

1 Q In a deposition, correct.

2 A Yes, the case that I gave deposition testimony
3 was not in that day.

4 Q All right. Now, you had occasion to review
5 the medical records of Mr. Meana; correct?

6 A Yes, I did.

7 Q And I have those -- some of those records
8 here. If there is anything you need to refresh your memory,
9 please let me know.

10 A I will.

11 Q Could you generally describe for the jury what
12 medical records you reviewed?

13 A As best as I remember, I hope I'm not
14 forgetting one, I reviewed medical records from the Endoscopy
15 Center of Southern Nevada. I reviewed medical records from
16 Mr. Meana's primary doctor, Junari (sic) or something like
17 that was his name. I reviewed medical records from a
18 gastroenterology consultant he saw, Dr. -- it was Sood or
19 Soot. And I reviewed medical records from the Philippines
20 from two hospitalizations he had in the Philippines. And I
21 think that covers it, although there may be one or two in
22 there that I'm not recalling.

23 Q All right. And did you also have the
24 opportunity to review the coroner's report, as well as the
25 autopsy report relating to Mr. Meana?

1 A Yes, I did.

2 Q And do you recall what the cause of death was

3 in the death certificate of Mr. Meana?

4 A It might --

5 Q If you need --

6 A -- help if I read it.

7 Q Sure.

8 A I mean, I recall, but I don't want to say

9 something wrong.

10 Q I'm handing you State's Exhibit 18 and 20.

11 A Okay. Shall I read it?

12 Q Sure.

13 A So this is -- it says certificate of death,

14 it's from the Philippines. It says immediate cause of death,

15 hepatic and uremic encephalopathy, antecedent cause says

16 sepsis, and then it says underlying cause is hepatitis C and

17 chronic kidney disease.

18 Q And with respect -- did you also review the

19 conclusions of the coroner in this case?

20 A Yes, I did.

21 Q And as well as the autopsy report?

22 A Yes.

23 Q And do you recall what the conclusions in

24 those -- those persons and entity were?

25 A Maybe I can just check here. They may not be

1 in here.

2 MS. STANISH: May I approach with my copies --

3 THE COURT: You may.

4 MS. STANISH: -- to expedite it?

5 THE COURT: That's fine.

6 MS. STANISH: Thank you.

7 BY MS. STANISH:

8 Q That's a big package there.

9 A Okay. Well, this one is the coroner.

10 Q Right. Okay. I'll leave this one with you.

11 A Okay.

12 Q I'll take that.

13 A So the coroner's final pathologic findings,
14 and these are pathologic findings from looking at the tissue
15 in the organs, it says hepatitis C infection genetically
16 typed, hepatic cirrhosis, splenic fibrosis. It says acute to
17 subacute pneumonia bilateral, and it says nephrosclerosis mild
18 to moderate.

19 Q Now, based on your review of all the medical
20 records, as well as the coroner's report, etcetera, can you
21 opine with a reasonable degree of medical certainty whether
22 Mr. Meana died because of the hepatitis C that he contracted
23 on September 21, 2007?

24 A Given everything else, you can't say that that
25 is the reason he died.

1 Q Now, I want to explore your conclusion in some
2 detail. But before I do that, when we use the term medically
3 certainty, what does that mean to you?

4 A A reasonable degree of medical certainty would
5 be, to me, this is the most likely thing that happened or out
6 of several possibilities what within the understanding of
7 medicine most likely was the cause of injury, cause of death,
8 or cause of whatever.

9 Q And as you sit here today, do you know what
10 caused the death of Mr. Meana?

11 A I can say there were several factors, and I
12 can't say which one was the immediate cause.

13 Q Now what I'd like to do, sir, is I'm going to
14 take you through a chronology of your review of Mr. Meana's
15 medical records, starting with what you observed in his
16 medical records prior to his visit to the -- to the gastro
17 center for a colonoscopy. All right? Did you note anything
18 in Mr. Meana's medical records prior to that date that caused
19 you concern?

20 A There were a couple medical problems that were
21 concerning and probably played a factor over the next few
22 years. One is he had hypertension that was being treated.
23 Another condition he had was benign prostatic hypertrophy,
24 which is an enlargement of the prostate gland that seemed to
25 be causing urinary obstruction so the urine wasn't flowing

1 properly, and that might have been increasing the pressure in
2 the kidney.

3 So I noticed, for one thing, two things that were
4 affecting his kidneys prior to then. And I also noticed on a
5 CT scan that I believe he had in June of 2007 there were a
6 couple of liver findings. And one in particular was dilated
7 extra hepatic bile ducts. So the bile ducts that take the
8 bile from the liver to the intestine were abnormally dilated.
9 And I noted he had also had his gallbladder removed at some
10 time prior to that, so suggesting that there had been and
11 might have still been some low grade obstruction of the bile
12 ducts in Mr. Meana.

13 Q Okay. And we're going to come back to that in
14 a moment because a lot of that you're going to have to
15 explain.

16 MS. STANISH: May I approach, Your Honor?

17 THE COURT: You may.

18 BY MS. STANISH:

19 Q I'm going to show you what's been marked as
20 Exhibit DD-1. Did you review this document?

21 A Yes. DD-1 is the results of a liver biopsy
22 that Mr. Meana had on July 25, 2008.

23 Q And there is a second page on that. If you
24 could identify that, as well.

25 A Yes, that's a continuation of the description

1 that was on the previous page.

