp that you can get off the freeway going the wrong way if you so choose.

In that situation, if you consciously think, oh, well, I'm late, I'm going to be late for this important meeting, there's no traffic coming, I can whip around real fast and go the wrong way. I know what I'm doing, I know it's risky, but I'm going to attempt it anyway. And I do that and I get in an accident, I'm in big trouble. I knew my behavior was a substantial -- it was a risk of substantial harm. I was conscious of it, and I said hell with it and threw caution to the wind and did it anyway. That's what crimes are made out of in these reckless endangerment type cases.

And there's also a component that's called proximate cause, which means my risky, dangerous behavior must have been because of the accident. In my little hypothetical, suppose I decide to go for it. I've got my business partner with me and I go the wrong way and I'm speeding up the off ramp. And while I'm speeding the wrong way, engaging in risky behavior,

I have a blowout in my tire because I didn't replace the tires and they were -- they were too -- the tread was too low. And I -- I was negligent.

In that situation, I'm engaging in risky behavior, but the risk I know of and I am taking is going the wrong way in traffic. Now, if I get in an accident through negligence and the accident isn't caused by my risky behavior of going the wrong way, then I didn't commit a crime.

Now, we've seen a lot of evidence in this case, which I am going to show you had nothing to do with proximate cause of the transmission of the hepatitis C at the clinics on those two days. And we spent literally weeks hearing about the lousy business practices, starting colonoscopies too soon, ending them too fast, using all kinds of cutting-corner cheapskate practices all intended to enflame you all, to make you think this is a guy that's worthy of convicting and take your eye off of the ball. Because all the evidence is clear that the only accusation and the only evidence that matters in this case is the accusation that unsafe injection practices by the CRNAs caused the transmission of the hepatitis C.

If you are to think that scopes did it or biopsy snares, whatever you call them, bite blocks, those aren't charged here. All of that was simply brought in over and over again. The evidence about starting a colonoscopy or endoscopy procedure before a patient was fully sedated, now you tell me,

how does that cause the transmission of hepatitis C?

CDC, Melissa Schaefer, all of them testified that bite blocks, they don't cause it. Bite blocks go in your mouth right here. There's no blood to blood. And if you take the bite block, and even though it's single use, and you take it and put it in the Medivator and clean it and sterilize it, there is a yuck factor, but there is absolutely no factor of transmission of any type of disease.

Then we heard days of testimony about those type of things. And the -- the indictment -- well, first, the jury instructions tell you that you've got to follow what the indictment is and follow what the law is. And the indictment and the jury instructions, and it's No. 15 -- pardon me, got the wrong number. No. 17 when you get back there, reckless endangerment and criminal neglect of patients.

Both the reckless endangerment and criminal neglect of patient charges consist of a criminal act that is committed with the requisite mental state in order for the defendant to be found guilty of the reckless endangerment or criminal neglect of patient charges, you must find that the defendant committed the alleged acts beyond a reasonable doubt. What alleged acts? We're limited to one alleged act in the indictment and in the instructions.

The alleged act is that Ronald Lakeman or Keith Mathahs caused the hepatitis C transmission by using unsafe

injection practices in connection with the administration of propofol. That is the only act alleged. Now, as -- that is the sole act that must be proven beyond reasonable doubt to have been the cause, and I will get into the Mendel component and what they must have known.

But all this like CDC, Southern Nevada Health District, everyone testifying, this is the most likely cause. Things like bite blocks or biopsy snares, scopes, those things are less likely. If you all were to determine it occurred in some other method than this, what's alleged, then you find him not guilty. This is the only thing. We -- we've heard the cutting chucks in half. Heard that from 11 different witnesses come in to testify that he's such a cheapskate he cut chucks in half. And that he used -- admonished nurses to not use so much tape.

The offenses, that I will ultimately get to the murder charge, but the offenses of criminal neglect of patients and reckless endangerment, I want to go through the elements of those, what you must find. And this is from the statute because you -- you will see nothing in the statute as we go through this.

It contains the words that I heard by Ms. Weckerly during the opening statement, that this case is about poor medical care. This case is about unreasonable practices. This case is about laziness. This case is about sloppiness.

This case is about arrogance. I could stipulate to all of those things and would make no difference in the outcome of the case. Because this case is about conscious, reckless disregard of a dangerous practice that I know is dangerous and say hell with it, I'm doing it anyway.

Instruction 15, a professional caretaker who fails to provide such service, care, or supervision as is reasonable and necessary to maintain the health or safety of a patient is guilty of criminal neglect of a patient if the actor or omission -- now, the act there, of course we're talking about multi-use propofol vials and reuse of syringe on same patient. I mean, that's the act we are talking about there.

The act is aggravated, reckless, or gross. The defendant must have been aware of the risk of the substantial harm presented by his act or omission. So that means I must know that what I am doing is a risk of substantial harm to the patient and I acted in conscious disregard of it.

That means mentally I just said, I know, people can get hep C out of this or may get sick and die out of this, but Mr. Lakeman and Mr. Mathahs supposedly just conspired with each other and agreed to say I know all of that, but hell with it, I'm going to do it and put these patients at risk anyway. That's what you have to find on the evidence in this case.

The act -- and then that's just the first step. We've got four of them. The act or omission is such a

departure from what would be the conduct of an ordinarily prudence and careful person on the same circumstances that it is contrary to a proper regard for danger to human life or constitutes indifference to the resulting consequences.

They were using a reasonable man standard. That means a reasonable practitioner standing in their shoes at the same time in September and July 2007 in this community would have recognized that this is absolutely dangerous, life-threatening behavior. And that's why, when I get to it, we brought in the evidence of what else was going on in every single clinic at the same time. Because it matters what the standard was, reasonably at the time, July 2007.

The third element, the substantial harm created as a result of the negligent act could have been foreseen by a reasonably person. That means I -- I know. Not only do I know I'm doing this, but I know what the consequences are going to be. And fourth, and every one of these have to be found when you go through the instruction for criminal negligence.

And the danger to human life of these patients was not the result of inattention, mistaken judgment by Lakeman and Mathahs, or misadventure, but was the natural and probable result of an aggravated, reckless, or grossly negligent act. That's the medical criminal negligence portion of the same counts, there's multiple counts, but that one covers

caregivers.

And there's another statute that's just called reckless disregard. And this statute applies to each patient or just leaves out a couple of the medical elements. This can apply to anyone, whether you're a doctor or not. But as you'll see, it has the same elements. A person who performs an act in willful or wanton disregard of the safety of persons is guilty of reckless disregard of persons. Willful means what? Voluntary and intentional. I'm intentionally doing the act.

Wanton, it has to be wanton, meaning unreasonably or maliciously risking harm. I know what the act is, and I know its consequences are such that I have unreasonably and maliciously saying hell with it, I'm going to do it anyway. And then I have to be utterly indifferent to the consequences.

Lakeman and Mathahs have to be like psychopaths who don't give a crap and know they're going to spread hep C and do it anyway. That's what's required under the statute. The defendant must have been aware of the risk. He has to know what's happening and the consequences, and then just utterly, indifferently disregard it.

The proximate cause, you must determine that the criminal act was the proximate cause of the substantial bodily harm. In other words, you have to find beyond a reasonable doubt. If you found all of that, and that's what Lakeman and

Mathahs were doing, then, of course, my client, Dr. Desai is an aider and abettor.

I'm just saying Lakeman and Mathahs on this because they are what we call the principals. They are the ones who did the act, and so they must have had all of these. They must have satisfied every one of these elements that my client, as an aider and abettor and conspirator, because he's the owner of the joint, must have said, yes, I know you all are doing that and I want you to do that and I agree with it. And even though we're going to put patients at risk and we're going to get sued up the wazoo, I want you to do it anyway. That's his theory.

So I don't want you to misunderstand when I keep saying Mathahs and Lakeman as if I'm trying to shove the blame over to them or something, because I'm not. That's just the theory of the liability here. And so what has -- if you find that all of that happened by Mathahs and Lakeman and that my client wanted that outcome and conspired and aided and abetted to do it, then you have to determine if that -- that conduct, that multi-use of propofol vial and reusing syringe for same patient at the same time, you have to find if that caused the hepatitis C transmission on September 21st and July 25th. So those are the elements of what we're talking about.

Now, part of my problem with this case, as I told you at the beginning, was I don't have immunity power and I

can't make witnesses talk to me. And I -- I can't -- I can go -- that's why I introduce myself to witnesses. That's why I introduced myself to my own witness I subpoenaed, Dorothy Sims. I subpoenaed her from BLC because the State didn't call her.

And so I subpoenaed her and it was like pulling teeth. She doesn't have to talk to me. I don't have the power to get witnesses under my thumb by immunity grants and police investigations and interrogations. It's not simple. I subpoena her, I get to put her on the witness stand, I get to examine her, and I have to life with her answers.

I am at times amazed when I do have a witness that I am having to pull teeth. Now, bear in mind, this is a lady Dorothy Sims was in charge of the BLC investigation. She was the equal of Brian Labus for the State of Nevada and was there for the -- for the 9th through the 17th investigating with two other investigators. And -- and I'm having to show her her notes, having to show her everything she had written to try to get her to answer a couple of questions.

And then the -- the testimony in this courtroom has been after BLC did their investigation, and immediately went out because what they learned was, holy smoke, multi-using propofol, using on multiple patients, this -- this practice is going on at Sunrise, at Southwestern Associates, 15 MD anesthesiologists working there. So they immediately start

inspections.

And what did they find? I'll get to that. That was the BLC report I made her read about finding an MD anesthesiologist on February 2008, a doctor reusing needle and syringe between patients, nothing that is ever even alleged to have occurred here. Those were the practices they're finding. So what do they do? They call CDC, they have an Epi-Aid, CDC sends people out, and they inspect all 51 ambulatory surgical centers in Nevada.

MR. STAUDAHER: Your Honor, I'm going to object to that. I don't believe that that's the state of the evidence or -- and I'm just -- I don't want to interrupt his argument, but --

THE COURT: All right. Yeah.

MR. WRIGHT: I don't mind if you think I'm --

THE COURT: I don't recall it that --

MR. WRIGHT: I'll explain. I'll explain it.

THE COURT: And, ladies and gentlemen, as I've told you, you know, Mr. Staudaher may object or it may go the other way. I may not recall, I may recall incorrectly. So it is your collective recollection of the evidence that's important. And if any -- you know, this is argument. It's not evidence. So if anyone says anything in their argument, that's different than your recollection. It's your recollection that should control us to what the evidence was.

All right. Go on, Mr. Wright.

MR. WRIGHT: Melissa Schaefer from CDC testified that -- because I showed her an article to refresh her recollection. Because CDC used the results of the Nevada -- I can't remember what they call it -- investigation. The Nevada investigation, Melissa Schaefer testified that they, the CDC, then used that to go to three other states and conduct an investigation in three other states to see if the practices nationwide on these pilot of three states were the same as the Nevada.

I showed Melissa Schaefer and article and I had her look at it. And she testified that out of 51, in Nevada, CDC went -- 51 ASCs were investigated and 28 of them she testified had -- I don't want to misstate it -- infection control deficiencies or practices, including multi-use of propofol vials and reuse of syringes on same patient. 28 out of 51 was her testimony.

Now, the -- I got off track. How I got to Melissa Schaefer is -- is because I was comparing Dorothy Sims and what had happened here. Melissa Schaefer came in. She testified. She remembered all of this. I put Dorothy Sims on the stand and I asked her, what was the result? You participated in an investigation.

You may remember. I got out of line and got facetious and said you mean to tell me you don't remember the

governor of the state of Nevada saying to do this? And she didn't remember five and a half years ago. And so I show her the report out of her own office and walk up and say look at that.

Now, I showed the same thing to Melissa Schaefer and it refreshed her recollection, 28 out of 51. I show it to a person who participated in it and she said I don't remember. I'm saying, come on. I don't have immunity. I can't do anything. How can you not remember? Was it zero? I looked at it, Mr. Wright, and my memory is not refreshed.

Hello? I'm thinking what went on here to my witness? I subpoenaed the witness who I've never interviewed, and I said who did you talk to? Mr. Staudaher and Ms. Weckerly. Anyway, I subpoena you, you come here with your lawyer from the Attorney General's office. I don't talk to you, and they get to talk to you, and now your memory isn't refreshed by your own documents from the agency. This is what you deal with when you defend cases like this.

And I point it out because I've heard, and I'm not accusing Detective Whitely of improperly pressuring witnesses to testify. I'm just telling you the reality of the system and the way it works pressures witnesses to testify and to say things. And the reality of it is in the immunity agreements. Not -- and you've seen it. I've thrown it on the screen with a number of witnesses because it lays it out perfectly for

them what their choices are.

Now, you only get this -- this happens to be the one for Eladio Carrera, but they're all the same. And so anyone who gets one of these, the district attorney writes to him and says it's my understanding that your client Carrera desires to make a proffer to the State which will be useful in making an evaluation of our position in this case.

People get letters like this, and this is a letter that's saying whose team are you going to be on? We need a proffer because we're going to evaluate our position for your client in this case. So we'll have your client come in and we'll make a deal, we call it clean for a day, client gets to come in and he agrees to provide information, and the State promises they won't use it against him.

In other words, I talk, but they're not going to use it, except they get to use it if he lies to prosecute him for perjury or the information may be used to prove that your client testified untruthfully, or you can use the evidence against the person if they ever testify contrary to the information provided in the proffer. You've heard me say it. We call this a lock in clause.

In other words, whatever the client says, you're locked into it and then we'll decide whether we're going to give you a pass. And if you ever back up on this or you change your mind, we get to go after you. And the whole

purpose of this, after the State discovers what your client has to say, bear in mind this doesn't say after we hear truthful testimony. It says after we hear what your client has to say and what he is willing to do for the State, we will make an evaluation.

Then you give these letters to somebody like Ann Lobiondo or Linda Hubbard, and they're banging on them and saying we don't believe you. And it -- this is -- this isn't a rubber hose when -- when we talk about coercing people to give a statement or say something. This is simply legal, lawful, proper pressure that can be used because the prosecutor has these tools which we don't, and he gets to do it.

As I pointed out with Detective Whitely, they also get to lie to you. But if you lie to them, it's a crime. Let me get these rules straight, and who would play a game like that? I go and talk to the government. They can lie to me, but if I lie to them it's a crime. They can say to me, like with Linda Hubbard or whichever one we were talking. Linda Hubbard, I think.

They can say we've looked at all the record and we can prove this and that against you. And that can just be absolutely bluffing, lies, and is perfectly permissible, and now you've got to make a decision which team you're getting on. And so Linda Hubbard gave a statement and she testifies

in here contrary to her statement.

And so they have to put Detective Whitely on the stand to say what she said back then to try to get it in as for the truth of the matter. And, of course, what happens when you start compelling testimony from people or you start getting people to say something to save themselves, sometimes it'll be truthful testimony, sometimes it'll -- they'll say what you want to hear.

And with Linda Hubbard, she gave a statement that just is factually impossible. She hoisted herself by her own petard. I mean, she said okay -- and bear in mind, this was after time outs, going off the record, stop, stop, talk, talk, talk, and then go back on the record again. Four time outs. And they're telling her all of this.

And so what -- what are they -- Linda Hubbard, she says when I first came to work I was taught the ropes by Ron Lakeman. And she's specific about it. And, of course, this is something where she's going to contend that -- that she was told to reuse needles and syringes by Ron Lakeman and by my client because that's what they wanted her to say because that's what they contend she had previously said, which she denies.

And so she says, okay, after a time out, I've got it, I remember. My very first meeting I was there, I was learning how to do billing, it was the first meeting, he was

teaching me how to do it when I first came to work and he taught me. And he really didn't say to do it, but he just said watch how I do it, and then you do it the same way.

And of course her problem was she fabricated this story about 50 cc vials, and she specifically remembered and told the police that Ron Lakeman would take and fill up from a 50 cc vial with a spike and that's the way he did it. And this all took place when she went to work in August of 2005.

And, of course, where she got mixed up is they never had 50 cc vials at the time. First 50 cc vials ever purchased were October 13, 2005. But, of course, that's what happens when you pressure people to say something. You push them hard enough, they'll come up with a story. But she comes up with one, but it just does not hold up.

The -- the inability of the defense to get witnesses to be interviewed, to offer them immunity in exchange for testimony is one of the hurdles. And that's why all -- all we can end up with is our, the defendants' right of confrontation, where at least the least I get to do is cross-examine them and try to expose in this courtroom what we believe the truth is. And the truth is what this case is all about.

And that's your job in the courtroom. I've told you what the law is. You all are supposed to find out who -- who is right, the State's version or the defense version? And if

it's you all who get to determine who has a motive to fabricate, who because of pressure said this or that, who is telling a lie and then pretending like they have no memory of a report out of their agency.

All of those things take place and we do it, and I don't do it to embarrass Dorothy Sims. It's not my job to abuse any witness. It's my job to try to get the truth out here. And we don't engage on the defense side in deception in my judgment. I don't put up evidence with false inferences. I don't drag witnesses into this courtroom to testify to things that are not accurate.

And the State of Nevada has done all of that in this courtroom and I'll go through them because when that happens you have the right to consider all of that. Because when -- when you stoop to this type of preparation and presentation, it calls into question the entire case. And we have seen circumstance after circumstance.

Now I hear from Ms. Weckerly, yeah, some witnesses may have said there were 80 patients a day or 90 patients a day, but those numbers don't really matter or anything. Well, they -- they mattered to me when they put witnesses on the stand sworn to testify and they allow those witnesses to mistakenly give false information, which is what to -- happens to be to the benefit of the State.

We knew -- we knew from day one, or the State did,

anyway -- I didn't, they seized all the evidence -- the total number of patients every single day in the clinic. It's not the State's job to go out and find a witness who has an ax to grind or who is exaggerating or angry and say something, and then say, oh, that sounds good. I'm going to put them on the stand to repeat that, when they know from the evidence that they have that it's false testimony.

Here -- here are the witnesses that have testified and the number -- number of procedures per day. Every one of these, you go by your recollection of these, but daily patient numbers per witnesses. Jean Scambio said 65 to 70 patients per day through Shadow Lane. Keith Mathahs, 65 to 80 per day. Daniel Sukhdeo, 65 to 80 per day. Dr. Eladio Carrera, 70 to 80 per day. Marion Vandruff, 70 to 72 minimum per day. Pauline Bailey, 60 to 70. Vince Micne, 70 to 80. Ralph McDowell, 60 to 70. Vince Sagendorf, 70 to 75. Johnna Irvin, 80 to 90.

And all of this while we're having this orchestration, this drumbeat of assembly line out of control, too many patients, how many can you do in an hour? And the entire time they have every -- every single record book, every single patient on every single day. And they have done the math and they knew the numbers. And they knew for 2007 it is 59 patients per day average. They know that the highest number that had ever been through the clinic was 76 on a day.

And when you know this and you have this evidence, it is impermissible. You exceed your license as a lawyer. You aren't playing fair. You can't say I get my witnesses as I find them, and so I'm just going to let them get up there and say something that I know is demonstrably false. It happened here with however many witnesses. Every one of those is wrong.

They put Marion Vandruff on and had him testify that when the CDC came in, January 9, 10, and 11, 2008, the clinic reduced the number of patients on the day that they were there so it wouldn't look so bad when the CDC was there. Let's reduce the patients. Look at January 9, 10, and 11 of 2008. The highest number of patients, 60, for the first ten days of January was on the 11th of January, the day of the inspection.

And of course the inference they were trying to draw through -- improperly through Marion Vandruff's testimony was that the clinic knew they were doing something wrong, so they intentionally scaled back and reduced the number of patients. You don't put witnesses on to say things like that. Every -- Vince Sagendorf, Vince is almost laughable on these numbers.

And how do we get to these numbers? That's why I took Ms. Lobiondo through her -- she called it pressure and getting interrogated by five people at once. And I took her through her Metro interview, her first Grand Jury appearance, her second Grand Jury appearance, so you could see how people

get worn down and beat up to finally say what the prosecution wants to hear. Because Marie --

Is that her name, Marie?

MS. STANISH: Ann Marie.

MR. WRIGHT: Ann Marie, Ms. Lobiondo. Ann Marie Lobiondo, they wanted out of her the quickness of Dr. Desai's procedures. And the first time she was interviewed, and I had her read all of this, the first time she was interviewed by Metro she said it really is unfair because every -- every single procedure is different. It depends on the prep, the age, everything else. You have all the records. I can't just give you an average number.

And -- and they pushed her on it. And she said I really can't. It isn't fair. And she said, well, a normal colonoscopy, what's the fastest it could be? She finally says four to ten minutes. Then she gets called to the Grand Jury and the prosecutor examines her in front of the Grand Jury.

And the detectives that interviewed her are sitting there. And they ask her again, tell us, what's the -- what's the average time for Dr. Desai, as if -- as if this is really relevant, the quickness of his procedures. What's the average time of his procedures? And she said it's really not fair. You can't even say it that way.

