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 dangercus. 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 sound 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 Lobicndo. 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