2 MS. STANISH: Your Honor, I'd move for the admission
3 of DD-1.

4 MR. STAUDAHER: No objection.

5 THE COURT: All right. DD-1 is admitted.

6 (Defendant's Exhibit DD-1 admitted.)

7 BY MS. STANISH:

8 Q Now, we'll come back to that exhibit in a
9 moment. But would you please explain to us in the most layman
10 terms you can what you just described regarding Mr. Meana's --
11 the condition of his kidney?

12 A Well, the kidney, from what I saw, was he had
13 hypertension that was being treated with one or two
14 medications. And he also had obstruction of the flow of urine
15 from his kidney out of his body. So both of those things over
16 time can damage the kidney.

17 High blood pressure or hypertension, by causing the
18 part of the kidney where the blood is filter, by getting
19 scarred so it doesn't work too well. And a urinary
20 obstruction is just really like a plumbing problem. The
21 pressure backs up into the kidney, and the kidneys over time
22 can be damaged. So with regards to his kidney, he had, at
23 least in 2006 or 2007, two processes that could have been
24 contributing to damaging his kidney over time.

25 Q And I should have dropped this off while I was

1 up there, but I need the exercise so let me give you what's
2 already been admitted as Defense Exhibit AA-1. You had also
3 mentioned that you noticed a cyst, a right renal cyst or --
4 could you describe what that means to us?

5 A Yes, there's -- there's -- well, let me just
6 read this carefully. Hang on. So there's a cyst in the
7 kidney and that could mean many things. Many cysts are benign
8 in the kidney. Sometimes they could be causing --
9 contributing to obstruction. I can't really say just based on
10 this.

11 Q And turning your attention to the second page
12 of Defense Exhibit AA-1, an exam that was conducted on June 7,
13 2007. If you would review, sir, the impressions there that
14 relate to the kidney and the extra hepatic bile ducts. Could
15 you explain those impressions to us?

16 A Okay. Well, really, No. 3 is what stood out
17 to me, which are the distended extra hepatic bile ducts.
18 Distal obstruction is not excluded. Changes of
19 cholecystectomy, probably small cyst of the liver, hepatic
20 nodule not excluded. And then they say a different type of CT
21 scan of the abdomen could be used to further assess the liver
22 and also to previously describe -- some previously described
23 kidney problems on here.

24 And it's important to lock up into the finer print
25 when I talk about the findings. There's distention of the

1 extra hepatic bile ducts up to ten millimeters in diameter,
2 and normally they're not more than six millimeters in
3 diameter. So, again, suggesting that there was some chronic
4 obstructive process obstructing, in this case, his liver. The
5 bile flowing from the liver into the intestine.

6 Q And I need you to go more basic than that.
7 Could you start off with explaining to us what an extra
8 hepatic bile duct is?

9 A Okay. So the liver sits in the right upper
10 quadrant of your abdomen, and the liver makes bile. And bile
11 is composed of several things. It's composed of bile salts,
12 which are salts that the liver makes from cholesterol. It
13 helps you digest food. It also has bilirubin in it, which
14 comes from the breakdown of red blood cells.

15 And in the liver there are small bile ducts that
16 take these substances and collect them and they go into larger
17 and larger bile ducts. And the bile ducts that you see
18 outside of the liver are called the extra hepatic bile ducts.
19 And those bile ducts lead to the intestine where the bile that
20 contains these substances is led to go where it helps with
21 digestion or some things are excreted that way.

22 Q And the fact that those are somehow enlarged,
23 is that what I'm understanding you to say?

24 A They're abnormally dilated, yes. They're --
25 they're diameter is bigger than normal.

1 Q What does that mean and why would you be
2 concerned as a doctor about that?

3 A Well, I would be concerned that if something
4 like that were present over time, which it seems like it was
5 not terribly symptomatic, but over time something like that
6 can cause damage to the liver in terms of scarring or
7 fibrosis.

8 Q And the fact that the findings also say that
9 there was no focal hep -- hepatic lesion seen at that time in
10 June of '07, how does that factor into the findings in your
11 analysis of this document?

12 A You know, focal hepatic lesions, you know,
13 those could be things like cancers or tumors or benign cysts
14 or things like that. And those aren't really that relevant to
15 Mr. Meana's progression and that they're not there doesn't
16 really contribute one way or another.

17 Q All right. Was there anything else you saw
18 prior to the September '07 visit to the gastro center that you
19 believe is important to determining Mr. Meana's ultimate
20 demise?

21 A I think the chronic insults to the kidney and
22 this dilated bile ducts that might say there's something wrong
23 with the liver are the two most relevant things.

24 Q All right. Now, let's move to the next period
25 in time, that would be after Mr. Meana goes to the clinic in

1 September of '07, but before he leaves the country for the
2 Philippines. And more particularly after he's diagnosed as
3 having hepatitis C, was there any other indication of medical
4 problems that cause you concern?