And I said isn't it a fact you told the -- you had been interviewed and you told the police it was four to ten

minutes? She said, yeah, but -- she said so -- so you admit it's four to ten minutes? Said, well, it's four to ten minutes if that's what I said. And they called her back to a second Grand Jury. And I took her through every one of these because by the time we get to the second Grand Jury and she said I can't tell you, I think four to ten was an average.

And then the prosecutor said I'm going to ask you that question one more time, ma'am. Isn't it a fact that the average is four minutes and it ended up being four to five minutes? Things like that was the reason why these times end up -- you've got one, two, three, four, five, six, seven, eight, nine, ten witnesses who are allowed to come in here, testify to something that I can absolutely without a doubt prove is false.

Now, do the times really matter? No. But the only thing were the number of patients. Does the number of patients really matter? No. Ms. Weckerly acknowledged it isn't the number of patients. Well, then why did we have ten witnesses come in and give false testimony?

Because I -- I have to use examples to show you that I can impeach witnesses and what they say when I have the tools and the ability to do it. I can show you that the State is just going to go ahead and put on evidence that is -- allows you to draw improper inferences. We saw it with the price of propofol.

If you remember in the opening statement way back two months ago, the prosecutor was telling you propofol is a very expensive drug and they go to 50s because it saves money. When did they go from 20s to 50s because it saves money? And he gave a price of something like $15 for a 20 cc vial of propofol.

And then once again, they -- the State has the evidence. They have all of the computers. They subpoenaed all of the records. They know what every vial of propofol costs. And they know from 2004 until the clinic closed in 2008 that the price never varied at all between 20s and 50s.

A 50 costs two and a half times a 20, right to the 10,000th of a cent. Well, on two occasions 50s were cheaper. So there was absolutely none of this motive to save money by going to 50s that the State said in their opening. And then they affirmatively put on evidence by which you could infer that.

When Mr. Carter was on the stand testifying, they compared for him an invoice or something out of a computer for one year for a 20 of something else, 11 months later for a 50, and they wanted you all to believe that a 50 was cheaper than a 20. Under that comparison it showed that you could literally, if you bought 50s, you saved two-thirds of the money under that comparison. It was an absolutely false comparison.

The records, all of these were in through testimony for each month, each purchase, and always absolutely the same price. Once again, how -- how does that matter? Well -- well, it matters because in this case you're always supposed to look for the truth. That means we each put forth our best effort at exacting accurate truthful testimony and leave it to you all through our efforts of cross-examination to sort it out.

And me, as an officer of the court, I'm not supposed to stick something on the stand, some witness, and I'm not supposed to put on evidence that I know is drawing a false inference. Because when things happen like that it's called prosecutorial misconduct. And in this case the State of Nevada had evidence stricken and an instruction that there was prosecutorial misconduct that had taken place. And when you have to descend to those type of actions in putting on a case, it calls into question the validity of your case and the prosecution.

So poor old -- poor old Mr. Mione who -- who was a victim of Brian Labus's either inaccurate recollection or mixing up of Vinnie Sagendorf with Vinnie Mione or whoever it was. And as it played out you have Mr. Mione who Brian Labus in the Southern Nevada Health District claims admitted that he was told to reuse syringes.

Mr. Mione absolutely always denied that and even

contended he wasn't even there on that date. And Mr. Labus was adamant about it. And Mr. Mione got called before the FBI, other agencies, was accused of lying because he wouldn't fess up to it.

And ultimately, in the courtroom here, Detective Whitely said I think I was the problem that led to that because I -- older -- older Vinnie or new Vinnie, and I said Mione and that's where it went. And so Mr. Labus got mixed up. And so the problem is Mr. Labus made no reports of anything. There isn't a single written document or note whatsoever in his investigation. And poor Mr. Mione --

MS. WECKERLY: Your Honor, I'm going to object. I think that --

THE COURT: That's sustained.

MS. WECKERLY: -- misstates the evidence.

MR. WRIGHT: I asked Mr. Labus --

THE COURT: I'll see --

MR. WRIGHT: -- when he was on the --

THE COURT: -- counsel up here, please.

MR. WRIGHT: Pardon?

THE COURT: I'll see counsel up here, please.

(Off-record bench conference.)

THE COURT: All right. That objection was sustained.

Mr. Wright, you need to be -- you need to rephrase

your statement.

MR. WRIGHT: Okay. When I addressed Mr. Labus on the stand, I asked him if he had anywhere any handwritten notes or a report of an interview of Mr. Mione, and he did not have any notes or any memorandum of interview of talking with Mr. Mione.

And he simply stated that Melissa Schaefer was there with him and heard the same thing. And that's when I -- of course I examined Melissa Schaefer about that and she had no recollection of ever having interviewed Mr. Mione in which he made those admissions.

Now, going to the issue of transmission of the hepatitis C and how it occurred. Because you know there's a few hurdles to get over. First of all, did everyone have the hepatitis C of the source patients? If you go way back and you remember Dr. Yury, whatever his last name is, from CDC, most convincing to me. You all make your own judgments. But we lawyers in criminal cases look at these things because the first thing is, okay, people got hepatitis C there on July and September dates.

Now, did they have the hepatitis C when I walked in the door, or did they acquire it at the clinic? Was it risk factors or what was this or that? Well, as far as anyone in there, if you followed all of those trees that Yury put up there and his genotyping and genetic testing, it looked to me

like state of the art was that everyone's hepatitis C at the clinic came from the two identified source patients.

And I'm not going to stand here and argue with you about reasonable doubt or anything else. I didn't see any other conclusion myself other than this hepatitis C happened at the clinic on those two dates and the hepatitis C was acquired from the source patients. The first hurdle over as far as I'm concerned.

Next hurdle, how did -- how did they get the hepatitis C? And we have to determine that beyond a reasonable doubt before we get to the mechanism and start applying did the act or know about it and was he cognizant of the risk and everything else. So on that next factor, how was the hepatitis C transmitted on those dates?

I'm going to leave some of this to Mr. Santacroce because he's the expert of the charts and the room jumping and who was in which room and where it was. And I don't know the answer. You -- you all have to make a determination to exclude every cause except one, and then find one beyond a reasonable doubt.

Southern Nevada Health District, CDC believe the most likely cause was the method of injection of propofol in combination of multi-dosing propofol vials and reuse syringe on same patient. Those two things, if everything went right with an imperfect horrible storm, this -- this could have

happened.

And those are their words when I say could have happened because that's what's in the CDC report and Brian Labus's interim report, the CDC trip report, and then ultimately the peer reviewed published report. This -- this is what could have happened. And so you have to decide if that satisfies you all that that's proof beyond a reasonable doubt, with certainty that's what happened on this date.

And, of course, there were unanswered questions that even -- even remained unanswered in June of 2010. This is Exhibit 165 in evidence. This is what we called the peer reviewed article of CDC. Gayle Fischer, Melissa Schaefer, our two CDC inspectors, Brian Labus, Larry Sands, his boss, Patricia Rowley, she's a Southern Nevada Health District -- Brian Labus's -- another boss of Brian Labus, Ishan Assam, state investigator, This is probably June 24, 2010.

As the two CDC witnesses, Ms. Fischer and Schaefer both testified it pretty much simply tracks their trip report. But in it they conclude transmission likely resulted from contamination of single-use medication vials used for multiple patients during the administration of anesthesia. That's their likely.

This would probably be good enough for a civil case. Where it's if they -- we can at least make it more likely than not. I mean, that's what you need for a civil, to meet a

preponderance of the evidence. But what they point out here is still in June 2010 it remains unclear why some susceptible persons became infected by your procedures while others did not.

Persons with clinic associated hepatitis C infection underwent procedures closer in time to that of the source patient compared with uninfected persons. These persons may have been exposed to higher viral loads which became diluted over time. Alternatively, multiple propofol vials may have been open at once, and the contaminated vials were only used for persons who became infected.

Additionally, the order in which persons underwent their procedures may not have been completely accurately recorded. And room numbers identifying where persons underwent their procedures were not documented. These factors limited our ability to trace how transmission might have been perpetrated.

At this point they are still -- now, bear in mind, I don't want to mislead you by this June 2010. Mr. Labus made his conclusions in December 2009, which predated this. But by then Southern Nevada Health District had figured out the rooms, or Metro had with their assistance, and they did come up with the correct chronology of patients. At the time this article was written and submitted, I'm not sure that it happened.

But the point is at that time of this article, the CDC, and of course the renowned Miriam Alter, and renowned she is, agreed -- she reviewed, she didn't participate in either investigation, but she reviewed their papers and said she concurred in their judgment and agreement that that's a likely cause.

Now, we know Mr. Labus, in his email exchange with CDC, is still looking for support. Mr. Labus was still looking for support for his serial contamination theory in March of 2009. Now, bear in mind, the investigation was January 2008.

He is on record and is admitted because I -- I read to him and had him admit to his testimony that he had made up his mind and reached his conclusion by Friday afternoon, January 11, 2008. I got there Wednesday afternoon. I looked at charts all day Thursday. I did observations on Friday. And he had made his decision.

And what I read to him was -- and this was a deposition of him February 24, 2009. My understanding is that you had already reached the conclusion by January 11, 2008, that the reuse of syringes on multiple times on one patient coupled with the propofol vials being reused on more than one patient was the source of contamination of hepatitis C at the clinic; is that correct? Answer, yes.

Mr. Labus had made up his mind, reached his

conclusion after being there two full days and has never wavered from his conclusion. He came up with the serial contamination, which has never been found elsewhere in published reports, ever been a case in which it has been documented.

And, in fact, that's why on -- right after this deposition, because I asked Mr. Labus on the stand, at that deposition you were asked by the lawyers is there anything that supports that in writing, any prior case, any published material, any of these esoteric journals?

And he sends an email to Melissa Schaefer, March 5, 2009. I read this to him and he read it. Melissa forwards it to everyone at CDC. Hi Everyone, Brian Labus called yesterday and was wondering if we were aware of any article in the published literature that documents serial contamination of vials, as we presume happened in Vegas. Presume. A presumption. Not as we found; not as we conclude. As we presume happened in Las Vegas.

He wants to cite an article in his report that describes this. Melissa Schaefer forwards that to all of CDC. And she says -- and she gets -- that -- that was her letter, her email to all of CDC. She gets a response. I had Mr. Labus read this. Here's the most infamous pooling outbreak I know of not exactly the same -- done the same, but seems like there's enough information here and from your investigation to

show that this is clearly a plausible explanation.

That this serial contamination theory is a plausible explanation. Not proof beyond a reasonable doubt. Not that we know that's what happened, but that's what CDC said. And that's Mr. Pretty (phonetic). And this was all forwarded back to Brian on March 27, 2009.

And, of course, I asked Mr. Labus on the stand, today in 2013 do you know of a single published article, do you know of a single case anywhere where this serial contamination theory of multiple vials being polluted, despite dilution, and going forward in needles and/or vials exists? And he said, no, the record still remains as it is.

So you -- you all determine that next term. Can you conclude beyond reasonable doubt, even though they can't figure out why it jumps room to room and why it jumps, some people don't get infected at all and some do. And the other mystery they can't figure out is with hepatitis C, one out of ten people is symptomatic. Maybe it's two out of ten, it's like 80 percent. No symptoms whatsoever.

So two out of ten people, yet somehow here, this virus on this date of September 21, all but one was symptomatic, got symptoms, got sick over it. It was some peculiar strange virus that they still don't have an answer for. So if -- going to progression, if you determine we find beyond reasonable doubt there's no other reasonable

possibility at all and we conclude hepatitis C was spread by multi-use propofol vial combined with syringe reuse on same patients, next step in your analysis. That is the act alleged.

And so the question then becomes when Mr. Mathahs and Mr. Lakeman, in July and September of 2007 were reusing needles and syringes on an individual patient, but changing the needles and were multi-dosing propofol, did they know at that time everything that's required by the instructions.

Meaning, did they realize and were cognizant of this risk of serial contamination in that they knew or could reasonably foresee and just said hell with it, I'm doing it anyway? That's your next big hurdle if you think that's how the hepatitis C was transmitted in this case.

And, of course, the -- the problem is that the -- this practice of multi-use of propofol vials was pandemic. It was everywhere. That's the evidence in this case. The witnesses who have testified to that, Ann Lobiondo, Vincent Mione, Rod Chaffee, Keith Mathahs, Ralph McDowell, Vincent Sagendorf. Vincent Sagendorf not only -- Vincent Sagendorf started in November 1, 2007, came to work at the clinic after the outbreaks had occurred, lucky for him or he wouldn't be -- he's still practicing in California today at a pain clinic.

And he testified he comes to work, he interviews. Every practice that he engages in at the clinic was identical

to what he had been doing his entire career. They didn't tell him to do anything differently. And they used 50s and 20s as multi-dose vials. That's the way he had been doing it. That's the way he had done it at the two clinics in California. And he understood it all and they all give their explanations and rationales for their reasonable beliefs because there is so much labeling problem and misinformation with it.

Because it was Mr. Sagendorf who was the same as Mr. Mione who talked about there is a shelf life with it. And so as long as once I open it, as long as I use it within six hours, that's the only reason it's called single dose, and so I am using it appropriately. And Mr. Sagendorf testified that to this day, he's working at the pain clinic in California, and they continue to multi-dose with propofol.

Linda Hubbard, Dr. Satish Sharma, Dr. Carmelo Herrero, Dr. Arnold Friedman -- and, in fact, on Mr. Sagendorf, he testified that he -- he went out and was interviewed at Southwest Associates trying to get a job, and that's where 15 anesthesiologist MDs work, and he tried to get hired there, same time, August to September, October 2007 and that they were all multi-using propofol, using the vials as multi-dose.

And they all gave their explanations for it. It comes with a spike. A spike only comes with a -- for a

multi-dosing. There's no other use for it. All of this is to show you the lack of consciousness of wrongdoing by Mr. Lakeman and Mr. Mathahs, that they are engaging in practices that are the standard of practice that was going on.

That doesn't mean it's right, and that doesn't mean -- I don't want any of you getting off into thinking that I'm like saying, well, if everyone is committing a crime, then my guy is not committing a crime. Are you following me? Because it isn't like speeding. It isn't like going through a school zone where ignorance of the law is no defense. You all heard that. I didn't know I was in a school zone. Tough luck. Ignorance of the law is no defense. You were, and that's what the speed limit is.

This is a case with a specific intent, a mental component. That's all of those elements I went through. They must have been cognizant of it and know they can't do it and know that it is a risk of substantial harm to be caused. Yet Dr. -- all of these -- all of these are the State's witnesses. Dr. Frank Nemec came in here and testified. Dr. Nemec testified that until this incident, the 50s were being multi-dosed, until this incident in 2007.

And when I examined the CDC, Melissa Schaefer, I asked her about the testing and what is still going on with multi-use vials and who is it? Why do you keep having these health bulletins and all of this go out, and there just still

ends up being confusion on the part of the practitioners. And she said that's why we keep educating and keep trying to do it.

And I asked her if it had anything to do with -- and she said that's what -- this is a current dangerous misperceptions that they put up because there's still the common belief by Mr. Sagendorf, obviously, and the pain clinics he works at, single dose vials with large volumes that appear to contain multiple doses can be used for more than one patient. That's under myths and dangerous misperceptions. That's the myth.

And it's called the myth because it persists. And myths happen to be actually believed by people. Mr. Sagendorf is a myth believer. And what's the answer? Single-dose vials should not be used on more than one patient regardless of the vial size.

And when I asked Miriam Alter about it and the confusion, and says isn't part of the confusion what's the difference between single-patient use, single-dose vial? I said they're -- they're contradictory. When I get that 20 milliliter, 20 cc vial, is that a single dose vial, meaning I can take out one dose only, I can never re-enter it, or is that a single-patient vial?

And she said well they -- they use the terms interchangeably, single-does, single-patient, single-use all

means the same thing. I printed out for the -- I don't want to say her website, but her -- her CDC currently right off the website. I said I -- I can't even tell today in 2013 when it talks about use and dose, a single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. That one I get.

Single-use vials contain only one dose of medication and should only be used once for one patient using a clean needle and syringe. So I asked her, I said does a single-use vial only contain one dose? Because that means I can only use it once and toss it, or can I use it all on the same patient aseptically?

She said, well, dose should mean use. And if they mean the same thing, I don't know what that means. And I said, well, what's a multi-dose vial according to CDC? I printed this on June 19, 2013. A multi-dose vial is a bottle of liquid medication that contains one -- more than one dose of medication. So if -- so if a vial contains more than one dose of medication, it's a multi-dose vial according to CDC?

Well, I -- I asked Miriam Alter, I said can I use the 20 on the same patient if she needs another dose? The answer is yes. I said then it's a multi-dose vial. She said, Mr. Wright, if I had my laptop here I'd get on the website and go to FDA and see what they have to say because there's confusion on what the CDC says and what the FDA says.

And, of course, that goes without the confusion of what Medicaid says. What does Medicaid -- it's Exhibit N1. Single -- wasting of drugs in single-use vial, March 30, 2006. Medicare's definition of single-use vial is a vial that has a volume suitable for administration to one or more patients. A single-use vial is a vial that has a volume suitable for more than one patient.

If, for example, the medication contains enough for three patients, and all three patients are scheduled to come in for administration on the same day, likely for the same reason, the manufacturer states that after opening, the vial is only good for 12 hours, at which time any remaining medication must be discarded. Administering this medication that all three patients within 12 hours of opening the container fits the definition of single-use.

So if you're billing this for Medicaid purposes, you're required to use the 50 on multiple patients as long as it's within the time frame. And so that's -- that is a permissible correct use. I asked the witnesses, isn't there confusion here about that? She didn't have her laptop up to explain it. But that must be why things like that persist. Because even Miriam Alter said if you use aspetic techniques and you used a brand new needle and syringe every time you went into it, there is no chance of transmission of hepatitis C by multi-using that vial.

And so when -- when Ms. Weckerly talks about Mr. Mathahs and Mr. Lakeman saying I didn't know, that -- that was her -- she had the words up there, recklessness, and she said the defense to the case is I didn't know. They didn't know what? Exactly what are we talking about? When Mr. Mathahs was interviewed and Mr. Lakeman was interviewed and they didn't know, what was it they didn't know?

They knew exactly what they were doing because they explained it. And Mr. Mathahs did it right in front of CDC. What was it they didn't know? And which the State says the "I didn't know" is a lie, they really did know? Well, what the -- what the State is saying is that Mr. Lakeman and Mr. Mathahs really did know the serial contamination theory, really did know you shouldn't be multi-using propofol even though everyone else is doing it, and didn't know you shouldn't reuse needles and syringe for the same patient after changing the needle.

So what she's saying is they were both lying, they really know that's risky and dangerous. Why would they know that? Who -- who would know? Who interviewed Mr. Mathahs? I mean, the one witness who actually talked to Mr. Mathahs, interviewed him right at the time, that was Melissa Schaefer and she testified she talked to him for 20 minutes.

And I asked her, was he genuine and do you believe he actually thought he was engaging in safe practices? And

she said yes. And she said, when I took her on recross, that was corroborated by the fact that he did it right in my presence. Because when people are doing something consciously wrong, I know I've engaged in wrong doing, I do what Miriam Alter testified about on her first or second New York examination.

That's where they examined a guy and he lied about it. He denied reuse of syringes. That's what someone does when they know they can't do something. They deny it. And what does Mr. Mathahs do? He is there. In comes CDC, in comes Brian Labus, BLC, they're all there, and right in front of them he is multi-using propofol just like they admitted doing at the clinic the moment all the investigators walked in. They admitted it. And so he does it.

And what does he do right in front of her? Needle and syringe, need to re-dose, take cff the needle, put on a clean one, and then she interviewed him about that. And he said that is safe. I would never use a dirty needle on the same patient. I always do that. She said, no, Mr. Mathahs, that -- that's one of the myths, changing a needle makes the syringe safe for reuse. Why is it a myth? Because these are misperceptions that continue.

And if -- and if you believe Mr. Mathahs and Mr. Lakeman were honest with Ms. Fischer and Ms. Schaefer, because each of them were interviewed when they said I do this, I

think it's safe, I change the needle, and I use negative pressure. That's what they believed. And Melissa Schaefer said she believed Mathahs, that he was sincere. And she said he did it right in front of me.

And Miriam Alter, she said the guy back there in New York, he lied about it. And only when they caught him because of supplies did he ultimately fess up to it. And if you take that -- I mean, this is like deciding to go the wrong way on the freeway, you're going to take that shortcut, and you do it right in front of the highway patrolman. I see him sitting there and I do it anyway. That just doesn't add up in this case.

If you think Mr. Mathahs and Mr. Lakeman were part of the -- I can't say majority, a large group of practitioner that were all believing the same and doing it the same and that's what they thought and it was mistaken, inadvertent, and that they didn't recognize the grave risk of what they were doing, then the State doesn't win the case. If you have a doubt about it, if you can't say I don't know whether Mr. Mathahs knew it or didn't know it, then you have a reasonable doubt.

You have to find beyond a reasonable doubt he knew exactly the risk and danger that he -- he -- he essentially had, when we get to the murder count, he has to -- he has to admit it was foreseeable, the harm he was going to cause was

foreseeable, and that he was doing this right in front of them and then lied to them about it and said I didn't know.