5 A Well, certainly the hypertension and the --
6 most likely the prostatic obstruction, although I didn't see
7 specific records at that time, continued. Otherwise, he had
8 hepatitis C, he had an acute infection that resolved and, you
9 know, the liver got better. He continued to have the virus in
10 his body with the fluctuating viral load, and at some points
11 the virus was detectable at a very low level, later to
12 intermediate level. And then really the liver biopsy that he
13 had in July of 2008 showed some other things that were going
14 on.

15 Q And that's already been introduced into
16 evidence, so I'm going to throw this -- my copy up on the
17 screen. And if we can -- if you could show us, if I need to
18 go to the next page, let me -- let me know. But if you could
19 -- you can point to that screen, by the way, and touch it, and
20 it will highlight information. And if you want to get rid of
21 a highlight just tap it on the bottom --

22 MR. STAUDAHER: Lower right.

23 BY MS. STANISH:

24 Q -- right. Okay?

25 A Sorry.

1 Q That was very good. And so will you explain
2 to us and maybe point out for us so we're clear what your
3 concern is about this liver biopsy result. And by the way,
4 what was the date and who recommended it?

5 A The date was July 25, 2008, and it says Dr.
6 Sood is probably the doctor who recommended this, but I see
7 there's names of another doctor there, too, that I don't
8 recognize. I may actually have --

9 Q Can you read that okay? Are you looking at
10 the right one?

11 A Oh, here we go. Dr. Sood, and there's another
12 doctor's name above it. Can -- how do I get the arrow? There
13 we go.

14 Q All right. So what is it in this lab -- point
15 out to us in this lab report what causes you concern.

16 A Well, the essence of the results are really up
17 here. I guess I just can't do this. Do you see the --

18 THE COURT: If you drag your finger, that would like
19 make a line.

20 THE WITNESS: How's that? This --

21 THE COURT: Or, Ms. Stanish, just --

22 MS. STANISH: Well, you could actually --

23 THE COURT: -- move the paper.

24 MS. STANISH: -- make me look at what I circled
25 here.

1 THE COURT: Just make a mark and she'll move the
2 paper.

3 THE WITNESS: Start right there where it says
4 diagnosis and read down. Okay?

5 BY MS. STANISH:

6 Q Okay. Go ahead.

7 A So there were a few things here --

8 Q We won't try the high-tech. Just explain it.

9 A Okay. Diagnosis, and here you can see it says
10 core biopsy. That means I stuck a needle into the liver and
11 took a tiny piece of liver tissue out. Well, it's gone.

12 Q No, see what I'm doing, I'm zooming in for
13 those of us --

14 A Okay.

15 Q -- that have to actually read this. And,
16 again, if you would tap on the bottom right with your
17 fingernail.

18 A Okay. Okay. So it says chronic hepatitis.
19 Hepatitis means inflammation of the liver. It says clinically
20 hepatitis C, and that means the pathologist is basing that on
21 the clinical history, and he or she even writes here that
22 there was hepatitis C virus detected in the patient below over
23 -- over here. Now, it says with moderate activity, Grade 3
24 out of 4, and periportal fibrosis, Stage 2 out of 4. So those
25 are important when you talk about, one, the degree of

1 inflammation, the inflammation is inflammatory cells in the
2 liver. Like if you banged yourself and it gets red and
3 inflamed, at a microscopic level similar things are going on
4 in the liver. And the second thing is fibrosis. That's the
5 amount of scar tissue in the liver.

6 So the amount of liver that's been replaced by a
7 scar. If you cut yourself and get a scar, fibrous tissue.
8 That's the fibrosis. And secondly there is a second problem
9 going on in Mr. Meana's liver here. Maybe not the most
10 dramatic, but certainly something else contributing here,
11 which is mild microvesicular and macrovesicular and steatosis.
12 And what that, steatosis simply means is fat in the liver.
13 And microvesicular and macrovesicular basically means the fat
14 are in little, little, little tiny drops when you look under
15 the microscope or the fat is in slightly bigger drops in the
16 -- within the liver cells when you look under the microscope.

17 Q I'm just going to call that fatty liver.

18 A That's okay. That's what most people call it.

19 Q And let me -- before we talk about fatty
20 liver, let me go back to this finding or this diagnosis that
21 relates to the fibrosis. Could you explain to us what exactly
22 is fibrosis?

23 A So fibrosis simply is scar tissue. The same
24 scar tissue if any of you have ever cut yourself or had a
25 surgery and the normal skin is replaced by scar tissue, over

1 time as the liver gets damaged, you get scar tissue in the
2 liver. And that can result from many, many processes. It can
3 result from viral hepatitis, such as hepatitis C, it can
4 result from fatty liver, it can result from obstruction, it
5 can result from drugs, it can result from maybe alcohol is the
6 most common cause in our country. So that's something that
7 can result from may long term insults to the liver.

8 Q And just to be clear, does hypertension or the
9 kidney issue relate to the fibroid condition at all?

10 A No, what's going on in anyone's kidneys, or
11 specifically Mr. Meana's kidneys, doesn't relate to this.

12 Q And sticking with the fibrosis for awhile,
13 explain to us what Stage 2/4 means.

14 A So in hepatitis C the degree of scar tissue in
15 the liver is generally graded from 0 to 4. Zero means there
16 is no scar tissue in the liver. 4 means there is full blown
17 cirrhosis in the liver. Cirrhosis is when the liver has sort
18 of balls of liver cells, if you will, sort of surrounded by
19 scar tissue. 1, 2, 3 are varying advancing degrees between
20 nothing and that, and 1 actually, if you want to get a little
21 technical, it's scar tissue confined to just little parts of
22 the liver called the portal tracts.

23 Stage 2 is what I think the pathologist actually
24 described here as periportal. So it means the fibrosis, the
25 scar tissue is extending from these portal tracts where the

1 blood vessels enter the liver into the major body of the liver
2 itself. And Stage 3 is a little more advanced fibrosis where
3 the scar tissue is stretching across parts of the body of the
4 liver called the lobule.

5 Q So this -- this is the sample, the liver
6 samples collected on July 25, 2008. Can you say with any
7 medical degree of certainty whether the hepatitis C virus that
8 was contracted in September of 2007, approximately -- was that
9 10 months before this, did that cause the fibroids?

10 A The fibrosis? I think it would be
11 extraordinarily unlikely that hepatitis C, in less than one
12 year, can lead to this degree of fibrosis. I mean, typically,
13 hepatitis C takes decades for the fibrosis to advance, at
14 least several years.

15 Q Would it matter that, you know, he was -- had
16 acute hepatitis C at one point and had a viral load that goes
17 up and down over time?

18 A Viral load doesn't really correlate with the
19 progression of fibrosis in hepatitis C, so that shouldn't
20 matter.

21 Q And if you would, please give us a
22 clarification on what is the term viral load?

23 A So viral load, when you measure hepatitis C in
24 the blood, we measure hepatitis C virus in the blood because
25 it's hard to go measuring it in the liver, you do a technique

1 where you can actually amplify the RNA, which is the genetic
2 material in a virus, and quantify it, get some idea of how
3 much virus there is in the blood, which roughly correlates
4 with how fast the virus is replicating in the liver. So
5 roughly a high viral load might mean the virus is replicating
6 or dividing very rapidly in a person, whereas a low viral load
7 would mean roughly that the virus is not replicating so
8 rapidly in the liver.

9 Q Now, is there -- on page 2 is there anything
10 else in the -- is this somehow connected to -- tap the screen,
11 please. Again. And again. Bottom right. There you go. And
12 does this document relate to the first page, or does it show
13 something different or more information?

14 A It says that there is mild microvesicular and
15 macrovesicular steatosis once again, which is --

16 Q A fatty liver.

17 A -- confirming what the pathologist wrote in
18 the main diagnosis. Otherwise, most of this looks like
19 negative or pretty much non-contributory descriptions of
20 what's going on here.

21 Q Now, let me return you to the subject of fatty
22 liver and have you explain that to us like we were three year
23 olds. What -- what is fatty liver?

24 A So simply fatty liver is abnormal accumulation
25 of fat within the liver, within the cells of the liver, fat

1 accumulates.

2 Q And is that something I need to worry about?

3 A Possibly.

4 Q Okay. What -- what -- that term fat. What is
5 it that causes fatty liver so we can all be forewarned and
6 understand this document?

7 A So there are really two major causes. There
8 are other causes, such as drugs and other things, but the two
9 major causes is, one, excessive alcohol drinking, and the
10 other one, which is probably much more common in America now,
11 is being overweight and being insulin resistant. So fatty
12 liver now in the United States has become an unrecognized
13 endemic maybe, probably. Some estimates say 25 percent of a
14 population have excess fat in their liver. And in some cases
15 over time that could also make low grade inflammation that can
16 cause scarring in the liver.

17 Q So fatty liver can -- can actually cause
18 cirrhosis?

19 A Fatty liver by itself can cause cirrhosis,
20 yes.

21 Q And by the way, just clarify for me, you know,
22 we've already seen that he -- he -- the liver biopsy shows
23 fibroids in his liver. How does fibroids relate to cirrhosis?
24 Is it the same thing or a matter of degree?

25 A So fibrosis, fibrosis is sort of the early

1 process that leads to cirrhosis. So cirrhosis is actually
2 defined pathologically and anatomically as regenerating
3 nodules of liver cells with fibrosis. So cirrhosis in a way
4 is very advanced fibrosis or scar tissue where the liver
5 begins to regenerate in an abnormal fashion. So earlier
6 stages of fibrosis such as you see here in various liver
7 diseases over time can progress to cirrhosis.

8 Q Now, I want to address a different subject
9 during this time frame after the colonoscopy, but before Mr.
10 Meana goes to the Philippines. Did you review the documents
11 pertaining to his treatment following the diagnosis of
12 hepatitis C?

13 A Yes, I believe after this biopsy or perhaps
14 even a little bit before, I can't remember the exact time, but
15 his gastroenterologist, I know he had seen a few, but I know
16 at least Dr. Sood and maybe another recommended that he be
17 treated for hepatitis C.