THE COURT: This might be a good time, Mr. Wright, to interrupt you, so we can take a brief recess. We've been in session for awhile now and I think some people need a break.

Ladies and gentlemen, we're going to take a brief recess, about ten minutes. 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 are not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case, and please don't form or express an opinion on the trial.

If you'd please place your notepads in your chairs and follow the bailiff through the rear door.

(Court recessed at 3:21 p.m., until 3:39 p.m.)

(Inside the presence of the jury.)

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

And, Mr. Wright, you may resume your closing argument.

DEFENDANT DESAI'S CLOSING ARGUMENT (Continued)

MR. WRIGHT: We've been talking about the propofol multi-use, the syringe reuse. Because, as you know, it's those two things that should have put them on this absolute

notice that they disregarded. I went through the witnesses on propofol reuse, the witnesses on syringe reuse.

Of course, we're talking this -- I hate to keep repeating myself. I only get to talk once. The State gets to talk again. They opened. I'm done. I can't get up and say, oh, I forgot, I hope you understood this, because they get to close and argue again. So bear with me the -- I want to be certain when I'm talking about the syringe reuse what we're talking about is reusing the syringe on the same patient, which is -- which is what was acknowledged happened here by Mr. Mathahs and Mr. Lakeman.

This isn't like the incident over at the Maryland Parkway clinic between patients. This is the belief that changing the needle and using negative pressure is a safe aseptic technique, two of the myths that CDC keeps writing about that practitioners keep doing.

And so when I'm talking about needle reuse, I'm talking about witnesses who testified that's what they do and they do it aseptically. Ann Lobiondo, Vincent Mione, Linda Hubbard, Keith Mathahs, Dr. Thomas Yee, Dr. Satish Sharma -- both of those are anesthesiologists that testified about it -- Carmelo Herrero, Dr. Eladio Carrera. Dr. Miriam Alter, she said you can use the same needle, same syringe, same patient, same needle -- needle and syringe, same unit. I didn't go through needle change with her or anything.

Dr. Arnold Friedman, an expert called by the State testified that in 2007, at the time he testified about the evolution of changed practices, best practices, how in the -- one time in the '90s like 40 percent of the practitioners were using same needle and syringe in between patients by changing the needle, and how that's down to like 1 percent now, and how it evolved 2002 up until the present time.

And with Dr. Friedman, he testified -- you recall Dr. Friedman. He's the fellow that I read him his deposition after I asked him in 2007 was it within the standard of care to reuse same needle, same syringe, same patient? In 2007 is that within the standard of care? He answered no.

And I said remember what you testified in one of the civil cases, Mr. Washington's case in 2009? I read him the deposition and then I had to hand it to him and he read it to himself over and over and over again. This is what he read. Question -- and there was -- there was confusion at the beginning.

"Question, Were there instances in July of 2007 where it was within the standard of care to reuse a syringe?

"Answer, No.

"Question, And let's see if -- we're not connecting here. I think I asked you in July of 2007 whether it was within the standard of care to reuse a single

syringe on a single patient as long as the syringe and the vial were thrown away?

"Answer, Under those circumstances, yes.

"Question, Okay. So in July of 2007 were there circumstances where the reuse of a syringe was within the standard of care; right?

"Answer, with the vial being thrown away, that's correct.

"Question, And today -"

2009 is when this deposition is being taken.

"Question, And today are there circumstances where reuse of syringes is within the standard of care?

Answer, Again, I think practices changed because of the recent several cases that have occurred because of the transmissions of the hepatitis virus. And I think the standard of practice now is to go to a single-use vial, defined as one draw, and throw the vial away, and one syringe and one needle.

Question, So the standard of care has evolved from July of 2007 to the present with respect to reuse of syringes?

"Answer, I think it's hard to put a year on it. I think this has been an evolution between, you know, to saying exact 2007 or a certain date.

"Question, What I was trying to say is that

somewhere between the year 2002 and where we are presently if changes in JCAHO in terms of what they -- they're coming up with, and, again, some of those things happened in 2004 and 2005, we are seeing a much stricter interpretation of reusing of a syringe a second time on the patient.

"Answer, I can't tell you an exact date. I can't tell you an exact year. This is an evolution of what has occurred.

"Question, All right. Just to make it clear, though,as of today do you believe it would be a violation of the standard of care to reuse a syringe in any circumstance even if it was only on the same patient?

"Answer, With a single-use vial, yes."

And he read all of that and then ended up concurring that in July 2007 the standard of care was using a vial -- a needle more than one time, with the caveat of throwing away the vial, throwing away the needle. At the end all of that is understood. What we're trying to get at is what were Mr. Lakeman and Mr. Mathahs thinking at that time.

Dorothy Sims, one of the two witnesses we called. Why did I call her? I called her because the BLC inspected the clinic and it -- it wasn't until after March of 2008 that the BLC, all three inspectors, all three nurses, Nadine

Howard, Leslee Kosloy, Dorothy Sims, it took until after March 2008 for them to recognize and put together the reuse of syringe problem with the multi-use of propofol as being a dangerous practice.

And so why did I bring her and have her put -- put in her BLC findings and reports? Because she testified that moment they walked in there, Jeffrey Krueger, Mr. Carrol, Dr. Carrol, Tonya Rushing explained on that Wednesday afternoon, Katie Maley, here's our practices, we multi-dose lidocaine propofol. That's what we're doing and it's right in the reports Wednesday afternoon. Multi-dose propofol.

No light bulb went off. I asked her, did anyone there in the meeting, CDC, Mr. Labus, did anyone say, wait a minute, that's dangerous, you can't do that? No. She didn't know at the time. BLC didn't know at the time. She came back the next day, Dorothy Sims, and she observed Dorothy Hubbard and did an observation of it and saw Linda Hubbard multi-dosing the propofol vials.

This -- this supposed conduct that is supposed to be so shocking that everyone in their right mind would say, whoa, risk, danger occurring. It is being done right in front of BLC, three inspectors, registered nurse inspectors for the State. I said did you say to Linda Hubbard you can't do that, what are you doing? And she said no.

Later they looked up on the Internet, talked to

Brian Labus, figured out, nope, it's single-use and it shouldn't be used as multi-use even though there's the shelf life issue. It did not dawn on them. They weren't cognizant of this risk that Mr. Labus and Mr. Mathahs were supposed to be so aware of.

And so then what else did Dorothy and Leslee find out as they investigated going forward? That's why I had her go through the interviews. She interviewed Linda Hubbard and she kept notes of it very nicely which Mr. Labus didn't and doesn't. And she interviewed Sagendorf, she interviewed Mione, and she interviewed Linda Hubbard.

And Mr. Sagendorf was the only one on -- and this was on January 16, 2008. It was doing it the BLC best -- BLC, CDC best practices way of brand new needle, brand new syringe, never reenter. Just every time I use it throw it away. Linda Hubbard, Mione, both stated they were reusing same needle, same syringes, same patient.

Still, no light bulb went off with BLC and the three nurse inspectors. They did not connect. They didn't say -- that's why I said did you say to Linda Hubbard or Mr. Mione, you can't reuse a needle and syringe like that? No, we didn't. Because they didn't recognize, they weren't cognizant of this deadly -- if -- if it is -- if this horrible storm is what actually caused the transmission of hepatitis C, they didn't even connect the dots.

That's why I had her read through the three findings of the BLC as to what the clinic did wrong at Shadow Lane and the three findings were multi-use of propofol vial. Number two, they weren't changing the detergent in the first cleaning for every single scope. They were doing two scopes rather than one scope.

And the third one was their policy for forceps was outdated. The written policy manual still said reusable forceps and they were using disposable forceps, so they had to rewrite the policy. Those were the three findings of transgressions by BLC that jumped out when they were fully cognizant of syringe reuse and multi-use of propofol vial.

And then I asked her, were you interviewed, all three of you on March 5, 2008, by Metropolitan Police Department? And at that time on March 5th didn't you, all three of you together, tell them that the reuse of syringes in that fashion was absolutely permissible and okay? She said yes. And I said and sometime after March 5th you learned that this combination could have theoretically very bad consequences on serial contamination of vials. And she said yes.

So that's why we called them. Because if this is so readily apparent and horrible that Mr. Lakeman and Mr. Mathahs are liars when they say they didn't recognize the harm that flowed from it, why didn't Dorothy Sims, Kosloy, and the other

one, can't even think of her name, why didn't they bring it up and stop it? Because it simply was not apparent and known even to these practicing nurses.

Before I move on to the murder -- murder part of the case, I just want to be positive. I'm not -- and of course, after -- after March was when -- well, I did forget one. Another reason I had Dorothy Sims come, Exhibit CC1. Just -- just to -- so we didn't just have the testimony of Dr. Nemec and the other witnesses that this was going on at all of the other facilities, this investigation took place.

MR. STAUDAHER: Your Honor, I'm going to object to that. I don't think that was the testimony, all of the other facilities. What facilities are we talking about?

THE COURT: All right. Well, that -- that's -- I'm not sure that was the testimony.

MR. WRIGHT: Okay.

THE COURT: So that's sustained. But, again, ladies and gentlemen, I'll remind you that it's your recollection that's important.

MR. WRIGHT: Well, their objection is well taken. I don't mean all of the other facilities. I mean, the facilities that the witnesses testified to, Sunrise, Southwest Medical Associates, Gastrointestinal Diagnostic Center on Maryland Parkway. It was where the witnesses said -- and Dr. Frank Nemec at the hospitals that he practiced at -- that this

was a common practice until all of this happened and everyone woke up to it.

Now, this inspection on February 15th, Exhibit CC1, this fits in the time frame when it is not yet public what had occurred at Shadow Lane. As you recall, the investigation, January, the public announcement, February 27, 2008. So before the public announcement they go out and do some surprise inspections.

And they go in on a surprise inspection to a gastrointestinal center where they're doing endoscopies, and you can look at page -- there's the date, 2/15/2008. It was accepted. In other words, the plan of correction accepted by BLC on March 12, 2010.

They inspect and this is exactly what I went through with Lawrence Sims -- Dorothy Sims. 2/14/08. At this point cold inspection. Just walk in the door. We're here to see what's going on and there's been no notification. No bulletins went out yet. Don't reuse propofol multi-patient. So what did I find? You can read it all, Patient 1, Patient 2, and to Patient 3.

Patient 3 was brought into the procedure room at 8:35 a.m. The anesthesiologist injected the patient with propofol through the patient's intravenous IV tubing. The anesthesiologist opened a new vial of propofol. They anesthesiologist used an opened needle and syringe to draw up

additional propofol from the vial. The anesthesiologist was observed putting the used vial with the remaining propofol back on the counter.

After the case, this was the only used propofol vial observed. The other vials on the countertop were new, unopened vials. Patient 4 rolls in, brought into the procedure room at 9:15. Anesthesiologist was observed drawing up propofol from the same vial that he had used on Patient 3 to inject Patient 4. 2, 3, and 4 were transferred out of here into recovery.

During the observation time frame the anesthesiologist was never observed opening new syringes. 9:45, interviewed the anesthesiologist. This is a doctor, not a CRNA. He stated it was okay to use single patient use propofol vial on multiple patients because the purpose of the single patient use label on the vial was to prevent bacterial growth in cases that required a long period of time.

An anesthesiologist stated that because these cases were of short duration, there was not enough time for bacterial growth to occur. Therefore, it was safe to reuse the propofol vials on multiple patients. The anesthesiologist was asked what the process was when he went from a used propofol vial to a new patient.

The anesthesiologist stated he would change the needle and reuse the -- reuse the same syringe. The

anesthesiologist explained that because a high port was used on the IV line it was safe to change the needle and reuse the same syringe on multiple patients. The -- another myth, syringes can be reused as long as the injection is administered through an intervening link of IV tubing. Truth, can't do that.

Another myth -- well, this myth doesn't even work. On this case they actually saw, the inspectors saw blood going in the IV line. It says an observation was made that one of the patients, the patient's blood flowed back into the IV tubing. One of the myths is if you don't see blood in the IV tubing or syringe, it means those lines are safe to be used.

It doesn't mean the conduct was right, safe. What the purpose of all of this is, and for this clinic, was that's what they thought was safe. Just like Mr. Mathahs and Mr. Lakeman gave their explanation. This anesthesiologist gave his explanation as to why he thought he was safely engaging in good practice. The State would have you believe that he was consciously trying to knowingly put patients at risk and harm them because his conduct is more egregious than what's accused of these fellows.

The plan of correction was filed and approved by the State. The plan of correction. All patients -- let me see. I'll get to the part where they're dealing with in-services have been done with MDs, anesthesiologists, and staff to avoid

further deficit practice.

Acknowledgement form signed, RN and MD, anesthesiologist signed off on procedure at the GI clinic on propofol. Emergency plan of action was implemented on 2/14/08 of the use of propofol. All anesthesiologists who were in-service signed an acknowledgement on patient safety on propofol, all signed the policy of IV safety and nursing staff will continue to be observed. They've all been observed by the RNs, anesthesiologists have been using sterile syringes and needles on each patient. Propofol is being used as single-dose vial. All unused propofol is discarded after each patient.

And, of course, after this inspection there's another exhibit in evidence, R1. This went out from the State of Nevada essentially saying what's been found in these clinics. And you can read R1. It's giving the best practices, safe techniques that should be used.

Thereafter notice has been given to every clinic. It's broken in the newspaper on February 27th. And after news reporting and it being sent to every provider in the state, they did their inspection of the 51 ASCs in the state, and found 28 of them still hanging out there, all showing they simply were not cognizant in recognizing the risk.

The -- I'm going to go to the murder charge, which essentially tags on because essentially the allegation is this

is a second degree murder case because Mr. Meana died. And there's no dispute Mr. Meana died, and there's no dispute -- I think one of the elements in this case is substantial bodily harm. And you've heard no argument from us, nor will you, that this -- this horrible virus that these patients have is not substantial bodily harm. That -- that is not an issue in the case.

Every -- I mean a couple of them took the Interferon treatment and have, according to Dr. Frank Nemec, he treated Ms. Martin, she has eradicated, the virus is totally gone. They -- it -- the -- the virus, no one wants hep C. I hope that none of you have it. Who knows? I keep hearing these statistics on how many of us might have it and don't know it.

But this -- that issue, substantial bodily harm, that element is not in dispute. All we're disputing is don't know how it happened. And secondly, if it happened the way the State theorizes is most likely, that's not proof beyond a reasonable doubt.

Now, Mr. Meana, he died. And so the question becomes did he die as a direct, foreseeable result of that act on July -- September 21, 2007. And was there no intervening act whatsoever that precipitated his death? And that's why we called Dr. Howard Worman who is an equivalent if you want to call Miriam Alter a dean of hepatitis C epidemiological studies.

Dr. Worman, who you saw from Columbia University, is an outstanding, renowned hepatitis C expert and does nothing but write, teach, and treat hepatitis C patients. And so he looked at all of the records of Mr. Meana to make the determination did he die of this hepatitis C infection. And you heard his testimony. Unfortunately, it was right at the end so it's most recent.

He cannot say beyond a reasonable doubt. He cannot conclude that hepatitis C did or did not, with the medical problems Mr. Meana had, both preexisting his treatment because of the kidney failure. And when asked, well, did it -- did it contribute? I can't answer that question. I mean, the ultimate questions you'd like to ask to be clear for proof beyond a reasonable doubt he couldn't answer.

What I'd like to ask, and it was one of the juror questions that was given to him, was can you say that if he didn't have hepatitis C and got it on September 21, 2007, would his death have occurred on the same date from those other causes? I mean, that would be nice if we could look and answer questions like that, but Dr. Worman said I cannot answer that question.

I'm just saying I cannot say with any degree of medical certainty. He died of hepatitis C, as opposed to died from the chronic kidney failure and the other problems that he had. So with the murder component of the case it's the

proximate cause issue.

Now, to get to all of that, I'm just jumping over. You have to have found how he got the hepatitis C and if Mr. Lakeman and Mr. Mathahs were in the wrong, and that my client aided and abetted and conspired to make it happen. And then you have to get to at the time it happened. As Ms. Weckerly said, the instruction for the murder requires that it have been directly [inaudible].

And, additionally, Instruction 27, the conduct constituting the crime of criminal neglect of patients and/or performance of reckless disregard. So it's the conduct we're looking at, the conduct alleged propofol use. The conduct is inherently dangerous where death or injury is a directly foreseeable consequence of that act.

And that even if you found that death was on the doorstep and on their minds when they were engaging on this anesthesia on Mr. Meana, you then have to say -- and where there is an immediate and direct causal relationship without the intervention of some other source or agency between the actions of the defendant and the victim's death, you have to find beyond reasonable doubt immediate, direct, causal relationship without any intervention.

And, of course, that's why we asked, well, did -- and read in portions of the deposition. Did he take Interferon? And he opted not to. And Dr. Sood's -- it was

read, his -- Mr. Meana's being deposed and explained that he understood the risks that were involved and that he didn't want the Interferon treatment and he knew there could be cirrhosis and he opted to not go forward with it and take his chances. And that's what's called an intervening cause in between if someone opts to do that.

And so on the murder count as to Mr. Meana, we don't see it directly foreseeable and we see intervening causes. And the interesting part about criminal cases is that State puts on their case and that we get to put on a defense. And then if we put on anything that is -- that can be rebutted, the State gets to put on more evidence again.

And, of course, we give them notice of our experts and where we're going, just like they give us notice of their witnesses. So like when we put on Mr. Howard Worman as an expert, if there was a single expert in existence who contradicted his testimony, the State brings him into the courtroom. And it -- on the other side, the State -- all -- all they have presented you other than Mr. Meana and his family, they didn't call Dr. Jurani, his personal physician.

They didn't call Dr. Sood who treated him, nor did they call any expert. They called Alane Olson, medical examiner from Clark County who went over and watched the autopsy, took samples, brought them back, they deteriorated and she couldn't test them. And so she said she agreed with

what the --

MR. STAUDAHER: Objection, Your Honor. That's not what she testified, and she is an expert. And the blood deteriorated.

THE COURT: Well, he's not -- he's not disputing. He's --

MR. WRIGHT: Okay.

THE COURT: It's partially sustained. It was the blood that deteriorated.

MR. WRIGHT: Okay. The blood was deteriorated and she had brought back the tissue believing that the tissue could be tested for hepatitis C, but when she got back the tissue was fine, but she found out they could not test the tissue because that type of testing is no longer in existence in the United States, apparently.

So the tissue was good. She got it so she could test for hepatitis C, but she didn't or couldn't or wouldn't test it. And the blood, which they normally rely on here for toxicology testing was deteriorated and she didn't have any to be tested. And so she simply deferred to the autopsy in the Philippines.

And, of course, the autopsy in the Philippines was stricken from the record. It was an exhibit initially admitted, but then stricken. And so all we have from the Philippines is the death certificate which shows exactly what

Mr. Worman was -- Howard -- Dr. Howard Worman was talking about, hepatic and uremic encephalopathy, kidney failure hepatitis.

And the State brought in no witness or expert to contradict those findings of Dr. Worman. And so it -- without any question, there is at the least a reasonable doubt as to the cause of Mr. Meana's demise, and the effect of the intervening causation, meaning declining to be treated for the hepatitis C. And secondly, the independent kidney disease which resulted in his chronic kidney failure and him being on dialysis and taking him into the hospital.

One other -- before I close, one other matter I want to touch on. A couple of things that the evidence came in regarding the -- some of the risks seen by employees that worked at the clinic. And it comes to mind Geraldine Whitaker, Maggie Murphy.

When you go back and look at your notes, these are two of the nurses, I think they were, two of the nurses who thought that because of the speed in the clinic, because of the patient load and turnover, they thought there was patient risk which would lead to a perforation, both of them independently. And I think there was one other witness that said that.

And I point that out to you because I don't want you to get sidetracked on taking evidence or beliefs that there

was just patient risk in the air, or foreseeable consequences that would flow from the way the clinic was operating. Because we're not here simply to decide was the clinic too busy. Was it run like an assembly line with profits over patients?

What you have -- if -- if they want to charge that, we'll go to trial on that. If they want to charge other things, you're here to make the one determination. And that -- and this matter is transmission of the hepatitis C by the method alleged by the State. And the fact that someone saw a risk of a perforation because Dr. Desai quickly did his colonoscopies is not any cognition of risk of hepatitis C infection from infusion practices.

And so they just don't mix together. Because as you saw from the instructions, for each of those you have to have that specific known risk, I know this conduct is bad, Mathahs and Lakeman have to be saying, boy, this can spread hep C, but hell with it, I'm doing it anyway.

Now, you've heard all of the evidence demonizing Dr. Desai. And the -- I -- I'd like you to take into consideration of a lot of the witnesses and why they -- what -- what their motives were and whether they had axes to grind. And I'd like you to recall one of the specific testimony of some of the nurses whose testimony simply didn't match with some of the other people who claimed this was the dirtiest,

filthiest, horriblest place on earth to work in. If you look at the testimony of Nurse Yost from Texas who worked there and testified.