18 Q And what would that treatment have been?

19 A The treatment then would have been a pegylated
20 interferon and ribavirin.

21 Q And in your opinion, based on your review of
22 the medical records, is that something that would have been
23 beneficial for Mr. Meana to undergo shortly after this
24 diagnosis or biopsy, I should say?

25 A Well, with acute hepatitis C there's a real

1 benefit of starting treatment early. Most patients with
2 hepatitis C who get treated, they have it for years or
3 decades, so starting fast doesn't often matter that much. But
4 the one time where it does seem to matter to start sooner is
5 when the infection is acute because there's data that say when
6 you're acutely infected, if you start treatment sooner, you
7 have a better chance of clearing the virus.

8 Q And do you recall seeing that Mr. Meana
9 ultimately did at least try to undergo the treatment in March
10 of 2009?

11 A Yes, I can't remember the exact date, but I do
12 remember it was sometime in 2009, not as early as his doctors
13 had recommended.

14 Q And does that have any significance to you?

15 A Well, he may have had a better response if he
16 was treated earlier. And from the records I have, it's not
17 entirely clear why once he started treatment he stopped. He
18 tried a couple times and just seemed to not do it, so I can't
19 say.

20 Q Okay. Now I want to move to your review of
21 the medical records in the Philippines. Can you first tell us
22 why was it he was hospitalized in the Philippines?

23 A So from my reading of those records, he was
24 hospitalized twice in the Philippines, once in late March or
25 early April of 2012, and again later in April of 2012.

1 Q And can you explain to us what was the reason
2 for his first hospitalization?

3 A So as best as I could ascertain from the
4 records from the Philippines, the first hospitalization
5 appeared to be for some confusion and some lab abnormalities
6 they were attributing to hepatic encephalopathy, which is some
7 confusion people can sometimes get when the liver doesn't work
8 well, and also for some kidney problems. He had a rise in
9 creatinine, which is a test of kidney function in the -- in
10 the blood. So it seemed like a mixture of, you know, I'd say
11 low grade problems or medium grade problems with his liver and
12 his kidneys not working well.

13 Q And can you tell us what happened during his
14 first -- well, let me ask you this. With respect to the
15 Philippine medical records, were they understandable to you
16 and organized for -- for your review?

17 A They were legible. They were understandable,
18 but they were not, I should say the best medical records.
19 There were not admission notes in there or discharge notes.
20 It was not like in -- typically in the United States where you
21 have much better summaries of why the patient came in and what
22 the situation was when they went home. It was more small
23 notes and sentences.

24 Q All right. Could you discern from the medical
25 records what happened during the course of his first

1 hospitalization in late March or early April of, what was it,
2 two thousand --

3 A 2012. And I think he was discharged around
4 April 6, 2012. And apparently they treated him, from as far
5 as I can see, fairly conservatively. And I noted right before
6 his discharge it said hepatic encephalopathy resolving. Then
7 they put -- said something like chronic kidney diseases, and
8 benign prostatic hypertrophy. That's the big prostate.

9 Q Now I need you to stop and decode that for us.
10 What does that mean?

11 A The enlarged prostate that he had had even
12 several years previously.

13 Q And what was resolving?

14 A What was resolving was the hepatic
15 encephalopathy. The note said, and it was just a small note,
16 but that would be the confusion he might have had from his
17 liver not working well. And I saw that he was discharged in a
18 wheelchair, awake and alert, and went wherever he went from
19 the hospital in the Philippines to his home or a relative's
20 home or wherever that was.

21 Q And then when did he return to the hospital,
22 if you can recall?

23 A He returned to the hospital approximately two
24 weeks later.

25 Q And what was the reason for his admission into

1 the hospital?

2 A The admission into the hospital, as far as I
3 could tell from the notes, was it said uremic and hepatic
4 encephalopathy. But from looking at the records -- and it
5 also said sepsis. From looking at the laboratory tests he had
6 a markedly elevated creatinine saying that the kidneys
7 basically stopped working in the two weeks since the previous
8 discharge and this admission. And also he had an elevated
9 white count, white blood count, that got even higher when he
10 came in, suggesting that he had -- or very strongly suggesting
11 that he had a source of infection. And they noted in the
12 notes urosepsis, which is an infection from the urinary
13 system.

14 Q And so the -- and correct me if I'm wrong, the
15 primary reason he was admitted was because his kidneys stopped
16 working and he had an infection due to a urinary blockage?

17 A It's not clear exactly if the infection was in
18 his urine or what the cause was, but that was their clinical
19 impression, and he did have some findings on his urinalysis,
20 many red cells in his urine and some white cells in his urine
21 suggesting there may have been an infection in the urinary
22 tract. But I'd say the main reason he was admitted were those
23 two reasons, kidney failing, and he was, in fact, started on
24 dialysis, and infection for which he was given antibiotics.

25 Q Was there any indication that he had pneumonia

1 at the time of admission?

2 A As far as I was able to tell, none of the
3 doctors had mentioned pneumonia as a high suspicion. Whether
4 I can say he had it or not, I can't.

5 Q And did you -- did you find it, as you
6 reviewed the records following the second admission into the
7 hospital, did you find appropriate testing of the blood or
8 other labs?

9 A I think there was, as far as I can ascertain
10 from those records, some testing was appropriate. What I
11 didn't see in there was a blood culture, which was a little
12 atypical to see if there was an infection in his blood. And,
13 again, I don't know if I missed it or it wasn't in there, but
14 I didn't see that in there. But for the most part I think
15 they treated kidney failure appropriately with dialysis. They
16 treated him for an infection, even though they may not have
17 known the exact cause, with antibiotics. And, you know, once
18 you're infected and your kidneys fail, it's possible that some
19 of -- some liver not working well was contributing. And they
20 gave him some medication to also help with the confusion that
21 may have come from his liver, too.

22 Q Give me a moment. Now, how long -- could you
23 describe for us how they treated the kidney failure? You said
24 they put him on dialysis?

25 A Yes, he received hemodialysis.

1 Q And what exactly does that mean?

2 A Hemodialysis is where an external machine
3 basically filters your blood. So it's an artificial kidney,
4 if you will, to some extent. You generally put a patient on
5 that three times a week, and it helps get rid of the things
6 that the kidney normally gets rid of.

7 Q And could you describe for us what you -- what
8 you noted in his -- in the hospital records as he -- his
9 health progressively declined during his hospital stay?

10 A I can't say much from those records except
11 they dialyzed him, they gave him antibiotics. He didn't get
12 better, his blood pressure dropped, they tried to maintain
13 that with types of drugs that raise blood pressure, but
14 ultimately he died.

15 Q And now let's discuss the findings of the --
16 the coroner in -- in the Philippines. Did I give that to you
17 up there, or is it --

18 A Yes. Well, I have the coroner from Clark
19 County.

20 Q All right.

21 MS. STANISH: Is it part of the Philippine package?
22 Court's indulgence. I've got to dig for this. I
23 might have it up here.

24 THE COURT: There's maybe a copy up here, as well.

25 MS. STANISH: Oh, okay. Thank you.

1 MR. WRIGHT: What are you looking for, Margaret?

2 THE COURT: Is that what you're looking for?

3 MS. STANISH: Yeah, I believe it is. Court's
4 indulgence.

5 THE COURT: I'm not sure if that's what -- what you
6 wanted.

7 BY MS. STANISH:

8 Q Let me start with the -- I'd like your medical
9 opinion on reviewing the findings in the autopsy. After you
10 reviewed the medical records, what is your evaluation of the
11 findings of the autopsy?

12 A Well, the autopsy report focuses on hepatic
13 failure, cirrhosis, and chronic hepatitis C, and it does
14 mention pneumonia. But what's a little bit striking to me
15 about the causes of death in the autopsy, even though this
16 pathologist mentions the condition is the lack of saying that
17 the kidney disease contributed to death here. And in
18 particular, even on the death certificate and from looking at
19 the records, it really looked like kidney disease was a major
20 player and also infection and why he came in in his final
21 hospitalization.

22 Q And the -- and if you turn your attention to
23 the death certificate, with respect to the finding of
24 pneumonia, how was that characterized in the death
25 certificate?

1 A Well, in the death certificate it's referred
2 to as sepsis because I think the clinician knew he was
3 infected, but wasn't sure it was from the lungs or from the
4 kidneys or somewhere else. But clearly the patient had an
5 overwhelming infection that they called sepsis on the --

6 Q Okay.

7 A -- death certificate.

8 Q That's where I was getting confused about your
9 testimony about you didn't see pneumonia as being part of the
10 hospitalization, but there is this infection. And so could
11 you explain to me a bit more?

12 A So the clinicians who were taking care of him
13 knew he had an infection, a severe infection because his white
14 blood count was very high, his blood pressure was very low.
15 And, you know, you call that, when it's a severe infection,
16 sepsis, or you can call it septic shock when a blood pressure
17 drops. So when the infection gets so bad, it gets into the
18 blood and your body really begins to fail. They didn't really
19 know what the cause was.

20 They suspected the urinal -- the pathologist, both
21 the coroner in the pathologist in the Philippines, when they
22 looked at his lungs under the microscope, they noticed that
23 there was inflammation in the lungs or pneumonia. Now, it's
24 hard to say whether pneumonia was the cause of that sepsis
25 that resulted from that sepsis. But from -- clinically you

1 can say you had a severe infection, and at the autopsy one
2 organ that they saw was acutely infected was the lungs, so
3 they call that pneumonia.

4 Q Now, we've heard testimony about the condition
5 of Mr. Meana's liver. By the way, how big is the liver? Is
6 it the size of volleyball, football, what?

7 A The normal liver is about 1,500 grams, so
8 that's --

9 Q Oh, okay.

10 A -- roughly --

11 THE COURT: And we thought it was 1,600 grams, so --

12 THE WITNESS: So my guess is Mr. Meana's liver at
13 the end was a little bit smaller. It's up -- I don't know,
14 that big, right here.

15 BY MS. STANISH:

16 Q How big? How big is this?

17 A Maybe the span -- the normal span in the
18 front, in the right midclavicular line, the right middle of
19 your chest might be about 10, 12, 14, 15 centimeters. So
20 divide that by two and a half will give you inches.