If you go back and look at your notes and memory of the Gestapo of the procedure room, Janine Drury who complained about Sagendorf eating. And she's the one who ran a tight ship and who would go toe to toe with Dr. Desai. And who Dr. Desai had hired at the end of 2007 to take over as charge nurse to run the place, and --- and look at her testimony and description of that clinic and the practices that were going on, and you will see there is another side of the clinic and of Dr. Desai the way he was there.

I'm not going to argue. He was a cheapskate, a skinflint. One witness called him anal about his obsessiveness on costs and not liking employees sitting around. He isn't on trial for that and that didn't contribute or lead to whether Mr. Mathahs and Mr. Lakeman believed their practices were correct. Because speed had nothing to do with their practices.

They weren't rushing. Mr. Mathahs wasn't rushing in front of Linda Hubbard. Whether Mr. Mathahs and Mr. Lakeman were doing 10 procedures a day or were doing 59 procedures a day, it wasn't that they were going so fast they mixed something up. They believed their practice was aseptic and safe. So take into consideration all of the concern about him

being so cheap and everything else and how that allegedly led to this.

People are peculiar. People are cheap. My parents were the cheapest people on earth. And it -- my mom, cutting coupons even when they didn't have to. They continued. And people are weird that way. And if you thought like to his family, cheap, cheap, cheap. Don't -- don't waste even when you don't have to.

The -- my dad used to take -- excuse me. He ran the Review Journal. He'd bring home paper that had been written on one side. One side is still good. He'd put together, my brother and two sisters, staple it, and I was supposed to take it to school. All used on one side, and I've got a new pad on this side. And absurdly I was ashamed of it at the time. I'm ashamed now that I was ashamed then.

But it was how goofy it was and people can be. And even when my dad didn't have to do that, he persisted in these ridiculous, cost cutting, stupid things. And my mom did, too. Cutting those damn coupons when she didn't have to later in life. And so don't -- don't just jump, he's the cheapest guy, he's a skinflint, he cuts corners, patient care gets thrown out the window like all of these damn partners there that all just supposedly turned a blind eye?

They were buying into it. They wanted the practice, other than the one guy, Carrera or something that got cut down

to 6.4 percent. But they all testified they'd roll their eyes at his ways and antics. But every one of them said they didn't perceive any putting patients at risk in any of this ridiculous frugal behavior. That isn't what criminalizes somebody. He worked, built a practice. Built it up until it was big. He's a capitalist. He wanted to make money. He tried to sell it in 2004 and 2007.

And he works, builds it, and then all hell breaks loose and all of this comes down. And then all of the other doctors -- I mean, I think Ms. Weckerly said all the other doctors, they all knew this was risk dangerous behavior or something. But why didn't they say something or do something? These doctors all pretend like they didn't see or know a darn thing, all of his partners. And they were all there happily working along. And as far as every one of the other partners, they didn't end up through bankruptcy.

They -- Ms. Weckerly says cases are strange. They take unique twists and turns or whatever. Circumstances require that Dr. Carrera and Dr. Carrol not be prosecuted for their conduct. Well, those are decisions -- those aren't just unique twists and turns. Those are decisions made right there.

Mr. -- Dr. Carrera was so callous about it. He -- he gets sued. He doesn't go through bankruptcy. He doesn't pay a penny out of his pocket. His insurance pays it. He

couldn't even remember the three names of the patients that he treated that got hepatitis C. That's how much he cares as he rolls on through his practice. So all this about demonizing him as if he is evil incarnate and the worst person to ever run a business and practice in this community, it just doesn't hold up.

So we ask, Margaret, Dr. Desai, and his family, that you analyze this fairly and correctly and look at it as we believe the law dictates and you will find that there was not criminal misconduct which took place in this case and you should return verdicts of not guilty. Thank you.

THE COURT: All right. Thank you, Mr. Wright.

Mr. Santacroce, are you ready to proceed now or --

MR. SANTACROCE: If you'd like.

THE COURT: All right. You don't need a break?

MR. SANTACROCE: Maybe the jury does.

THE COURT: Everyone all right?

All right. Mr. Santacroce, you may proceed.

MR. SANTACROCE: Thank you.

DEFENDANT LAKEMAN'S CLOSING ARGUMENT

MR. SANTACROCE: We're not going to break any new ground here today. You've heard everything that I've had to say, and I'm going to say it again. Only this time I'm going to tell you how I view the evidence as it applies to my client.

And you have a jury instruction that tells you that you're to view the evidence against each of the defendants individually. There's two men sitting here that deserve the attention that you give them to the evidence as it applies to each of them. And so I want to talk to you for a few minutes about how the evidence unraveled in this case as it applies to Mr. Lakeman. And do to that, we need to go back in time to the beginning of this investigation to show you how we got to the point that we got to.

And we go back in time to the beginning of 2008 in January when the CDC gets a telephone call from the Southern Nevada Health District that there's a problem in Nevada, that hepatitis is popping up and they need some help. So the CDC is invited to come to Las Vegas and conduct an investigation. And they assign Dr. Langley, Dr. Fischer, and Dr. Schaefer to come to Las Vegas and take a look as to what's going on.

But before Dr. Fischer and Langley get here, they have a meeting with the higher ups at the CDC and they finally laid some preliminary opinions as to how the infection may have happened. And they come to a preliminary, even before getting here, that we're going to look at the injection practices at the clinic and see if that's the potential for the transmission of the disease.

So they come out to Las Vegas. They conduct first a records review. Before that they meet with the Southern

Nevada Health District. They advise them. They talk about what they're going to do. They go to the clinic, they review the records, and they do some observations. And then they come up with a trip report, a preliminary finding. And coincidentally, that preliminary finding mirrors or matches exactly the opinion they had when they came out here.

Now, they're telling you that, well, we ruled out all the other mechanisms of transmission. But they will also tell you they were not conducting a criminal investigation. Their interest was a public health issue. And so they weren't looking for the scrutiny that would be applied in a criminal case. And so they come up with a preliminary finding that the mechanism of transmission of the disease is through unsafe injection practices and they issue their trip report.

Now, remember, there's some important things that were uncovered after the CDC left. For example, the CDC didn't know which patient was in which room. They didn't know basically which CRNAs or -- or what types of procedures were initially. All this information came up after the fact, after the report. And Dr. Fischer, when she was on the stand, testified when we showed the charts -- and we're going to look at those briefly -- when we showed the charts and information.

Now we have all the segregated rooms. We know which patients were in which room. We know the sequence of the patients. And what was her opinion? She said, well, in order

for their theory to be valid, the infected propofol would have to go from room to room. And when Dr. Schaefer was presented the evidence that they didn't have at the time of their investigation, her conclusion was that she would have to -- she would have to reconsider her opinion.

Now, Ms. Weckerly made a comment in her closing that we know that propofol went from room to room. We don't know that. What we know and what the evidence suggested was that at the end of the day the propofol would be taken and collected and the half used or partially used bottles would be thrown out and the full bottles would be returned to the locker.

So when she made the statement that we know that propofol went from room to room to room, she wasn't talking about July 25, 2007, and she wasn't talking about September 21, 2007. Because we know on those particular days Dr. Carrol -- let me get this easel. We might as well go to this thing. I dread it, but we're going to have to do it.

We know that on September 21st Dr. Carrol was the doctor for the source patient Kenneth Rubino. And we know that Dr. Carrol testified that he never saw propofol go from room to room. And we also know that Dr. Carrol testified that he never saw a CRNA leave a procedure room in the middle of a procedure.

What evidence and testimony do you have, ladies and

gentlemen, to show that on September 21, 2007, or July 25, 2007, that the propofol went from room to room? You have no evidence of that. And as Dr. Fischer told you, in order for the State's theory to be valid, there'd have to be a showing that the propofol went from room to room. They don't have that.

The CDC issued their trip report and their preliminary findings and they said this was the likely mechanism of transmission. We're not dealing with likelys or maybes or probablys. Two men sit here and their life is at stake on probablys and maybes and likelys? Our system doesn't work that way. There has to be proof beyond a reasonable doubt. We can't speculate as to how the transmission occurred. There has to be proof beyond a reasonable doubt.

And I submit to you, ladies and gentlemen, the State has failed miserably in that regard. But how did the State get to this position? Well, let's go back in time again. March 2008, Detective Whitely, as he testified -- where is he? He left? I wanted to point to him. I've got nobody to point to.

Detective Whitely -- Detective Whitely said he was told he was getting this case and he's assigned to investigate. So what does he do? He looks at what is out there. What did the CDC say? What did the BLC concur? What did -- what did Brian Labus subscribe to? It was all that it

was through these unsafe injection practices and contamination of propofol.

Now, Detective Whitely told you that, you know, they eliminated all these other things. Well, did they really eliminate all the other things? They conducted a search warrant of the clinic. They identified the scopes. They were smart enough to take a picture of the scopes, but they didn't impound the scopes.

Now, why is that important? Because you have heard testimony over and over in this case that a possible mechanism of transmission was the scopes, the dirty scopes. We had testimony as to how to clean the scopes. Dr. Nemec told you his practice is to clean them for 55 minutes. Why? Because that is a potential mechanism for transmission.

The scopes weren't impounded and the detective told you, well, you know, we probably couldn't have found anything. It was four months later. Well, maybe you couldn't have found the hepatitis, but you may have been able to find if there was fecal matter in the scopes and in the -- in the grooves of the scopes. Maybe you would have been able to find if there was blood in the scopes.

But that wasn't done in this particular case. Why? Because there was a preconceived notion and idea that the mechanism of transmission was the contaminated propofol.

So now the -- the search warrant reveals all of

these patient records. And Metropolitan Police Department decides, well, we're going to put all this information in a nice little chart and we're going to present this to the jury. So they do that.

Only, there's a problem because the nice little chart that they've prepared doesn't substantiate the theory of the transmission. So now the State tries to distance themselves. They say, well, all the times are wrong. You can't go by the times. And so, you know, it doesn't -- it doesn't work.

Well, okay, let's get rid of the times. Right away this testified that the sequence of patients was accurate. And what do we find when we look at the sequence of patients? And, believe me, contrary to Mr. Wright's representation, I am no expert in charts. I'm no expert in any of this stuff. But the fact of the matter is you can use common sense and logic to come to the proper conclusion.

When you walk in the courthouse door, we don't ask you to check your common sense at the door. You have a jury instruction that says bring your life experience, bring your common sense with you and apply that to the evidence. What does common sense and logic tell you here?

The source patient, Kenneth Rubino in Room 1, is followed by another patient who we know as Lakota Quannah who is not genetically linked, and then we have Rodolfo Meana.

And then what happens after that? One, two, three, four, five people who aren't reported as having hepatitis C. And then all of the sudden it appears again in Sonia Orellono. And then it skips over the next patient. And then it hits Gwendolyn Martin. And then we don't see it again in Room 1.

Somehow, during the same time period, it jumps over to Room 2. And Stacy Hutchison is infected by a genetically matched link of Kenneth Rubino. And then it skips somebody, and then Patty Aspinwall. And then it skips one, two, three, four, five people, and then Carole Grueskin gets it.

What does common sense tell you? How does the disease skip over all of these people and just land sporadically? It tells me that there has to be some other mechanism of transmission.

Now, remember, the State is committed to this theory. They have to prove to you it was the propofol. They can't lay all these theories out in front of you and say pick whatever you want and convict. That doesn't work that way. And the defense is under no obligation to show to you or prove to you what the mechanism of transmission is. All we can tell you is that there were other possibilities for your consideration.

And as Detective Whitely said, we may never be able to prove this case. And as another witness said, we may never know the cause of the hepatitis C. And that may be very well

true. But you must know if you are to convict these two gentlemen. You must have a deep, abiding, moral conviction that the mechanism of transmission was the propofol. If you don't have that, if you have any doubt, you must acquit them. Because everything flows from the transmission of the disease of hepatitis C.

Now, let's look at the chart a little closer. And they tell you you can't go by any of the times. And yet they have chart -- procedure start times, end times, they have nurse log times, they have machine log times, they have monitor log times. They have all of these times. And when you get this chart back there I want you to look at something. I want you to look at any one of the times. You pick whatever time you want to pick. You pick the time that you believe was most reliable from what you heard.

And I want you to look at Kenneth Rubino. And then I want you to compare that to Stacy Hutchison any time you want. And you will see that both of them were undergoing a procedure at the same time. How does Stacy Hutchison get a disease from Kenneth Rubino when they are both anesthetized in different rooms by different CRNAs at the same time? I don't know.

So what do we do? We look for commonalities. Not to prove another alternative method or mechanism, but there are other commonalities. We talked about the saline in the

pre-op room. You've seen this chart a hundred times. You've seen the infected people in Room 1, the infected people in Room 2, and we know that Lynette Campbell and Jeff Krueger started those IVs. We know, too, that they shared saline. We also know that it was all in the same pre-op area.

There was no room changing of the saline. There was no isolation of the saline bottles as was suggested by the BLC to put it in a central medicine area. That wasn't the case. The saline was here for both of them to dip into. Lynette Campbell was a new nurse. I'm not suggesting that Lynette Campbell did anything intentionally, but I'm suggesting she was a new nurse.

And what was the testimony regarding IVs? If IVs couldn't be started, who did them? The CRNAs. Well, why couldn't an IV be started? It's because they had multiple pricks, couldn't find a vein. And the State wants you to believe, well, they never went back into the bottle. There's no testimony to that fact. But the circumstantial evidence and testimony is that there were times when the nurses couldn't start an IV, so they would go to the CRNA. That suggests to you that there were times when there was a possibility or potential that the saline bottles were infected.

We don't know what Jeff Krueger did. We don't know what Lynette Campbell did. All we know is that they shared

saline bottles. They shared a procedure room. And we don't even know if they shared needles or not. But it is a mechanism for transmission.

It's interesting to note that in the State's presentation Ms. Weckerly told you we could rule out biopsy forceps for the contamination on the 25th of July. And -- and she told you that because I have been arguing or bringing out throughout this trial that both the source patient and Michael Washington on the 25th both had biopsies.

And we know that some of the biopsies were reused. And we also know that there was improper cleaning practices at the clinic for scopes and biopsy equipment based on the BLC's inspection and the CDC. And what did -- what did Ms. Weckerly tell you was the reason that we could rule out the biopsy forceps in this particular case? Do you remember? Because other people had procedures, biopsies on that day, and nobody else got it.

Isn't that the same defense that we have been talking about for the last two and a half months? If you can rule out biopsy forceps because other people had procedures and didn't get the disease, why can't you rule out the propofol for the same reason? It's simply common sense and logic. You don't have to be an epidemiologist to reach these conclusions. You don't have to be a specialist in hep C to reach these conclusions. It's right there for you to look at.

We also know from the testimony in the case that in the beginning of the day, what did the CRNAs do at the beginning of the day? We know that they checked out flats of propofol and we know that that propofol was stocked into one room, and propofol was stocked in another room at the beginning of the day. There was no reason way propofol would have had to go from room to room.

We also know from testimony that in the beginning of the day the CRNAs would preload a bunch of syringes because of the time factor. People were being rolled in and out. So syringes were preloaded. You'll notice on the 25th of July that Mr. Sharrieff was the first patient of the day in Room 2.

How could a bottle be infected if there were preloaded syringes and he was the first patient of the day? How could the disease have skipped over three people, landed in Mr. Washington and nobody else got it the rest of the day or reported having it?

Ladies and gentlemen, I suggest to you that the cause of the hepatitis C outbreak cannot be proved beyond a reasonable doubt. It is unfortunate that we don't have an answer because the public is clamoring for an answer. That's why you see all the television cameras and the news reporters because the public wants to know.

And so the State and the District Attorney's office was forced into the position of taking this approach and

prosecuting two individuals, Dr. Desai and Mr. Lakeman, to the exclusion of all the other CRNAs, to the exclusion of all the other doctors. They had to come up with a sacrificial lamb because the public wants to know. And they got a sacrificial lamb. They got Mr. Lakeman. But I'm imploring you not to allow that to happen.

And it's going to take courage on your part. You're going to have to put blinders on. You're going to have to ignore the public outcry. You're going to have to ignore the television. You're going to have to ignore the pressure that you may get from the decision you make here in the next few days.

But when we queried you in the beginning of this process, we believed that each and every one of you was strong enough to handle the pressure. We believed that each and every one of you was fair and unbiased. We believed that each and every one of you would do the right thing, that you would hold the State to their burden of proving each and every element of the crime beyond a reasonable doubt. That's why you're sitting here.

And we call upon you to honor that oath and that promise you made to us in jury voir dire. And we call upon you to be strong because this is an important case. The State, the public has vilified this man. If we had a big oak tree out in front of the courthouse, in days gone by they

would have strung them up. There would have been no questions, no trial. But we've evolved. We're better than that. We give people a fair hearing and make a fair decision, and that's all either one of us are asking is that you do that.

Now, we have to talk about this theory that the State has that somehow Mr. Lakeman is involved in Mr. Meana's death. And after sitting here for two and a half months, I'm still unclear as to their theory. But I believe that their theory has to do with something called conspiracy. Because remember, Mr. Lakeman had nothing to do with Mr. Meana. Didn't treat him, didn't see him, was in a different room. Didn't know Mr. Meana from anybody, and yet he sits here charged with murder of somebody he never even saw.

How do we get to that point? Well, the State wants you to believe that somehow Mr. Lakeman was involved in a conspiracy with Mr. Mathahs and Dr. Desai. And because of that conspiracy he is liable for everything that flows after that. But let's look at the conspiracy instructions. A conspiracy is an agreement between two or more persons for an unlawful purpose.

And then it goes on to say that a person who knowingly -- knowingly, there's that element of knowledge again, does any act to further the object of a conspiracy. Well, let's stop there. Has there been any proof, evidence,

anything, that Mr. Lakeman knowingly did something to Mr. Meana? I didn't see any. But, again, you need to rely on your own notes and memory.

A person who knowingly does any act to further the object of the conspiracy. What acts did Mr. Lakeman do to further conspiracy which resulted in the death of Mr. Meana? Has there been any evidence of that? No. Or otherwise participates therein as criminally liable as a conspirator. Now, note this, however, mere knowledge or approval of or acquiescence in the object and purpose of the conspiracy without an agreement to cooperate in achieving such object or purpose does not make one a party to conspiracy.

The fact that Mr. Lakeman worked at the clinic, worked at the same time, on the same day, in a different room, does not make him a party to a conspiracy. There had to be an agreement between the coconspirators, Mr. Lakeman and whoever else the State suggests, there had to be an agreement between those individuals. And that agreement would have to be furthered by an act which was the object of the conspiracy. There has been no evidence whatsoever to meet any of those elements of this crime. And yet this man stands here accused of murder.

The Supreme Court, when it talked about the duty of a District Attorney's office said it is not the duty of the District Attorney's office to obtain a conviction. It is the

object of the District Attorney's office to do justice. Does that sound like justice to you? Charging a man with murder of someone he never had contact with, someone he didn't know, someone he never treated? Is that justice to you?

Now, the district attorney will stand up in a few minutes and say, well, what about justice to the victims? And believe me, we are not unsympathetic to the plight of the victims. We feel terrible that this happened. We feel terrible for them that it happened. But you just can't set aside the burdens of proof from the State to convict somebody just to achieve what's perceived to be justice to the victims. There has to be equal justice.

And that's why when you walk in the courtroom the Lady Justice has scales in her hand, because she balances the justice and the equalities of people. She's blindfolded because she doesn't see that race, gender, social economic status have anything to do with a decision when it comes to meting out justice. And you have to look at it the same way.

Now, let's continue with the conspiracy. In order to be -- have a conspiracy -- note this line here -- both conspirators must have the specific intent to commit the crime. First of all, what is the crime? Secondly, what was the intent that Mr. Lakeman had in the death of Mr. Meana? Did Mr. Lakeman have some kind of criminal intent for somebody he never knew, never met? It's illogical and it doesn't hold

water.

The next instruction, No. 9 on conspiracy, evidence that a person was in the company or associated with one or more other persons alleged or proven that have been members of a conspiracy is not in itself sufficient to prove that such a person was a member of alleged conspiracy.

So the fact that these two individuals worked together, that they worked in the same place, at the same address, did the same job, that in and of itself is not proof of a conspiracy. It says, however, you are instructed that the presence, companionship, conduct before, during, and after the offence are circumstances from which one's participation in the company, conspiracy may be inferred.

So let's look at that. Was there a relationship by -- between Mr. Lakeman and Mr. Mathahs outside of the workplace? Was there a relationship either before, after, or during other than a professional work relationship? Was there any evidence presented to you of those facts? The answer is no.

Now, the State is going to say, well, there was a conspiracy between Mr. Lakeman and Mr. Mathahs and Dr. Desai because Rod Chaffee heard a conversation at the nurse's station where Mr. Lakeman was talking about PacifiCare patients.

First of all, let's talk for a minute about

witnesses. There's an instruction in your packet here which talks about the credibility that you give to witnesses. That's strictly up to you. You can give them whatever credibility you want. But if the -- the instruction tells you that if you believe they have lied, that you can either choose what portion of the testimony you want, or you can discard it all together.

And I wanted to talk about this conversation that Mr. Chaffee had. And it also goes to another instruction that we have on statements that are alleged -- allegedly given in this case. So let's look at that Instruction 37. You have heard testimony that the defendants made certain statements. It is for you to decide whether the defendant made the statement, and if so, how much weight to give to it. In making those decisions you should consider all the evidence about the statements, including the circumstances under which the defendants may have made the statements.

Now, we were talking about Mr. Chaffee. And you remember Mr. Chaffee? He's the one that gave evidence or testimony that needles and syringes were being reused and he saw that, and then he went home and he read the newspapers and he saw that his statements were inconsistent to what he had testified previously, and he comes into court and he recants everything he said about the reuse of needles and syringes. This is the same individual who tells you now that there was a

conversation that he overheard that Mr. Lakeman was talking to other CRNAs about scheduling PacifiCare patients.

Now, first of all, it's up to you to decide whether that conversation ever happened. But, secondly, if it did happen, so what? So what? Does that show a conspiracy? Between whom? He couldn't identify who was there. He only identified Mr. Lakeman. He didn't identify Dr. Desai. He didn't identify anybody else.

And what does that suggest to you? That there was a conspiracy to move PacifiCare patients around? What does that have to do with murder? What does that have to do with the object, to further the object of the conspiracy? It has nothing to do with it whatsoever.

So the State is going to pull out all of these little things and try to infer to you that there was a conspiracy. They're going to suggest to you, well, all the CRNAs bill at 31 minutes. Was there an agreement between Dr. Desai and the other CRNAs to bill at 31 minutes?

If you recall the testimony, Ann Lobiondo is the first CRNA. She brought her own billing stuff. She then told Keith Mathahs. Keith Mathahs presumably told Mr. Lakeman this is how we do it here, you bill 31 minutes. Did anybody ever, any of the CRNAs ever testify to you that they knew the reason for that? Did any of the CRNAs tell you they were involved in the billing process? Did any of the CRNAs even know the

billing process? Could we know the billing process?

You heard from insurance carriers. You heard from people that talked about CPT codes and modifiers and all of these other things that went into the equation of paying a claim for insurance. Do you think that these CRNAs knew all of that stuff? Do you think they had any idea about billing? What they did was they put 31 minutes, they put the paper in the bin, somebody from the billing department would pick it up, put in the information, press the send button, and that was the end of it.

Did any of the CRNAs get any of the money from the insurance companies? Remember, there was a CRNA account. Who got the money from the CRNA accounts? The doctors. The CRNAs didn't get any money from the CRNA account. They didn't get any additional benefit from the payment of the insurance companies. They got a salary. They didn't receive any additional funds. And so that goes to all of the insurance fraud and all of the billing issues raised by the State.

And I just want to go over some of those with you real quick, if we can. And just to point out where they're found in the indictment. With regard to Count 1 -- you can't see that, can you? Can you see it now? Count 1, can you read who that is, Ziyad Sharrieff? Somebody talk to me.

JURY PANEL: Yes.

MR. SANTACROCE: Okay. Ziyad Sharrieff, there's one

count of insurance fraud. Again, it's alleged as a conspiracy. But you'll remember that Ziyad Sharrieff, if you look at his EOB form, this was the one where it was base plus one unit. They had put eight minutes. And so the insurance company considered that one unit. And so his claim was paid at $206.82, base plus one unit.

And you remember that everybody got the base for anesthesia time. Everybody. And then it was just added by the minutes. There was no fraud for that because that's exactly what it was. It was base plus one unit, eight minutes. It could go from zero to -- what she say, 15 minutes, right, for one unit? So there was no insurance fraud there. What about -- let's look at another one.

MS. WECKERLY: It's Michael Washington.

MR. SANTACROCE: Okay. What are we doing about that? I thought it was omitted.

THE COURT: Are you looking at the jury instructions?

MR. SANTACROCE: I'm looking at just the indictment.

THE COURT: From the jury instructions?

MR. SANTACROCE: Yes.

THE COURT: That -- I don't think that's the right count.

MS. WECKERLY: It's 4.

THE COURT: It's Count 4 that was omitted.

MR. SANTACROCE: Oh, okay. Count 4 is -- oh, this is performance.

THE COURT: Right.

MR. SANTACROCE: I'm sorry.

Okay. Here. Count 4 is omitted, so you don't need to consider that one.

Kenneth Rubino. And I want to talk to you about people that Mr. Lakeman didn't bill. You're going to see insurance fraud claims for all of these people up here in Room 1. Mr. Lakeman didn't bill for any of these people. So he didn't submit any kind of insurance form regarding Kenneth Rubino, Rodolfo Meana, Sonia Orellono, and Gwendolyn Martin. And so, therefore, I'm going to ask you to acquit him on every single insurance fraud charge related to those people he didn't submit forms for.

Now, the State is going to argue the same kind of conspiracy, that there was this conspiracy. But remember, they have to prove to you the agreement, the furtherance of the act, the intent. All of those things have to be proved beyond a reasonable doubt. So with regard to all of those people, I'm going to ask you to acquit Mr. Lakeman on all of those people that he didn't submit an insurance form for. Because you'll see in the -- in the language of the fraud there has to be some material of misrepresentation on the form. And since he didn't submit a form, there can be no

material misrepresentation.

Now, with regard to the other patients, Carole Grueskin, that's in Count 21. I'm not going to go through all of this. You can do it in the back, but I'm going to just highlight some of these counts. Count 21, Carole Grueskin, that was a Mr. Lakeman patient. You remember she received a flat fee of 90 bucks. That was it. So it didn't matter how much time you billed. If you billed, you know, an hour, two hours, five minutes, it didn't matter. They were getting 90 bucks and that's it.

And you need to look at, too, how the indictment is pled because that's very important on the insurance fraud counts. It talks about -- it says -- let me go up here a little bit. False representation resulting in the payment of money to the defendants and Keith Mathahs and/or their medical practice which exceeded that which would have normally been allowed for said procedures. That's important language because the 90 bucks, that's all the insurance company paid anybody. It didn't exceed that which would normally have been allowed for said procedure. You can't convict on that.

Now, let's talk about -- who else did he treat? Stacy Hutchison, 90 bucks, flat fee. Patty Aspinwall, $249.92 was paid. And then she had another insurer, a secondary paid $78.20. She was out of pocket nothing. Did they provide any information to you, any evidence as to what normally would

have been allowed by that company for that procedure? No.

So those are the insurance claims. And the theft claims Mr. Wright went through. I'm not going to go through all that math with you. the substantial risk, those -- those claims, Mr. Wright went through those with you, as well, so I'm not going to go through those again. But be advised that there has to be -- and Mr. Wright went through this meticulously with you, so I'm not going to try to pretend to embellish upon that.

There were elements in each one of those crimes that needed to be proved beyond a reasonable doubt. There needed to be some intent. There needed to be some deviation from what was standard and customary practice. And he went through all of that evidence with you as to what was standard and customary. They would have had to have known. There would have to be foreseeability that what they were doing was going to cause this harm. None of that has been proven. None of that was present. Therefore, you need to look at that very closely.

Ladies and gentlemen, again, on behalf of Mr. Lakeman, his family, and myself, I want to appreciate and thank you very much for the service that you rendered here. We know that all of you underwent hardships to be here. And without you, our system of justice wouldn't be what it is. And we truly appreciate, and I can only hope that when you

look back at this experience in retrospect it will have enriched your life just a little, if not a lot. And we -- for that -- for that we thank you very much.

As I said before, these are hard decisions. But when you look at all the evidence, and it all flows from here, the infection. If you don't prove the infection happened here, you don't have any of the other medical claims and the medical counts. It all flows from that.

And I beg and implore you to look at it closely. Look at it carefully. Bring your common sense to your decision. And when you've done that, I hope that you will agree with me that all of the counts against Mr. Lakeman, he should be found not guilty. Thank you.

THE COURT: All right. Thank you, Mr. Santacroce.

Ladies and gentlemen, we're going to take a really quick break while we switch over some of the equipment, and then we'll move into the State's rebuttal argument.

Before we take our quick break I must remind you 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 report of or commentaries on the case, person or subject matter relating to the case, and you're not to form or express an opinion on the trial.

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

(Court recessed at 5:13 p.m., until 5:24 p.m.)

(Inside the presence of the jury.)

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

And the State may begin its rebuttal argument.

MR. STAUDAHER: Thank you.

STATE'S REBUTTAL CLOSING ARGUMENT

MR. STAUDAHER: Ladies and gentlemen, I know you're getting hungry. I know you're tired. And I have a number of things to go through with you. I will try to do it as quickly as I can. This is important, though, to the defense, the defendants, plural, and the State of Nevada. Because of that, I'm going to try to do my best to move through it as quickly as we can.

A couple things. At the beginning of this trial I told you that this case was about a breach of a fundamental trust. A breach of a fundamental trust between one of the most intimate relationships you can have. And I'm not talking about a sexual relationship.

I'm talking about a trust relationship, that between your caregiver, your doctor, and yourself. Someone you have to turn over your -- your essential life to at some point in your life, if not multiple times. And during the times that you have to do that, you have to rely on those people to do the right thing with the right motivations. The right thing

with the right motivations.

Now, you've heard the evidence and you've heard the witnesses. And I had to go back in my -- my notes just to make sure that when counsel was -- was talking about, gosh, that we were trying to put somebody on the stand to perjure themselves and mislead you.

In the beginning, if -- if I'm not mistaken -- and, again, what's very important, and I'm going to illustrate that in a moment, too, as to why what I say right now, what counsel has said, what I said in opening, none of that is evidence. It's my view, the State's view, or the defense view of what the evidence that's been presented in this case shows. It is up to you.

And as Mr. Santacroce said, there is a jury instructions, specifically I believe it's the Instruction 41 on common sense. You as a collective group, you as a collective group have more knowledge, experience, training, life experience, period, than myself or anybody else. That collective knowledge, that collective experience, whether you're highly educated or have a high school diploma or never even finished school does not matter.

What matters is that you bring that life experience with you. You don't leave it in the jury box. You don't stay here as robots just going back and crunching numbers. If that was the case, we wouldn't need you. You have to filter all of

the evidence that's come before you through your life view as well as -- then apply that to the law given to you by the judge.

Now, in this particular case, at the outset I told you that there were issues with some of the witnesses, a number of them. They were uncooperative, a number of them had to be granted immunity to even give information. They had -- all had lawyers or most of them did. Some of them had incomplete memory. Oh, and one of the other points was, gosh, things were bad, but I didn't do anything wrong. A recurrent theme. I tried to give you a heads up that that's what you were going to be experiencing.

Now, what that means is you take the other instructions and the common sense instruction and you have to take the evidence as it comes in through the testimony, as well as all of the evidence that you have in this case, and you have to filter that through that sort of prism of whether it's something you need to believe, what portion of it you need to believe, if any, you can disregard it.

You can take a witness, if you think they've lied, misrepresented in some way, and disregard the entirety of their testimony, the entirety of their statements. Or you can take it for what it is and use it in whatever way you want. Meaning, that if it's corroborated by other evidence, if you hear other witnesses saying the same thing, if you see

documentary evidence that supports that, then maybe you can take and consider it. It is up to you and you alone. There is nothing here that the State is trying to hide from you.

Now, I will -- I will acknowledge one error. It was an error on my part. It was a gotcha moment. Kind of like Mr. -- or Dr. Worman on the stand when he was talking about these journals that are third rate journals, Chinese journals that aren't worth anything, and you can't publish anything. And it came out that he was on the board of editors for one of those journals.

Now, for me, that was a piece of evidence that I misinterpreted. Now, it's in evidence. You can look at it yourself. It's not like it's misrepresented. But my interpretation of that evidence was that there was a difference in cost of the propofol at least at one point. Ms. Stanish pointed out, and correctly so, that it was not appropriate or not -- it wasn't reasonable to compare those two for the cost of the actual propofol.

The original reason to bring that forward is to show you that the cost of that item was far and above the cost of all of the other items. But in doing so, I misinterpreted a piece of evidence. That's why you're here, ladies and gentlemen, because it's your interpretation that matters. The rest of it that we put up witnesses to perjure themselves and that you were supposed to -- to use that information, ladies

and gentlemen, these are representative of the charts. These are representative of the charts of the evidence that's sitting right over there.

You can all go through the books. We're not hiding them. You can go through the books and look at all the numbers. And Mr. Wright said, gosh, you heard these witnesses come in and they talked about 75, 80 patients a day, 65 patients a day, whatever. Is that what it was every single day? No. An average of 59. And he's correct.

And you know how you get that? By a piece of evidence that you have that you can just easily take a calculator a piece of pencil and paper, and you take that number right there which is the number of syringes and you take that number of patients, and by gosh, that's the number of patients. The number of patients in the year of 2007.

You know that the work days in 2007 are 254. You make a division and you come up with an average of 59 patients per day. Now on the two days in question, these two days, you know exactly how many patients there were, 63 and 65. That's more than the 59. But, of course, an average is just that. There are extremes on either end.

Now, ladies and gentlemen, the evidence that you have, you can sift through that in any way you want. The witness testimony you have, you can sift through that in any way you want. It is up to you to apply it to the law given to

you by the Judge to come up with your verdicts in these -- in these cases, or in this case.

The issue of the propofol that I told you about earlier, which was -- the primary reason was to show that it was more expensive than any other item, and maybe that's a motivation or a reason why it would want to be conserved, at least by Dr. Desai, the, as the defense said, admitted penny pincher.

The tape that he -- and you've got these -- all of these invoices in evidence over here. The tape that he would use, that he would restrict was 78 cents a roll for an entire roll. The K-Y jelly was 29 cents a tube. The chucks were less than a penny a piece. The alcohol pads were less than a penny a piece.

And probably the most important item beside the propofol, we know the propofol was in the range of anywhere from two and a half bucks to fifteen bucks. So it -- it varied. The syringe, the 10 cc syringe, 10 cc syringe, 7.4 cents a piece.

So when Ms. Weckerly told you that this was a case of pennies, that's exactly what it is. A case of pennies of a person, an individual who had either such power or influence over his employees to create such a work environment to where people checked their morals, their ethics, their training at the door and engaged in practices which were known risks to

patients for what? A dollar. A penny. Money. He had to maximize the profits of that business.

And what were the examples? You heard Tonya Rushing say that one of the things that he did was he ran -- he ran the costs of the -- one of the most expensive costs related to the clinic would have been salaries, CRNA salaries. He ran that through the gastro center so that it wouldn't appear on the books so he could officially raise the value.

That's why when these -- these insurance people -- excuse me, the insurance people came in and they had to provide their contracts. Remember, we had to wait and do some out of -- or out of context. We had to take them because we had to get some of those contracts.

There was some difficulty doing that because they had contracts with the gastro center and they had contracts with the endoscopy center and they were being asked specifically about CRNA anesthesia type billing. Well, that's run through a different entity. It wasn't readily apparent in the contract they had with the endoscopy center.

An example, ladies and gentlemen, of what we're talking about. Every possible way to inflate the value of that clinic was going to happen. And if it meant running patients through at a perceived rate of every person coming in here that told you about that, 70, 80 patients a day, that's what they told you. That's their perception. You've got the

records. You know the number. It's not like we're hiding the number. You've got this chart. You've got this chart back in the -- in the room when you go back to deliberate. All of the numbers are representative of what happened at the clinic.

The -- all of the argument about propofol, about propofol reuse, no question it's being reused. These are the two days, ladies and gentlemen, that are charged. This is how many vials of propofol were used. This is how many patients they had. There is no possibility on those two days that if every patient got propofol, that if every patient got propofol, that there wasn't reuse of the propofol bottle from patient to patient.

You've heard the CDC come in. You heard other people come in and say, okay, grudgingly on CDC that, you know, if you -- if you reuse the syringe on the same patient and you use the same bottle of propofol, you know, it's not the best practices, but as long as everything gets tossed at the end it's okay. Because there's no risk of contamination that is going to be spread to another patient regardless of what your practices are. There's no risk of you use the same syringe on the same bottle.

I mean, everybody pretty much agrees that -- agrees with that as long as that bottle, that syringe is not used on another patient. The problem comes, and there's not a single person that came in here and said it was okay to do this. The

coupling of the two, the reuse of the bottle from patient to patient and the reuse of the syringe on the same patient.

Now, when you go back and look at those records on -- on what the cost of things were, look at the cost of a 60 cc syringe. It's more money than a 10. A 20, they didn't buy any so we don't know. I'm making an inference here. I would make the inference reasonably based on the evidence that's in question, and I get to do that in argument, that a 20 is more money. Maybe a penny, maybe two pennies, maybe even ten pennies. I don't know. But it's more. And because of that, that's why they use the 10s.

If they had used a 20 and the 20s were such that you drew those up and that was the majority of the patients that actually went through and used about that much, 180, 150 milligrams. Remember, we talked about milligrams. It's ten to one. So it's 10 to 15 ccs or so. Then every 20 cc syringe would have been done with the patient. They could have tossed it.

But what would that have meant? What would that have meant? That would have meant propofol wasted unless you used the propofol in the syringe you just used on a patient for the next patient, or put it into a bottle and you used that in some way on the next patient. Even as bad as things were in the clinic, that practice wasn't followed.

Now, we get to the -- the whole thing about speed.

You heard ad nauseam, and I -- and I -- maybe you were nauseated about it, I don't know. The GI techs, the nurses, everybody coming through talking about fecal material splattering, about speed of procedures, procedures starting too quickly, all of those kinds of things, just brought in to muddy up Desai? Muddy up Lakeman? No.

First of all, defense, at least for Lakeman, the whole issue is making the transmission something other than the propofol, other than what the CDC saw, other than what the CDC observed and heard from and people admitted to, making it something else. That was coming out. We brought it out primarily to you because we know it's coming out. And for the primary purpose, which was to show the level of the environmental stress that these people were under, to give you an idea of how fast things were running in that clinic, how many patients were put at risk on a day to day basis.

And when you have people coming in here and saying that they worked in the clinic a day, they worked in the clinic three days, they worked in the clinic a week and they're out of there because of what's going on, and the GI techs aren't getting trained properly because there's so much turnover they're having to pull in people from the clerical staff to cover because they can't get people there. They can't keep people.

It is such a high stress environment, the pumping up

of the numbers, the running of the patients through, what happens when people are run to their maximum capacity? They make mistakes. If you push people knowing that's going to happen, you are -- knowing that there is a risk and disregarding it consciously. We have people that have come forward in this trial and told you that they thought something was going to happen. They confront Desai about it. And what does he do? Disregards it. He disregards it.

Now, ladies and gentlemen, Gayle Langley at the CDC observed Keith Mathahs reusing syringes. This was an observation of a practice that was occurring. When they talked to him, he admits to doing the combination of the reuse of the syringes and the bottles moving from one patient to another. They stop him.

Now, he said at the time -- we're going to get to some of the things he said in a moment. But what he says at the time, I didn't know it was a problem. Now, you'll hear that theme over and over again. They were told it was standard practice, standard practice in the clinic to do that, to reuse bottles of propofol on more than one patient.

Now, we know that that's the case because of this. We know it has to be, physically. And we're talking about on the 25th of July of 2007, 65 patients, 22 bottles of propofol. If you give propofol to every patient, you've got to reuse them. 21, 63 patients, 24 bottles of propofol. They had to

be reused.

This is another part. Talking about the skips that you see over here and why they might -- you know, you heard that the CDC saw not just with -- or, excuse me, with Hubbard, that there were open bottles of propofol. One would be used, and it would be set up on the -- on the table. Then others would be used. And then all five of them are up there, four of them were up there, they would be collectively pooled and then used on new patients.

Ladies and gentlemen, if there's a contaminated bottle that gets set up on the table and doesn't get used for two or three patients until they pool them to use on another patient, you get holes regardless of whether the viral load is so high or not so high.

This chart here is up here from Mr. Santacroce and Mr. Lakeman. Because you notice he had the other chart. Yeah, they had -- well, this is the one. A little bit different color on the one that you have. It's a little yellow, but this is green. This is the 25th. He didn't show you this chart. He didn't show you this chart in his closing because he can't explain this.

If it's the saline, if it's the scopes, he can't explain that. Because he's -- this guy is right down here. Mr. Lakeman is down here in this room. The first patient of the day is Ziyad Sharrieff. Ziyad Sharrieff bypasses the

procedure room where they put in the IVs. He bypasses that and goes right into the clinic. Excuse me, into the procedure room. He gets his IV put in by whom? By Ronald Lakeman.

Ronald Lakeman deals with the source patient on that day. Now, there's no dispute that these are all genetically matched patients. Not even disputing that. In order for that patient to have contaminated the next patient via unsafe injection practices, which is what he admits to, Ronald Lakeman would have had to have been the one to contaminate that patient with practices that he admitted to doing.

The reason the biopsy forceps issue isn't an even -- even remotely here is because there are patients in between who had a biopsy. So we have individuals who are having -- unless we take the biopsy -- if we're reusing at that time and that's another thing we'll get to, but the biopsy forceps come out and they immediately go into the next patient without cleaning? I guess that could happen. Of course, how does it happen in here where you've got one in between an infected patient? He can't explain this without giving liability to Lakeman, so he doesn't show it to you.