21 Q Well, we don't need to go that --

22 THE COURT: And while we think about that, the jury
23 tells me they need a break right now.

24 MS. STANISH: All right.

25 THE COURT: So, ladies and gentlemen, we'll take a

1 relatively quick break. The bailiff will let me know when
2 you're ready.

3 During the break you're reminded that you're not to
4 discuss the case or anything relating to the case with each
5 other or with anyone else. Don't read, watch, or listen to
6 any reports of or commentaries on this case, any person or
7 subject matter relating to the case, and please don't form or
8 express an opinion on the trial.

9 Notepads in your chairs, and through the rear door.

10 (Jury recessed at 2:59 p.m.)

11 THE COURT: One of the jurors feels sick, and that's
12 why we needed to take an immediate break.

13 You can take your break. We don't need you for
14 this.

15 THE WITNESS: I cannot practice medicine in Nevada.

16 MS. STANISH: Do they need a liver doctor?

17 THE COURT: So that's why I said as long as the jury
18 needs. So we'll see what's up with that.

19 MS. STANISH: I'm almost done, Your Honor.

20 THE COURT: Yeah, I mean, she just said like she
21 needed an immediate break.

22 MS. STANISH: Okay.

23 THE COURT: So that suggested to me like a stomach
24 type of an issue. That's why I --

25 MR. SANTACROCE: Which one?

1 THE COURT: Ms. Booker.

2 MR. SANTACROCE: I saw her kind of moving -- moving
3 around.

4 THE COURT: Yeah, so we'll see. So we'll -- I'll
5 update you.

6 Yes?

7 MS. WECKERLY: I just wanted -- well, Mr. Wright
8 left. But I wanted to put -- just enter something as a
9 Court's exhibit. When Dr. Carrera testified, the defense
10 entered a community letter, proffer letter into evidence
11 after, and Mr. Pitaro was present in court when that happened.
12 After court Pitaro contacted me and said he thinks that's the
13 wrong letter or the witness thinks it's the wrong letter. I
14 provided the right one to the defense. I told them if they
15 want to switch it out that's fine, or we can leave it how it
16 is because it was admitted, but I'd just like to have this as
17 a Court's exhibit that I provided it to the defense on the day
18 I got it.

19 THE COURT: Okay. And then, Ms. Stanish and Mr.
20 Santacroce, how do you want to handle that?

21 MR. SANTACROCE: It matters not to me.

22 THE COURT: I mean, do you want to substitute for
23 the correct one?

24 MS. STANISH: I have it --

25 THE COURT: I don't know what the --

1 MS. STANISH: Yeah.

2 THE COURT: -- difference is between the two.

3 MS. STANISH: I don't know either, so let me talk to
4 Mr. Wright about it. I think he stepped out.

5 THE COURT: Okay. You might want to compare it to
6 the other one to see really what the difference is.

7 MS. STANISH: Right. Thank you.

8 MS. WECKERLY: Yeah, so -- all right.

9 THE COURT: Okay.

10 (Court recessed at 3:02 p.m., until 3:14 p.m.)

11 (Inside the presence of the jury.)

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

14 And, Ms. Stanish, you may resume your direct
15 examination.

16 MS. STANISH: Thank you, Your Honor.

17 BY MS. STANISH:

18 Q So, Dr. Worman, right before the break I was
19 about to broach with you the subject matter of Mr. Meana's
20 cirrhosis. We've had testimony, and I think that the document
21 of the coroner shows that he had cirrhosis, he had at the --
22 during the autopsy evidence of ascites?

23 A Ascites.

24 Q Yeah, that's what I meant. So can you explain
25 to us how he got to that point in comparison to where he was

1 prior to the September 2007 time period? What happened to Mr.
2 Meana?

3 A Well, all I can tell from these records is the
4 degree of fibrosis in his liver progressed from a State 2 in
5 2008 to a Stage 4 sometime in 2012, which would be cirrhosis.
6 And, you know, that would be extraordinarily atypical to occur
7 just because of hepatitis C.

8 Q And I'll come back to that in a moment, but I
9 want to go back to something I meant to ask you about the
10 mental condition of Mr. Meana when he was hospitalized.
11 What's that word? I know I can't pronounce it.

12 A Encephalopathy?

13 Q Yeah, it sounds like something from Sesame
14 Street, that elephant. But the -- that -- that issue, what
15 causes that?

16 A So encephalopathy is a broad term, really,
17 just meaning that the brain is not working right. It can
18 happen in end stage liver disease or in very severe acute
19 liver disease, but that's not the only cause. It could also
20 result from kidney failure, which he had at the end. And, you
21 know, looking at the death certificate and the medical
22 records, they were attributing that to both his liver not
23 working and his kidneys not working.

24 I should say after he left the hospital the first
25 time, as best I can remember it says encephalopathy was rather

1 mild. He just had problems sleeping and perhaps was a little
2 bit confused, but still awake and alert and knew, for the most
3 part, where he was and, you know, what was going on.

4 Q And just briefly on the topic of dementia.
5 Are you familiar with whether or not the medicine regimen for
6 hepatitis C treatment, does that cause dementia?