MR. SANTACROCE: I object, Your Honor. I did show that chart in my closing.

THE COURT: All right. Sustained.

MR. STAUDAHER: There was a biopsy on a patient between Ziyad and Washington.

Now, Marion Vandruff. I'm not -- and because I don't want to be accused of telling you things that are just my interpretation, I'm going to go through some of these witnesses and some of the things they said. Desai -- saw Desai snap scopes out of patients, cracking the whip. He said that in court.

Now, what is the purpose of that? What is -- what is that kind of thing? It shows that he, Desai, is moving patients through so fast that he really doesn't care. He's putting patients at risk. The procedure is not the issue. The speed is the issue. The speed, speed, speed is the issue. Not just forcing the patients through, but forcing his staff through, putting people at risk just because of the environment.

If patients are moving through at breakneck pace -- and, ladies and gentlemen, one of the things that I want to point out here on this, this chart, and both charts had the same thing happen to them. You're going to actually have to go back and look at this just to make sure. And all the numbers are there so you can add them all up yourself.

But on the 25th, this chart right here, I want you to notice something. Room 1, Room 2, Dr. Desai is the doctor. Dr. Desai is the doctor. He is the doctor in the morning until about 11:00. From 7:00 until about 11:00. Four hours. In a four-hour window, a four-hour window, we're talking about

whether we can tell whether or not the times are correct and what times are right, you already know you can't go back in time. I think that's pretty well known for most people.

Look at these times. These times are the times on the records. They're unreliable. They're here to show you that and to show you how unreliable they are. Because you can just start looking at them and see that they don't match up. You certainly can't compare room to room to exact minutes. But we can look at the doctor, the personnel, the doctor who was here, going back and forth, room to room, room to room, four hours. 29 patients in four hours.

29 patients in four hours for one man, that guy over there. That is 8.9 minutes per patient. That's turnover, cleaning, everything that goes along with it. So an average of 8.9 minutes for 29 patients on that day alone, I submit to you that there is no way that these are all over 10 minutes, even the procedures.

When we go to the next chart, different doctor, same result. We've got Dr. Carrol in there. Dr. Carrol in the morning goes from room to room to room to room. Dr. Carrol in the same time period -- well, actually, it's a shorter time period. It's three hours, 19 patients in three hours. His time averages 9.47 minutes per patient. That's how fast these guys were doing it. That's how fast they were stressing the staff.

The staff was moving, as they all came in and told you, at a break neck pace. They all perceived that there were that many patients, whether there were or not. You've got the records. Look at them. They're all in evidence for you.

Now, Marion Vandruff, this whole thing about starting procedures, why would -- why would Desai not stop? Two reasons. You know what, the medication that we give, this propofol -- and this is not propofol. It's just a representation of propofol. Propofol, you head that it had what's called an amnestic effect, at least that it has some amnestic effect. That means you don't remember.

So, you know what, if you're not going to remember, what does it matter? That's the attitude. That's the attitude that is pervasive that invades every portion of this practice. The guy -- the only one who is in charge of anything in that practice of any importance is Desai, and that's why he doesn't do this. He will not stop. The patients are bucking around.

And -- and how does that enter into patient care? Not just the fact that the patients are under anesthesia or not yet under anesthesia, but the fact that when he doesn't stop he puts the patients at risk. Because when you have something inside of you and you are moving around, there is a chance that something bad is going to happen. Even staff thought that the speed of procedures, how he was whipping them

in and whipping them out put people at risk. At risk. Risk is the issue here.

When they tell him that they want to stop and the patients want to stop and he doesn't -- he disregards that, he is consciously disregarding a known risk, a risk that has been made known to him by the staff, by the people he works with. Now, the CDC, he also said, didn't see how things truly were. You know that when the CDC came over, they came over, they went to the administrative offices, they didn't do any inspection that day.

They came over the next day and they started doing the chart review. It wasn't until the third day that they actually did the procedures. Whether the numbers truly dropped or not drop, they were, as he said, tightening up procedures, that they didn't really get a good feel for what was going on at the clinic.

Now, they all felt pressure, or he did, felt pressure because of the patient load. He also says this tackle box. Now, whether it was a box or a tray or something, some physical object was -- was used to have those items in it, the anesthesia items, and it moved room to room. We not only have the tackle box, but we have the -- that he witnessed this move room to room and had another person do the same thing.

He also saw open bottles of propofol go room to

room, and Ann Marie Lobiondo, as you'll see in a minute, also admitted that she carried her own open bottles of propofol from room to room. A regular occurrence. This is the other thing. CRNAs would follow the doctors from room to room. This chart, the 21st, the 21st, we're talking about -- you need to look at -- make sure you look at the doctor to see if the doctor could be in two physical places at the same time. Because the first patient of the day up here, the first patient of the day down here supposedly start at the same time.

And Dr. Clifford Carrol is the doctor in both rooms. Look at the times. They don't even remotely match up anywhere along the line. But the one thing that happens on the 21st, and Dr. Carrol said that he actually remembered this day for some reason. He remembered that Desai came and relieved him. Well, that shows up on the record. Dipak Desai shows up here, and he's there for the second patient. Clifford Carrol is for the source patient, then we have Dipak Desai, and then look down here. We have Dipak Desai.

You heard that the CRNAs would follow the doctors from room to room. When Dipak Desai is up here and he goes to this room or however it was, we've got Keith Mathahs who is in this room all of the sudden appearing in the record down here as if he followed from room to room, followed the doctor with his propofol, with his syringe, whatever container it had - he

had.

Whether he brought a syringe with him or an open bottle of propofol, he brought something because there is only one way -- actually, a couple of ways, I guess, to actually get transmission. And the one that they saw, the one that everybody admitted to, the one that is the one that's in all of these studies is unsafe injection practices. CRNAs who use the supplies of other CRNAs. He saw that. He's not a CRNA.

Now, Vince Mione, you've heard a lot about him. He told you that there was a lot of pressure to cut costs. There was -- Desai wanted to use less propofol, less propofol to put patients to sleep. He came up with that bizarre thing about pushing saline in and maybe it'd make it work better, following it along, getting the last bit out of the little needle or making it -- force it into the patient's body. It's not completely clear.

He was the one that told you that this is how -- how much time they had to go out and take care of patients beforehand and take care of patients afterward. As soon as he finishes one patient, by the time he's turning around, the next one is being wheeled in.

At 8.9 or 9.4 minutes per patient, believe me, if you're including a procedure, the turnover, the putting on of the -- of the sort of the monitoring leads, all of the things that have to happen, that is not a lot of time. So how long

do you think the procedure actually takes place on those? And those are all mixtures of EGDs, the upper endoscopies, and the colonoscopies. So it's not like you just have one of the shorter procedure.

Desai, he got so impatient. He's not an anesthesiologist, ladies and gentlemen. He's reaching around and he would push the propofol in himself. How safe is that? Known risk, consciously disregards the risk, putting a patient secondary to his desire to go faster.

He also saw the yanking out of the scopes. He would tell Desai the patients are moving around. He's concerned about the scope being well -- and we're not talking about the very end. We're talking about the scope being well into the patient. The patient is moving around. Desai knows the risk. He's a gosh darn gastroenterologist. He knows the risk and he's consciously disregarding it.

And not only is he consciously disregarding it, but he's ordering somebody who is informing him again of the risk at the very time it's happening to not do something about it. He would start procedures before anesthesia was given. The speed issue, he's not going to wait. You're not going to remember. It's okay to perform an operation.

Who is going to submit? What reasonable person would submit to an operation of any kind knowing that they were going to, at least during the time of the operation, feel

every bit of it, the cutting, the sawing, the drilling, whatever, only to know that at least at the end a drug would be given that you wouldn't remember? Who would ever submit to that?

He admitted to using open bottles of propofol from other CRNAs. He said it was like an assembly line. He said the start time is when the patient enters the room and the stop time is when the patient leaves the room. That's what it is. And you've got a piece of evidence in there that came from the clinic.

There is no question about this Lawrence Preston issue. It's the policy of the clinic, ladies and gentlemen, that matches the CNS and the ASA guidelines which is that very thing. Start time is when they come in contact with a patient, and stop time is when they leave. The base unit that they get -- the reason that they get that base unit, you heard on the witness stand from the insurance people, is because the pre-op evaluation, if there is one, is included in that.

He, Mione, said Desai specifically said 31 minutes. And he said it was because PacifiCare -- this isn't just something that he said Desai said. He gave an explanation. Desai said it was because PacifiCare would not pay unless they were 31 minutes.

Well, you know that that's false. You know that on the PacifiCare record, on all of them, that they require the

start and the stop time because they wanted to make sure that they knew what the actual time was. That created some problems at the clinic. But that's what Desai uses as his reason. Conscious knowledge.

He's going to have to disregard it for the insurance issue or the theft issue. He was told to bill for 31 minutes. Desai told him to do that. That's where the information came from. He said all of the records were in that range, all of them, the ones that are back and forth, eight minutes or less, the patient nine minutes or less. This is -- this is key, too, about everybody's knowledge, acquiescence, the conspiracy, the aiding and abetting.

Desai had whatever influence or power over these people to get them to do this. You heard that every one of these people who came in had never done this stuff before. They leave the clinic. And if they got a job in medicine, they have not done it since, including Ronald Lakeman. And in between while they're at the clinic, they check everything at the door, all their morals, ethics, everything, and they do this.

And what do they do? The blood pressure and heart rate were key here because they're not just putting down false times because the times don't matter. They're doing something else falsify a medical record that another professional may rely on in the future, a medical record that would have vital

signs like blood pressure, heart rate. They put that on there. Why would they do that? So the record would look good if anybody ever looked at it.

What does that tell you? If you're fabricating information on a record so that if anybody ever looked at it would look good, that means you must have knowledge that there is going to be a problem if somebody looks at this and I don't do this. Desai wanted to do as many patients as he possibly could. That comes from Vince Mione. At the VA they would use real times. Desai is not at the VA.

Vince Sagendorf. This is the other Vince. We've got two Vinces here. A little confusion on the witnesses, but a Vince gave some information. At the end of the day he said that the staff would bring him partially used bottles. At lunch he would see open bottles in the other room. Open bottles means what? You've got a CRNA that's left. He hasn't taken his set and -- and tossed it. There's an open bottle there. That person knows they're going to come in.

Vince Mione would use the open bottles of other people. This was something that went on on a regular basis at the clinic. Mathahs told him not to waste any propofol. He was told to do 31 -- add 31 minutes. He was clear that this was about insurance billing and he says everyone knew it. These are anesthesia people.

They fill out very few records in the chart. One of

those records is an anesthesia record and it has time on it. The time is how it's billed. This is not rocket science. It's not some cloak and dagger thing that you have this guy that's been working for 30 years or 25 years that doesn't know that. They know the purpose of the record. You don't falsify records, first of all, on a medical chart.

Hubbard would try and give him half-used bottles of propofol. Now, she got on the stand here. She got on the stand here and she had no memory of anything. We, as a matter of fact, had to bring, as counsel said, a detective up on the witness stand with her statements to get those statements in. Because I don't remember, I don't do that, never did that practice.

This is another one of Vince Sagendorf, though. He calls -- Desai called him into his office. Now, remember Sagendorf is not one that worked with Desai much. But Desai knows how much propofol he's using. That's how micromanaging he is in the practice. He knows everything that's going on.

He calls Sagendorf into his office and he says, guess what, you're only going to use this much propofol on a patient. Now, what does that tell you? Patients are different weights, they're different ages, they have different medical conditions, they need different amounts of medication to do the same thing. You heard that even on an upper -- upper endoscopy, even though it's a shorter procedure, you

might have to actually use more because you have to get through the vocal cords. That's a very sensitive area.

But he's restricting staff on what they can use before they even get to see a patient, before they've made their evaluation of a patient. It's -- he knows, knows that that can be risky because of the other issues, other medical issues. But yet in advance he's telling these people to disregard this.

Jeff Krueger, Desai wanted to know the exact cost of the endoscopy, colonoscopy. Now, this was the one thing, you heard about the syringes. You heard about that whole thing with the -- what they found with the propofol bottles.

And also the chart that you have back there about the 2007 propofol includes Ms. Stanish's one record for 2007 on the propofol. The propofol is not the issue. The syringes are the issue. We know that the propofol was being reused. There's no question. It's whether the syringes were being reused on the same patient with the same propofol bottle.

If, in fact, you're going to do this, reuse propofol patient to patient, then you have to have enough syringes for at least, in most cases, two syringes per patient. We're going to get to this in a bit, but the numbers here, we've got 17,100 syringes ordered. No -- no lost records on the syringes.

Remember, that was McKesson, it was in town, easy to

get, they would get them the next day. Nothing like the supply issues that sometimes happened with propofol when they had to get other vendors or so forth. There's been nothing that has come out in evidence that shows that there was a missing record regarding syringes.

If you have that many patients, multiply 17,100 times two. If you're going to give two syringes per patient for most patients. Some take more, some take less, but on average about two. You'll see the averages. You're going to need over 30,000, 34,000 syringes.

So you've got a situation here where, yes, this up here, and I want to make sure it's clear, this is 2007 comparison of syringes ordered, not taking into account any preexisting inventory. They kept their inventories lean. You hard Jeff Krueger say that they didn't keep more than about three or four boxes on hand at a time. And how do we know that? Because right at the beginning of the year -- you've got those charts. Look at them.

At the beginning of the year of 2007 within a few days of the year they're ordering more -- more supply. So they didn't have a whole room full of syringes at the clinic and then you just ordered some more. Also, what that doesn't take into account is any preexisting inventory going over into 2008 from this year.

I would submit to you that it's reasonable that

that's likely to have balanced. And it doesn't take into consideration any sort of syringes going from clinic to clinic. This does because this -- these are the combined numbers. These are the combined numbers over here for the total number of syringes and the total number of patients. And as you can see, even if you combined all the inventory at both clinics for the entire year, there's not enough for two syringes per patient.

With Maggie Murphy, Desai bragged about how fast he could do procedures. What would be the purpose of bragging about that? How does the speed of a procedure on an endoscopy or colonoscopy going to benefit the patient? What is the purpose of doing those procedures? It's to look for pathology, for something wrong. The faster you look, the faster you do the procedure that you're looking around nooks and crannies and maybe the preps aren't well -- well done by the patients, you're compromising the patients by the speed. But he brags about it.

Again, she's another one. All of these people -- and, again, why do we have these people all come in and they're all saying the same thing? Ladies and gentlemen, each -- each person had a different little piece, but most of the people saw common things.

The common things are to show you with patient after -- or, excuse me, witness after witness that this wasn't

something in isolation or some, as counsel said, disgruntled employee with an ax to grind. This is everybody that came forward was saying these same kind of things if they had expcsure to those areas of the clinic.

Desai would not stop again. She saw the double dipping. The double dipping is the bottle, syringe, patient, going back in the bottle, the double dipping, contaminating potentially that bottle if that bottle is used on the next patient. So she saw it, said it was fairly common.

She was worried about the volume of patients because she thought something was going to happen. Something was going to happen. She thought it would probably be a perforation, but she said something. You couldn't run the patients at this load without thinking that something was going to happen.

She complained to Desai multiple times. This is where we had the conscious disregard. Known risk, she's telling him about a risk. What is his response? Nothing. He didn't do anything. He's consciously disregarding that risk.

Waiting room was so crowded that patients would cheer when somebody got called in. What does that tell you? The volume of patients and the number of procedures being done is taxing everybody, including the patients waiting in the room.

She also saw the tackle boxes and she described

them. Used a formula for putting times on the record. And you heard that over and over and over again. And you've got the records and you know that they follow that exact formula. Why would a person do that? None of the staff had done that before and none of the staff did it afterward. It's coping.

People who are stressed and have so much that they have to do and they have limited time to get it done do what? They cope. They start cutting corners. They start doing what they can to minimize extra effort so that they can get things done. That's why procedure charts are filled out beforehand. That's why things are done so that they can move the patients through at a breakneck pace.

Saw Desai take sheets off and reuse them. That's how down in the trenches he is. Take a patients sheet off and reuse it. What does that show you? It's not just to show you that he's, you know, not a nice guy. It's to show you the level that he is willing to go to to save money. Why money is so important to him and what he's willing to do as far as patient care to save money, fractions of pennies, even.

The pre-charting. The patient load would not allow them to do it correctly. To even look at a clock and put the correct times down. They didn't have time. See that? The pre-charting was done not only for speed, but because the times wouldn't match up in case something happened, meaning somebody looked at -- looked at the records. The times all

had to match. If they follow the formula every time. It's all going to match up. You're not going to have a time wrong here and there.

Anne Yost, you were told about that. She was told to do it. She wouldn't do it. And she's told specifically make sure those times don't overlap. They're focused on this overlapping in times. She's encouraged to pre-chart for other nurses, a time saving effort, the speed, the time, the pressure.

Can you see a pattern? It's the same thing over and over again. Worried about her license, there's no cleaning in between the patients, 8.9 minutes per patient or 9.4 or whatever it ends up being. Rolling them in, rolling them out. There's not enough time. They don't -- they're not cleaning. They're not doing anything except for rolling the patients through. The volume was so high she couldn't keep up and she was brand new. It burned her out in a day.

Janine Drury. Now, she was the pre-op nurse that trained and watched Lynette Campbell. And you heard some things about Lynette Campbell. Lynette Campbell was the new nurse, but Janine Drury, the -- excuse me, the Gestapo of the pre-op area, what does she do? She watches over her like a hawk. You have not one shred of evidence, not one witness, not one piece of evidence that says that Lynette Campbell ever deviated from safe injection practices.

Mr. Santacroce brought up in his closing, he said, well, you know, Lynette Campbell, you know, sometimes they would make a mistake out there in the -- in the room and they would put an IV in and they had to have somebody else put the IV in. I fail to see how that's possible that that has anything to do with a flush. Because if the IV never gets put in properly in the first place, it doesn't get a flush.

And if it does need a flush, there's no reason to go back into a saline bottle. There was no reason to do that. They flushed once, the patient was gone. You think those patients were really sitting in the pre-op room for very long? They were getting their IVs in and they were moving out.

Campbell said she never did anything that was a problem, and Janine Drury never saw anything on her that would cause any concern. The CRNAs would follow the doctors into the room and back again. She saw that. So when you've got this right here about the fight, what's the fight about? The fight is about Desai reusing biopsy forceps. Now, that's a mechanism, potentially.

But what happened with the biopsy forceps? Remember, she, Janine Drury, had medical problems and she had to leave. You heard Jeff Krueger come in and talk about when he came over, and we'll get to that in just a second. But Jeff Krueger also talked to Desai about it. The biopsy reuse had stopped prior to the infections at the clinic. The biopsy

reuse had stopped prior to the infections at the clinic.

Ruta Russom, the GI tech, saw Lakeman double dip. Lakeman admitted to it. Here's somebody else in case the CDC person got it wrong on the phone. Here's somebody that actually saw him, said it was standard practice and all the -- all the CRNAs do it.

Described an incident with Desai again. This one was a bad one. It really stuck out in her mind. This incident was an incident that she saw with Desai where Desai is starting on a procedure on a patient. The patient is awake. It's -- it's hell be damned, he goes forward, the patient was awake, remembered it, it upset Russom, it upset the patient. This isn't one where the patient forgot, unfortunately for her.

Now, Peter Maanao, and I don't know how that's pronounced. This is an important one because he overhears a conversation between two people, Desai and Carrol, about what? About syringes, the price of them, and that they had to get the staff to reduce or minimize the things that were used. That is corroborative of Vandruff, of Rod Chaffee, saying about the syringe reuse. Linda Hubbard's statement that she was instructed to do that. Desai and Carrol are discussing syringes and minimizing the use of those supplies. This is before the CDC comes in.

Now, Peggy Tagle saw CRNAs go back and forth from

room to room, so we know it's happening. We know that the nurses sometimes, according to her, relieved another CRNA before the procedure was done. Actually, that's nursing, not CRNAs. I misspoke.

So the nurses in the rooms would leave. And the part that's significant about that is if you've got -- if you've got a nurse leaving a room before the procedure and they're filling out charts in advance, the next CRNA may not even be the right person on the record, hence the reason over here where it's even possible where it says Ron Lakeman, he's gone for the period of time in this room.

It's very possible that he could have been there, I mean, with Keith Mathahs, that he follows Desai over for this procedure because who's doing that -- that person? Desai is. Desai was over here, and then he comes across there. Does it seem reasonable or logical that somebody who says that they follow the -- follow the doctor that he would stay in his room if there's another CRNA down there, Lakeman, and that he would then come across to that room when he's got to be back up here again with Desai?

You heard about Chaffee. Chaffee has got his issues, no question about it. But Chaffee told you some things that are corroborated by other people. Didn't see any patient care issues with Chaffee. He's not even in the clinic. He's gone in April. He's gone. He never comes back.

He's not any rogue employee. He's not there.

Sukhdeo, another one that I have trouble with. He saw Mathahs with a tackle box go back and forth. Another person who saw something like that. Desai said that the CRNAs were using too many supplies. The CRNAs, what supplies do the CRNAs use? Propofol, needles, syringes. That's what they use. They don't use the other stuff. That's what they put people to sleep with. Desai showed them how to squeeze out even the last drops out of K-Y out of a tube. That tells you how down in the trenches Desai is with saving money.

Clifford Carrol, the first thing he did -- now, this is the doctor. This is the doctor who is, according to this record here, going room to room to room doing patients, 19 patients, less than 10 minutes a patient. He feels that the patients are so -- I mean, the patient load is so high that the first act he does when Desai is not there and he gets a chance to do it is to reduce the patient loads.

The Rexford lawsuit, though, the 30-minute issue, now counsel talked about that. The 30-minute issue. He talked to Desai when that came up, and Desai's first statement to him is that there was no billing issue. Second time that he talks to Desai about this is not when he sees that anesthesia record. It's -- it's when there is about a week later that still the deposition thing going on. That issue has come up again. He goes back and talks to Desai. And not

Carrol's words, because I asked him about this specifically, no Carrol's words, but Desai's words. There is no billing fraud. He, Desai, used the word fraud.

Clifford Carrol noticed the anesthesia record filled out before he starts the procedure. Now, this isn't something where it's just a little filled out. He said it was completely filled out before he even walked in the door. That's vital signs, that's the time, that's everything. That's when he goes -- he gave up. He got very upset.

He goes upstairs and talks to Tonya Rushing, then they go down and talk to Desai. He confronts Desai about it, and he agrees begrudgingly that the end time had to be the end time. He doesn't justify, well, that's not what the end time is even though our own policy says that, even though that's what everybody else knows. He wasn't surprised by it. He later reviews the anesthesia records and he finds out that they all say 30 or 31.

Now, this was important because he remembered the call to PacifiCare. That call that came in from Keith Mathahs, the PacifiCare issue, he remembered it. And Desai took it. Carrol was terrified about the implications of the falsified records because he had done that, and he also saw that all these records are 31 minutes. And he knows how fast he's doing them, and he knows how fast Desai is doing them, and he knows how many procedures are getting done in a single

day.

Now, Ralph McDowell, he works with Desai only a few days. Only a few days, ladies and gentlemen, but during that time Desai tells him too much propofol. He's the most expensive CRNA. Vince Mione frequently offered him open bottles of propofol. This is a regular occurrence. We've got open bottles of propofol being offered to people, going room to room, being in rooms, there's clear mechanisms, vectors for this contamination to take place in the way that the CDC saw it.

Desai met with Desai -- or with McDowell right after the outbreak and said, if you are asked if you use multi-use vials, you say to him, what's that? You make your own interpretation of what that means.

Rod Chaffee, he too -- and the reason I put Rod Chaffee here was because the other people saw exactly the same thing. Open bottle in the hand. Who said that they carried an open bottle in their hand from room to room? Ann Marie Lobiondo. Saw Lakeman carrying half-filled bottles of propofol from room to room. He left in April before the infections. Stopped reusing biopsy forceps and snares in 2006. Again, that stuff which would have been a potential mechanism wasn't even being reused at the time, even though it had been before.

Lakeman, these are things attributed to Lakeman.

Again, you'd have a -- this is not to be used against Desai directly. Against Lakeman. Lakeman complained about having to put the 30 minutes on the records. Conscious knowledge of that issue.

Issue about PacifiCare. He's aware of it. Not only is he aware of it -- now, he didn't want to do too many of them because you're going to have to take the next patient because I've done - I've done too many PacifiCare patients. Conscious knowledge of that issue.

I can't make the times work. Does that -- does that scund like somebody that just doesn't know? Just has no clue as to what's going on? Lakeman would say that if someone asked they would justify the 30 minutes by what? You heard this a couple of times. By saying that PacifiCare would not pay unless the record said greater than 30 minutes. That's what he said is what the answer would be if anybody asked about it.

This was a gem. If the shit hits the fan, I'm not covering for him. Does that sound like somebody that doesn't know what's going on? He knows exactly what's going on. The pressure of that clinic, it shows the conspiracy, it's shows the aiding and abetting because he's coming up with ways of explaining it away if he needs to. He's involved at all levels. When he's the direct actor, when he aids and abets in the process, and when he conspired with these individuals

because clearly we're showing an agreement between two or more persons to commit a crime. That's a conspiracy.

She mentioned, Ann Marie Lobiondo, had open vials of propofol brought to her. She said she would carry them room to room, saw open bottles in other rooms when she relieved other CRNAs. Saline flush was short lived. That's not an issue in the case. That's something that you're considering. May of 2007 that was done. So that was before the clinics.

Desai -- this is attributed directly to Desai. Remember 31 minutes anesthesia billing time. Desai would say that it was -- say that in the endoscopy suite that the time had to be over 30 minutes. Desai's direct knowledge encouraging, counseling, advising. It goes to the aiding and abetting. He's using others to perform the tasks that he's directing them to do.

Testified that the anesthesia time is -- well, she knows what it is. It's when you have contact with that patient, when you first see them, when you leave them. That's the anesthesia time. She said that you cannot count the time in between when a -- or when you are working on another patient. You can't do that.

This is another one. Also shows a lack of concern for patients. The conscious disregard of risk to patients, which blends itself into the actual harm that occurred in this particular case to the victims in this. Desai tried to get

her to do something to a patient that she thought was medically not proper for the patient. She argued with him. You heard that they were going to get the lawyers, all that. She leaves the clinic. Desai wanted her to do it anyway, even though she expressed to him what her -- what her concerns were, what the risk was. Now, that's important because she came in and testified here and you're going to hear that Keith Mathahs had the same thing happen to him except with the syringe reuse.

These are statements that Lakeman made to the CDC. Again, this is offered for Lakeman. Lakeman asked Schaefer if she was recording their conversation. She said no, but she was taking notes. Lakeman said he would deny the conversation if it ever came out. Again, does that sound like somebody who thought what they were doing was proper and reasonable?

Even Mr. Wright said, boy, people that deny something they've done with the taxes or whatever shows what their mental state is. That's what we have to prove. The difference between civil and criminal in some cases is your knowledge, your intent, and all the stuff that we brought in is to show the knowledge and intent. It's called circumstantial evidence of what his knowledge and intent was.

Lakeman said if he walked into a room to give a break he would use partially used bottles of propofol drawn on another patient. Now, you heard from Ann Marie Lobiondo. You

heard from Vince Sagfendorf. You heard those people tell you that there is a risk, pretty clear risk. You don't know who did what to that vial, but you're going to take that risk for the patient. You're going to take that risk for the patient.

That's the key here with Ronald Lakeman. He believed he could do that. The chances were low. He didn't go out and ask the patient, you know what, I don't know where this has been. I don't know who's done what to it, but I'm going to use it on you and I'm going to put it in your body, in your blood system. And if, gosh, it's got a contamination like a virus or a bacteria, it could cause some problems, but a pretty low risk. He didn't ask the patients.

He admitted, admitted to the practice which the CDC said caused this infection outbreak. Admitted to double dipping, same syringe to draw up more. He would use -- he would even -- here's -- here's another thing. The fact that he would use some technique to minimize the risk indicates that he knows there is a risk.

He's aware of the risk, he did things to minimize it. Now, this is another telling part. He leaves the clinic. He goes to Georgia. He's working there. Does he continue this practice that this is okay? No, he does not. He doesn't do that. They use dedicated vials of propofol there for the patients.

Linda Hubbard, she told Schaefer -- she told

Schaefer that she did not reuse syringes, but she was told to do so. Now, that's corroborative. That's Schaefer, the CDC person. That's corroborative of the statement that she gave that we had to bring our here with Detective Whitely.

She was told to reuse syringes even though she didn't do it because it was unsafe. Saw Lakeman reuse syringes, changing the needles. So she's actually seen him. Not only does he admit it, but she sees him do it. Lakeman told her that that was the way to do it. That was the way it was done at the clinic. She told Lakeman she couldn't do it. But what happens after she tells Lakeman that? She gets a visit from Desai. She gets a visit from Desai who approaches her and tells her that he wants her to do it the way Ron does it, to reuse the syringes. He doesn't use those words. He uses these. But it's immediately after she tells Ron that she refuses to do it.

Keith Mathahs, he thought the number of procedures -- this is just a reference to a place in the transcript. Mathahs thought that the number of procedures per day were unmanageable. He's in the trenches doing it. He thought it compromised patient care, developed foot rot in 2003 because he couldn't leave the darn room. That tells you how much he's getting up and seeing patients before and afterward.

He would relieve others for breaks and lunch and bathroom breaks. Went to the pre-op area to deal with

patients rarely. It was a rare occurrence for any CRNA to go out to the patient room, the recovery room. Patients going in and out, no cleaning, only a minute or two between patients, Desai was the one that pushed him to move faster, Desai regularly ordered additional medication or ordered that no additional medication be given, contrary to patient care needs.

He bragged about the number of times he -- or about how fast he can do procedures. Desai would push Mathahs to start procedures before he was ready. That means that he's trying to fill out -- he's trying to get this anesthesia bill, he's trying to get the information that's appropriate or important for him to be able to use this information for a patient. And Desai wants him to disregard that. Desai was emphatic that the times had to be 30 minutes. You've heard that over again. Procedures did not last very long.

He knows -- he knew that this time related to billing. He fabricated vital signs on the record so it would look proper. Have you heard that before? Knew it was going to the insurance company. The pre-charting was going on all the time. Why? Because of how fast they were moving. The environment was very stressful. His words. I mean, it was just speed, speed, speed, speed. Come on, let's go faster and faster. It gave him concern that it might cause trouble, and it did.

After 2004 PacifiCare patients were treated differently, and that's the whole thing about Desai getting a call, or him getting the call, Desai going in, and afterward he comes back, Desai comes back and tells him from now on we're not going to do PacifiCare patients back to back. Conscious knowledge of them, all of them agreeing, a memo brought out so that everybody follows that procedure so that nobody makes a mistake on it. It's all about overlapping times. That's what Desai told him.

Couldn't waste the propofol. Desai would start procedures before the anesthetic. Desai would know the patients were awake and proceed anyway. The sharps container. He would come into the rooms and look in the sharps container to see if there were open bottles of propofol or syringes to see if they were wasting it or not. He paid attention to it. He saw if there was a syringe on the counter. He would get upset by that because if there was any propofol in it, what would happen? It would probably get discarded.

It is common practice to use the bottles for more than one. Desai instructed the CRNAs to reuse syringes on the same patient. This is Mathahs telling you this. This is direct action of Desai ordering the reuse, the forbidden thing. They're reusing the propofol. You can't reuse the syringes and the propofol together. This is Desai ordering that practice. This was common practice according to him.

He expressed his concerns about it. And this is where you have to make sure that we have proven the issue about Desai's knowledge. Not only his knowledge and training and so forth, but Mathahs even confronts him about this and expresses the risk to Desai. And what -- what is Desai's response to that? Desai's response is just go ahead and do it. That's what his response is to that. Hey, if we reuse the syringes and we reusing the bottles of propofol, this could cause a problem. Just do it. And if you then do it and you have the knowledge whether you're the direct actor or Desai, you're both equally guilty.

Now, this is important, and this is where these bottles come in. July 25, 2007. And all this is in evidence. You can make the calculations yourself. Room 1, Ms. Hubbard. If you go through and add up all of these milligram amounts, you come up with, for Room 1, 5400 milligrams. There are 66 -- if you add up, if you go through this on each one of these things and you see where the times are, the first one, for example, has 350 cc -- or, excuse me, three 50 milligram injections. That's 5 ccs a piece, one 10 cc syringe.

That means if you weren't reusing syringes, you'd have to use two syringes. Go through that process on every one of these, and you come up with, in Room 1, that they would have -- if they were not reusing, they would have needed 66 syringes for that room alone that day. They did 34 patients,

15 EGDs, 19 colons, if you can see that.

Room 2, Lakeman. This is how much was used. 4102 milligrams of propofol, 49 syringes if no reuse, 31 patients. Again, a mix of -- of the procedures. A total of 115 syringes if no reuse, 65 patients, that's 1.77 syringes per patient if no reuse.

Now, the propofol, same thing, the 25th. 20 -- these are 20 ml bottles. There were two used that day. That's 400 milligrams, 1 milliliter per 10 milligrams. 50 ml bottles, 20 were used. 10,000 milligrams. According to injection amounts, that number, the 5400 from the previous and the 4100 from the previous slide gives you 9,502 milligrams. You subtract -- or the checkout amount was this amount, the 10,400. If you subtract that, you end up with 8 -- or 898 milligrams which is 8.98 mls. That's how much was wasted.

That is a representation of how much propofol was administered to 65 patients. That's how much was given, that's how much was wasted. They weren't wasting a drop. If you start thinking about the amount of waste from just residue inside a bottle that doesn't get out and in that many bottles, that's how much, ladies and gentlemen.

Now, on the 21st, Room 1, Mathahs, same -- same deal. This is Mathahs now. 5970 milligrams. If no reuse, going through that same process, it would have been 71 to 73. Depending on how you do it. There was a way to make it less,

so I made it less because I didn't want to misrepresent. So 71 to 73 syringes if no reuse.

Room 2, Lakeman, he used this much. 57 syringes if no reuse. He had 31 patients. So there was either 129 or 131 syringes that would have needed to be used that day if they had not reused the syringes. 2.05 or 2.08 syringes per patient. You know from this chart here, the number of patients, that they didn't have enough for two syringes per patient. With all inventory combined at both clinics.

The propofol, same thing. There were no 20s used that day. There were 24 50s used that day for a total of 12,000 milligrams. Reported injection amounts were this, the amount checked out was that, and you subtract those, and it's 1260 milligrams for a total of 12.6 milliliters. That's the waste. That's a representation of how much was actually given to patients that day. This is how much was wasted between two rooms, two CRNAs, 63 patients I think it was that day.

They did not waste a drop and there weren't enough syringes to give that medication the way it was supposed to be given. They had to do both. The cardinal sin from everybody that's testified here. They had to reuse syringes and reuse propofol on the same patient.

That -- and how did the CDC, how did -- when Miriam Alter came in and said in New York, remember, that they couldn't figure it out, the person hadn't disclosed that they

had done this stuff. They had to go back to this, the supply issue. They found out that there weren't enough supplies to do what the person said they were doing. It is exactly the same situation here. There were not enough supplies.

Now, the scopes, this is a possibility. Langley said very low likelihood. Alter said it has never been the scopes. In all of those studies, it's never been them. No evidence that she saw here that implicated the scopes. And she went back and looked at all the data that they had done. And not only did she concur, but she said it's not the scopes.

The defense expert, Mr. Worman even, low, low, low, low probability that the scopes would be the mechanism. And he's testified previously in another case where three patients, it wasn't the scopes.

The infected patients were done back to back, and I'm talking about these right here. If it's the scopes, for these patients to get infected, ladies and gentlemen, from the scope, because there's no way that you're going to go in two minutes cleaning. You'd have to literally take the infected scope out and take it and put it right back in the next patient and take that one out and put it right back in the next patient, three in a row. It's not the scopes.

None of the infected patients had any common scopes. If you look at your chart here, there is a place, and let me see if I can find it. Where is it? Oh, here it is, scope

number. That column, none of the scope numbers are the same. It's not the scopes. The biopsy forceps had been discontinued. They didn't reuse them anymore.

There's only so many ways you can get a blood-borne transmission. They saw the practice. It was admitted to, it was observed. The CDC looked into the cleaning and found the Medivators at that time were functional. You head about the stuff that happened before, but they were functional at this time. Another reason why it's not the scopes.

The saline flush issue. Different nurses on -- on 9/21. There were two different nurses that worked on 9/21. No evidence at all that there was any issue between -- and you heard that from Janine Drury, Jeff Krueger, and Lynette Campbell.

Now, the saline flush issue. They had no reason to reuse. No one observed any reuse or anything by any person. And Stacy Hutchison, what about Stacy Hutchison? She came in and testified to what? She came in and told you that she was the one person out of the whole group who actually remembered her flush. She remembered it because she was curious. She watched it.

What did she tell you? When the person came out to do the flush, they popped the top off of a brand new saline bottle. A brand new saline bottle was used for her flush. There is no way that Stacy Hutchison down here who gets a

brand new saline bottle could be infected from this patient if it was through that mechanism.

And we know that on the 25th it was Ziyad Sharrieff was the source and that the contamination started with him and moved to Michael Washington, both of which were Lakeman's patients, and no nurse or saline flush was implicated there. It's not the saline flushing.

Disregard for the patient, Sagendorf. Started procedures and would not stop despite knowing. Desai's knowledge of risk, Krueger. This is -- this is one related to Krueger where we know absolutely that Desai knew the risk. And why? It's not a stretch to see how he disregards it when he's disregarded it here.

You've got Krueger. Desai was ordering staff to reuse the biopsy forceps. Krueger goes to Desai and the tells him, he says, look, you can't do this. He presents him with a paper, a scientific paper that says this is risk behavior. You cannot do it. Desai acknowledges, Krueger goes away because, remember, he was at Burnham.

Later, Krueger hears from the staff that, hey, look, he's pressuring us to do this again even though I've just had the conversation and I've given him the paper and he knows the risk and he's agreed to not do it because of the risk. What happens? He had to go back over to Desai.

And the only reason that that ever happened, why the

reuse stopped, was because the manufacturer found out about it and they started brining in the scopes -- or, not the scopes, but the biopsy forceps on a par rate or a par thing where they just kept replacing them so the staff never could run out and they didn't cost Desai anything additionally. So because they didn't cost Desai anything additionally, he didn't care. So it's not the biopsy forceps.

Ziyad Sharrieff, the source patient. That man did not want to be part of the infection. That man certainly, Kenneth Rubino, didn't want to. Michael Washington was infected. You saw him. Who among you would want to have a liver transplant regardless of how much money you got? Stacy Hutchison, Patty Aspinwall, Gwendolyn Martin, Sonia Orellono, Carole Grueskin.

Dr. Worman on the stand, absolutely no evidence in the literature of any infiltration of the hepatitis C virus into the brain. Three out of the four papers I provided to him show just that. Invasion of -- hepatitis C viral RNA into astrocytes within the brain.

Lewis came in and told you that she was mentally okay, he was her patient -- excuse me, she was his patient -- until she had the colonoscopy. And even until later when she started getting the anxiety and everything related to the fact that there was an outbreak and she was infected and she didn't know what that meant. She's never recovered.

Rodolfo Meana. You know, this is the -- the murder charge. Ronald Lakeman is -- is partly -- I mean, his -- his role here is not a direct actor. It's through an aiding and abetting, the conspiracy. You are liable for the foreseeable results of those actions which you had specific intent to engage in.

It's not that you wanted to engage in -- this is not first degree murder. This is second degree murder. It's engaging in an unlawful act, the acts that he was talking about, which are putting people at risk. Putting people at risk, a conscious disregard for that risk. A conscious disregard for the risk, a known risk, consciously disregarding it, and somebody gets death as a result of it.

Now, Rodolfo Meana, this is where he is later. Look at his abdomen. That's that ascites fluid that we talked about, that buildup of fluid. That's what he was at the end. And when we look at -- remember Worman was saying, gosh, if I had any evidence that said that there was this hepatorenal syndrome onboard with this patient, yeah, I might revisit my opinion. But I didn't see any. Oh, I saw some sort of thing about mention of it somewhere, but I didn't see any evidence of that.

Did you review the medical records? Yes. The hospital in the Philippines, the records that are sitting right over there, this is the record that I was trying to find

the other day. And that part right there is a note on the first section of the record. And you've got the real record to look at, but that says assessment, hepatorenal syndrome. It's in the medical record that is in evidence sitting right over there.

Now, that's not all. In the same medical record there is a chart, a piece of paper that has his past medical history, past medical history. July 21st to 26th of 2011, edema ascites cirrhosis issues. The beginnings of kidney insufficiency. The beginning. So he's got cirrhosis, he's got liver problems onboard, and now he's getting the beginnings of kidney problems. Not the other way around.

We move forward in time to August 24th and 27th of 2011. We've got hepatorenal syndrome of kidneys. 2012. He has now -- has a diagnosis of this, which began up here, progressed down here, in his past medical records. This is not the other way around.

Hepatorenal syndrome, as you were told by the defense expert, was that the failure of the liver causes damage to the kidneys, and then results in - as a cascade multi-system organ failure, which the encephalopathy up in the brain because the toxins that are building up causes the brain to eventually shut down and you eventually die.

This is in the medical record, not the -- not the certificate of death, the medical record in this. And you'll

have it. It's talking about CP arrest, cardiopulmonary arrest, secondary to hepatitis and uremia, and over here it's talking about secondary, again, to hepatitis C. The hepatitis C caused these conditions. The autopsy in the Philippines confirmed that fact.

And Dr. Olson, who was present, who did her own evaluation, saw her own thing there, brought tissues back and looked at the tissues, concurred with that very thing. So the actual death certificate, which mirrors what was in the hospital record, remember, the autopsy report follows the hospital record and is more complete than the hospital record because now they've cut the body open, they can do things, and look inside of it, intestines and the like.

This matches up with the hospital record. This whole issue about why there were some wording differences, it's the same exact kind of thing. But even in the hospital record, even in the death certificate, the underlying cause is hepatitis C. If he had driven down the road with his condition and been hit by a car and was killed, that would be supervening intervening cause of death. Desai and Lakeman would not be on the hook.

The fact that none of that stuff happened means that although you see the word immediate, that means that it has to have been the focal point of the cause of death. That had to have occurred in unbroken chain to the death. The fact that

because of these things you can -- other organ systems failing at the time does not mean that you are not responsible.

Alane Olson, her decision, what she testified to is that he ultimately died as a result of chronic active hepatitis cause be hepatitis C. Now, Ronald Lakeman and Dipak Desai sit in two different positions. Ronald Lakeman is only brought into this because it is aiding and abetting his -- and conspiring -- his agreeing to that process.

In the scheme of things, the more culpable person is clearly Desai because he's the one that directed this, he ran the clinic, he set the -- the policy, he set the -- not only the policy, but the atmosphere in that clinic which caused the conditions for these people, Ronald Lakeman being one of them, to engage in unsafe injection practices which you know from the evidence caused the death, ultimately, of Rodolfo Meana.

Ladies and gentlemen, that -- that's all I have. At the end of the day the State believes we have proved to you beyond any reasonable doubt that the crimes of criminal neglect of patients and performance of an act in reckless disregard and second degree murder have been proved beyond any reasonable doubt, that the mechanism in this case of the transmission is through the unsafe injection practices, the propofol being it. There is not another alternative that is plausible.

Ladies and gentlemen, one of the last things you --

I want to say to you is that you have two instructions. And I -- I use an example to illustrate this, the direct and circumstantial evidence instruction, which is 35, and the reasonable doubt instruction, which is 32.

Imagine if you would that you are not in Las Vegas at this particular time. You are someplace where it is cold, really cold. And you're at work and you're coming home, and you hear on the radio as you're coming home that there is a snow storm coming in.

A snow storm coming in that night, and you drive home, and as you're driving home you get out of your car and snowflakes start to fall. That's direct evidence that it's snow or snowing. You see it. You can feel it. You can taste it. You go into your house and everything is all snowy.

Now, same situation except for you hear that, you go home, you don't see any snow, you get inside the house, you are sitting around the table, you heard the wind rustling outside. The leaves that are still available, if there are any, are rustling around. You go to bed.

You wake up the next morning, you come out to get your paper, and lo and behold, directly in your field of vision outside your front door there is snow covering the cars and the trees and the houses and so forth. That is circumstantial evidence that it snowed last night.

Now, is it possible that it didn't snow last night?

Is it possible that while you slept a legion of noiseless snow blowers blew through the area blowing snow everywhere that you were going to come out and look at that morning? Is it possible that Steven Spielberg or somebody came in and put stuff out there that looked like snow? Is it possible?

I submit to you, ladies and gentlemen, that anything is possible. But is it reasonable? I submit to you that in that case no. In this case is it reasonable for there to be any other mechanism of transmission in this particular case other than unsafe injection practices and the mechanism of that through the use of propofol with the -- with the CRNAs. That is what you have to determine.

The very last thing, then I'm done. The theft counts, the insurance fraud counts, you put knowingly false information into an insurance record that you're submitting for the purposes of billing, that's material, to get more money than you should, you're done. That's insurance fraud.

The actual amount that you get back if you represent to the company that you're putting in a legitimate claim, you heard every single one of these witnesses that came in and said we rely upon good faith claims. We believe the people are doing it. If we have any reason to not believe it, we don't pay the claim. If they don't pay the claim, they're not entitled to any of the money regardless of how legitimate or not legitimate that is.

They're not entitled to any of the money. That is the theory by which the State goes for. You can parse this out. If you parse it out like counsel has mentioned, then there are -- then most of the thefts are misdemeanor theft counts. Some of them none at all, if that would be the case. But even on the flat rate ones, if you're submitting a claim for a -- a false claim, and the insurance company will not honor it if there is false information there, then you're getting every dollar more than you would ever get back normally.

And in this case, Sonia with Culinary, Sonia Orellono with Culinary was $306 was the charge. Stacy Hutchison with HPN, the flat rate was $90. Kenneth Rubino with Blue Cross Blue Shield was $245.12. Patty Aspinwall, United Healthcare, was $249.92, and Blue Cross Blue Shield, the secondary, was $56.48. Ziyad Sharrieff with Blue Cross Blue Shield was $206.82. Michael Washington, the VA was flat rate, that was $100. Carole Grueskin was with HPN. That was a flat rate, that was $90. Gwendolyn Martin, PacifiCare, was $304. Rodolfo Meana with Secure Horizons, also PacifiCare, was a hundred and thirty, I believe one or nine, dollars and 20 cents.

The two that were separate counts of obtaining money under false pretenses individually were Sonia Orellono at Culinary of 306, above the $250, and Gwendolyn Martin of

PacifiCare of 304, above the $250. The rest of them are aggregated. You add up the dollar amounts. The State submits to you that we get to count the entire dollar amount because they weren't entitled to any of it because they were filing false insurance claims and there is not a shred of evidence that --

MR. WRIGHT: Objection, Your Honor. That's a misstatement of what's charged. That's a very --

THE COURT: I'm sorry. The bailiff was speaking to me. I'll see counsel at the bench. And there's some ringing going on up here.

(Off-record bench conference.)

THE COURT: Sustained. Mr. Staudaher will rephrase.

MR. STAUDAHER: The insurance -- excuse me. The anesthesia times were inflated, which would have resulted in paying them money which would have been in excess of what was allowed. That's what it says in the indictment.

The State's theory is that any money would have been in excess of what was allowed because of the falsity of the record on those claims where it was a flat rate. The rest of them where there were dollar amounts involved where they got specific amounts of reimbursement because of the time that was given that was false, they weren't entitled any of it because they would have never been paid.

Ladies and gentlemen --

MR. WRIGHT: Mischaracterizes the evidence, Your Honor. The evidence and the testimony was that they would resubmit it correctly.

THE COURT: All right. And, ladies and gentlemen, again, it's your recollection of what the witnesses said regarding that that should control. Whether the witnesses said to resubmit or they wouldn't pay or they would pay anyway, that's entirely up to your recollection. All right.

MR. STAUDAHER: It all comes down to trust and whether or not you consider that those things that we've mentioned, that the patients -- I mean, that there wasn't a known conscious risk that was disregarded by these people for the purpose of getting money, more money, that every single person that was involved in that clinic did what they did.

These two individuals, meaning Desai and Lakeman, Desai running the show and directing and encouraging and the like, and Ronald Lakeman agreeing to do that and doing it, and instructing others to do it. He's involved. They're intimately involved, both of them. We ask you to come back with verdicts of guilty on all charges. Thank you.

THE COURT: All right. Thank you. And, Mr. Staudaher, would you take --

Okay. Kenny, take that down so I can see the jury.

And the clerk will, in a moment, swear the officer to take charge of the jury.

(Officer sworn to take charge of the jury.)

THE COURT: All right. Ladies and gentlemen, in a moment I'm going to have all 17 of you follow the bailiff through the rear door. Because of the late hour, you will not be deliberating tonight. We will have you return tomorrow to deliberate.

As some or all of you may know, a criminal jury is composed of 12 members. Five of you are the alternates who were designated prior to jury selection so that the selection of the alternates is somewhat random. Those are Jurors No. 14, Ms. Harsonyee (phonetic), Juror No. 15, Mr. Nadonga (phonetic), Juror No. 16, Ms. Conti, Juror No. 17, Ms. Stevens, and Juror No. 18, Mr. Keller.

Now, the role of the alternates is very important and it is not over. So before you leave, please leave phone numbers where you can be reached. Because if, God forbid, prior to the time a verdict is reached, one or more of the other jurors cannot fulfill their obligations, you will be called in.

For that reason, until you hear from someone from my chambers, the bailiff or the judicial executive assistant, that the jury has reached a verdict, you must be mindful of the prohibition on discussing the case, reading, watching, listening to any reports of or commentaries on the case, doing any independent research relating to the case, and forming or

expressing an opinion on the case.

For the rest of you who will be deliberating tomorrow, obviously tonight you also must be mindful of that prohibition. You're not to do anything relating to this case, discuss it anything like that, until you return tomorrow and begin your deliberations with one another.

In a moment I'm going to have all of you get your belongings and your notepads, which you will be turning over to the bailiff before you leave. He will be distributing parking tickets, vouchers, whatever, to all of the jury so you can get your cars tonight.

And then the bailiff will give you further directions on when to return and make sure that the alternates all have good numbers so that if, God forbid, somebody becomes sick or something like that we can be able to contact you.

So having said that, if you'd all get your things and bailiff through the rear door.

(Jury recessed at 6:58 p.m.)

THE COURT: We probably already have all of the lawyer's cell phone numbers, but just make sure that Denise has good numbers for all of you. As I said, they'll be going home tonight and then probably 9:00 or 9:30 tomorrow coming back.

MR. SANTACROCE: I wanted to put an objection on the record. During Mr. Staudaher's closing he asked the jury

improperly if -- how would they feel if they --

THE COURT: Yes. Put --

MR. SANTACROCE: -- had to have a --

THE COURT: -- themselves in the --

MR. SANTACROCE: -- liver transplant.

THE COURT: -- shoes of the victims by having a liver transplant.

MR. SANTACROCE: Improper prosecutorial misconduct.

THE COURT: I caught it as well, but I didn't sua sponte do anything because then he moved on and I figured that might be worse and nobody objected.

But I did -- I did catch it as well when he said how would you like to have a liver transplant. And that's kind of asking them to put themselves in the shoes of the victims. And he moved on and that's why I didn't call him to the bench and nobody asked.

But you're right, Mr. Santacroce, I caught it, too.

All right. Well, like I said, leave numbers and --

MS. WECKERLY: Just for the record, from the State's perspective, that certainly wasn't the only improper argument that was made during the closing.

THE COURT: Yes, Ms. Weckerly. As you know, I cautioned -- believed, and I mentioned at the bench, that I thought Mr. Wright was crossing the line when he suggested, when he was disparaging opposing counsel by making the

suggestion --

MS. WECKERLY: Yeah.

THE COURT: -- that there should be some kind of disciplinary bar action taken against opposing counsel. I felt like that was crossing the line to disparaging opposing counsel.

Is that what you were talking about, Ms. Weckerly?

MS. WECKERLY: That was one of them.

MR. WRIGHT: I -- I dispute it. I did not suggest any disciplinary act against counsel. I said the State of Nevada. And I said counsel, as officers of the court. I don't buy this distinction that I can put up someone and let them say something when I know it is false. They didn't commit --

THE COURT: No, I --

MR. WRIGHT: -- perjury up there. Those witnesses gave false information and it was 11 of them aided by the State. And that is unethical and improper. I didn't say anything about that in my closing argument. I didn't say it was unethical. It happens to violate the prosecutorial function of the district attorney's office.

THE COURT: Well, perhaps I misheard you because what I heard was something about their licenses or something like that --

MR. WRIGHT: I did not.

MR. STAUDAHER: That's what the State --

THE COURT: -- which, to me --

MR. STAUDAHER: -- heard, as well.

THE COURT: I'm sorry?

MR. STAUDAHER: That's what the State heard, as well.

THE COURT: I heard something about their licenses, which, to me, is their license to practice law which suggests that there should be a disciplinary action taken against them. You know, again, I -- I didn't say anything during when the comment was made.

They didn't object, but, to me, I think it was getting to disparaging opposing counsel by suggesting that the -- I mean, the suggestion was, I thought, that the State Bar should, you know, take some action against their licenses. That was -- you didn't say that explicitly, but that was the suggestion.

For the record, Ms. Weckerly, what else are you alluding to?

MS. WECKERLY: I just wanted -- I just wanted to clarify on the record, seeing Mr. Santacroce felt like it was necessary to add that in, that, you know, there were a lot of things said during defense counsel's argument. We didn't object. Certainly objecting during that point is sort of a strategy call --

THE COURT: Right.

MS. WECKERLY: -- for us. But it's not like it's proper argument. And it went way over the line in my mind. And it's -- you know, we don't have a remedy to that, so it should --

THE COURT: Yeah, but I think --

MS. WECKERLY: -- be on the record.

THE COURT: -- I think it's important, Ms. Weckerly, if it ever comes to an appeal and the Court's looking and doing some kind of a totality analysis or something like that, what exactly you're referring to that Mr. Santacroce did.

MR. SANTACROCE: Did I do something that -- she didn't object.

MR. WRIGHT: I don't understand. Tell me the line. I mean, I'd like a ruling. Tell -- tell me a line I crossed over. I didn't engage in prosecutorial misconduct. I didn't do what went on in this courtroom.

THE COURT: No one --

MR. WRIGHT: And so --

THE COURT: All right.

MR. WRIGHT: -- all I did --

THE COURT: All I'm saying -- no one is saying that you did anything wrong in your questioning of the witnesses or your presentation of the evidence or that you were unethical in any way.

The implication was sort of, I thought, and I think Ms. Weckerly and Ms. Staudaher thought, was -- maybe I heard it wrong, was that you were somehow suggesting that they should be disciplined by the bar in some way. I mean, I thought heard licenses or something to that effect. I'd don't remember the --

MR. WRIGHT: I said a lawyer exceeds his license. That's a phrase --

THE COURT: Okay.

MR. WRIGHT: -- I use as an officer -- when I'm in here I exceed my license when I put a witness up there and I let them say something --

THE COURT: There is nothing to -- you know, I think that that's certainly fine comment that -- that they put up, you know, witnesses who testified inconsistent with what was known in the documents. You said that. I don't know that --

MS. WECKERLY: Right. But that doesn't mean that they're lying.

THE COURT: That doesn't --

MS. WECKERLY: That's their perspective. We don't show them the procedure books and go, hey, Marion, count this back up, you're wrong on that assessment.

MR. WRIGHT: I got news for you. I can't put a witness on, but I -- I get some nutcase that thinks it's -- he's going to put my client somewhere else or something, and I

know it's absolutely false, and I'm just going to stick it on?

THE COURT: Well, I don't --

MR. WRIGHT: I got a better shot --

THE COURT: Okay.

MR. WRIGHT: -- at doing that --

THE COURT: I don't know if --

MR. WRIGHT: -- as a defense attorney --

THE COURT: -- the State wants to --

MR. WRIGHT: -- than the State does.

THE COURT: -- defense themselves. But I think, you know, when you went through the numbers and you said, oh, there was 77. I'm looking at -- well, 60 to 80, I don't know, that fits in there. I don't think it was so far above what was in the books to suggest that it's deliberate prosecutorial misconduct.

MS. WECKERLY: We brought in the books.

THE COURT: And that was their -- that was their perception, that they were rushed. And so, you know, I don't know if the State wants to defend themselves in any way, but that was my perception of -- right or wrong. I'm sitting here, I'm listening to everything, that was my perception.

Mr. Staudaher, in your own defense --

MR. STAUDAHER: Part of it was, and I laid it out for the jury in the very beginning and I said it in opening. I said, look, these witnesses -- these witnesses are going to

come and we -- you're going to have to evaluate what you believe and don't believe with regard to them because obviously they -- they have different issues.

They saw everything going bad at the clinic and I didn't do anything wrong, which is inconsistent with the evidence. I'm telling them that up front that there's going to -- they're going to hear stuff from these witnesses that's inconsistent with the evidence as we know it and that it's in. So I don't know what more to do to even preface that.

I wasn't required to do that, but I think that that was something we did in advance to give them, the jury, a heads up that these are not clean, untainted witnesses that are going to be coming in in this case, that they got information, that you're going to have to evaluate it. And there's an instruction on that that the -- that the Court gives. So I don't know what to say, I mean, other than it's --

THE COURT: Well, I -- I don't know.

MR. STAUDAHER: -- I thought it was improper, as well.

THE COURT: I think that the defense would be complaining if they had shown them all the books and said, hey there's 55 on this day, make sure you say there's 55 on this day, then the allegation would be witness coaching. So, I mean, I -- I don't know --

MR. WRIGHT: I disagree. I don't -- I think you're trying to sugarcoat what occurred here. I've moved for mistrials over it.

THE COURT: All right. Well, I --

MR. WRIGHT: I think it was absolutely improper back at the beginning of the case when they -- when they said that a motive of this was to save money on propofol and that's why they went for 50s, and they put witnesses, and they put up --

THE COURT: Hey.

MR. WRIGHT: -- false --

THE COURT: Wait a minute. First of all, I'm not trying to sugarcoat anything. Secondly, I agreed with Mr. Santacroce who said it was misconduct. Thirdly, I agreed with you on the Nancy Sampson testimony on the dosages and the vials and everything else which wasn't accurate.

However, I do not agree with you that if a witness's perception is 70, and the true number is 55, that somehow the State should show them the book and say, hey, you're wrong. Look, it's 55, testify to 55. To me that is clear witness coaching and would be -- would be not what they should do. I mean, it's their perception as Ms. Weckerly said. So, no, Mr. Wright, I don't --

MR. WRIGHT: But --

THE COURT: -- agree with you on that. That doesn't mean I'm trying to sugarcoat anything that the State may have

done. All I'm saying is that is my perception sitting up here. My perception may be right, it may be wrong. But all I can tell you is what my honest perception is.

And my honest perception is when I look at those numbers and that's what people perceived, that the State is not knowingly putting forth perjured testimony, number one. And number two, that it would have been wrong from them to tell these people, hey, no, that's the wrong number, testify to this right number here, which we can show you in the book.

I mean, they can't do that because if they're mistaken, that has to come out, and then that goes to their overall memory and credibility. Like, hey, they said it was 80, what else are they confused about? What else are they mistaken about?

I'm not going to debate this with you. That's my perception.

Ms. Weckerly, do you want to put --

MS. WECKERLY: No.

THE COURT: You know, you said Mr. Santacroce did something wrong. I didn't really catch it, but I think to be fair to Mr. Santacroce, you ought to say what it was.

MR. SANTACROCE: Yeah, I'd like to learn.

MS. WECKERLY: No, I'm not -- no, that's not where my objection was.

THE COURT: Okay. Because like I didn't -- I didn't

catch anything and --

MR. WRIGHT: I didn't -- I didn't state it was perjury of the witnesses, and I don't think if you read the prosecution function in the ABA standards --

THE COURT: Mr. Wright --

MR. WRIGHT: -- what they are not supposed to do is ask the witness the question and -- and pull it out of them when they know. I didn't say tell them to give a different answer. The prosecutor cannot elicit information or inferences that are false, and you don't bring it out. And it's right in the ABA standards for the prosecution function. And that's exactly what happened here, and it happened with the propofol pricing, also.

THE COURT: I agree with you on the propofol part.

MR. WRIGHT: Okay. That is unethical and it violates the standards of practice. And when I pointed it out, it's like I'm doing something wrong for pointing it out to the jury.

THE COURT: Who said you were doing anything wrong?

MR. WRIGHT: I thought I crossed over the line and I can't find the line.

THE COURT: Well, perhaps I misheard you or perhaps I didn't articulate it, but I think Mr. Staudaher and Ms. Weckerly kind of heard it the same way I heard it, which was somehow suggesting, you know, that they, I don't know,

shouldn't be lawyers or shouldn't -- that's kind of how I heard it, but I don't know what they heard.

MR. WRIGHT: I didn't intend that. And if I -- it came out that way, I apologize and I misstated it. Because I -- I didn't intend -- I don't go -- I don't complain and send anybody to the bar. I didn't -- on my go -- go free letter was Scott Mitchell. I didn't run to the bar and say you were unethical or something. I don't do that, and I didn't intend to.

THE COURT: All right. Well, maybe it was misheard or whatever.

MS. STANISH: Judge, just to note, I see that some of the State's exhibits have tabs all over them. I just want to make sure all the little go-to marks --

THE COURT: Okay. Basically --

MS. STANISH: -- are taken off.

THE COURT: -- we're making sure that the tabs are off, and you folks have made sure that any highlighted exhibits have been substituted out for non-highlighted exhibits; correct?

MR. STAUDAHER: I believe so.

THE COURT: Okay. If -- I'm sure she won't catch anything. If she does catch something, then obviously the court clerk will contact you and make sure we have a clean exhibit. But I think --

MR. STAUDAHER: The only --

THE COURT: -- they've all done that already.

MR. STAUDAHER: -- highlighting that we ever did was in yellow. A photcccpy of that doesn't show up. So if there's an issue with -- and I think I saw the same thing with defense counsel's exhibits. We can just have them make a copy as far as that's ccncerned.

THE COURT: Yeah, I don't foresee an issue.

What time are they coming back?

THE MARSHAL: 9:30, Judge.

THE COURT: Okay.

(Court recessed for the evening at 7:11 p.m.)

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ATTEST: I hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

JULIE POTTER
TRANSCRIBER