7 A No, absolutely not. Interferon and ribavirin
8 does not cause dementia. No.

9 Q And does having either acute or chronic
10 hepatitis C cause dementia?

11 A Dementia? Absolutely not. No.

12 Q Are you familiar with any literature that
13 supports that?

14 A There is no mainstream medical literature on
15 that. And if you look in terms of treatment at the labels,
16 the FDA approved labels for the drugs, dementia is not an
17 adverse event. I mean, dementia is something different. I
18 mean, liver disease can cause neurological problems and so
19 could the medicines, but not dementia. Absolutely not.

20 Q Okay. Returning to Mr. Meana now. Based on
21 your review of the medical records, can you -- can you tell us
22 with any degree of medical certainty whether the hepatitis C
23 was a direct and immediate cause of his death?

24 A Direct and immediate cause? I cannot say that
25 based on reviewing all the records.

1 Q Thank you.

2 MS. STANISH: I have nothing further.

3 THE COURT: All right. Thank you.

4 Mr. Santacroce, do you have any questions?

5 MR. SANTACROCE: No, Your Honor.

6 THE COURT: Cross, Mr. Staudaher.

7 MR. STAUDAHER: Yes, Your Honor.

8 CROSS-EXAMINATION

9 BY MR. STAUDAHER:

10 Q Sir, I want to ask you a couple of questions
11 first about your training that counsel went over with you. I
12 noticed on your CV that it said board certifications you have
13 two; is that correct?

14 A No, I'm board certified in internal medicine.

15 Q American Board of Internal Medicine?

16 A Yes.

17 Q Is that the only one you hold?

18 A Yes.

19 Q On your CV it says National Board of Medical
20 Examiners back in 1986.

21 A Oh, yes. That's the -- means you passed all
22 of your exams and you're certified to become a -- do an
23 internship and become a physician. That's not a medical
24 specialty.

25 Q Oh. So when it said -- the confusion there I

1 wanted to make sure I was clear was that you're not a medical
2 examiner; correct?

3 A No, I'm not a medical examiner.

4 Q You're not trained in pathology?

5 A I have learned liver pathology in part of my
6 training as a hepatologist, but I'm not a pathologist.

7 Q Okay. And that's what I'm talking about, a
8 pathologist who studies disease of various organs and the
9 like; correct? I mean, that's their focus.

10 A Well, I study disease of organs, but I'm not
11 formally trained as a pathologist.

12 Q Okay. Have you ever opined or have you ever
13 given testimony as to cause and manner of death in any case?

14 A Cause of death? No, I don't believe so
15 until --

16 Q Until today --

17 A -- now.

18 Q -- right?

19 A Well, I've looked at cases and, you know,
20 looked at what -- well, actually, I take that back. I
21 probably have opined as cause of death in drug overdose cases
22 related to the liver, yes, I have.

23 Q Okay. How many cases have you reviewed for
24 that kind of a thing? I mean, actually primarily you're
25 looking at why somebody died, the reasons behind it.

1 A In terms of legal cases how many have --
2 Q In general. I mean, have you ever been asked
3 to come in and say, hey, why did this guy die?
4 A Well, we do that sometimes at conferences
5 or --
6 Q You specifically. Not just at conferences.
7 A So in legal cases maybe three or four times.
8 Q Well, let's talk about those. What were the
9 three or four times?
10 A Those were cases where there were overdose of
11 a drug where a patient died.
12 Q So all of them were like that?
13 A Those cases all involved drug alleged overdose
14 or possible overdose.
15 Q And what was the drug?
16 A The drug was acetaminophen.
17 Q Because that's toxic to the liver; correct?
18 A It's toxic to the liver only if you take it in
19 excess. That's correct.
20 Q You were asked some questions. I'm going to
21 use my -- I don't know what the exhibit is. I'm going to use
22 the one that counsel gave me for -- to go through this.
23 MR. STAUDAHNER: And, Madame Clerk, I don't know what
24 the exhibit number is on this.
25 You may actually have a copy up there.

1 MS. STANISH: Yeah, I think it's up there.

2 THE COURT: I think it's --

3 THE WITNESS: DD-1?

4 BY MR. STAUDAHER:

5 Q DD-1.

6 A Is that correct?

7 Q I'm going to leave that with you so that
8 you've got it if you need it. A couple things I want to ask
9 you about related to this. First of all, this is the date up
10 here is the 25th of July of 2008; correct?

11 A Correct.

12 Q So this would have been if the infection
13 occurred to Mr. Meana in September 2007. We're talking about
14 the next year, mid-summer.

15 A This is approximately ten months after that.

16 Q So in this report, the part that you were
17 asked about, and I'm going to zoom in on this a little bit so
18 that we can see it. The part you were asked about was here
19 where it said related to the diagnosis chronic hepatitis,
20 clinically hepatitis C, and then it comes across here and it
21 says with immediate -- or moderate activity Grade 3/4. What
22 does moderate activity Grade 3/4 mean?

23 A That's the degree of inflammation. So you
24 look at the inflammatory cells in the liver and you grade it.

25 Q So he -- his liver was pretty inflamed then at

1 that time?

2 A Well, it's exactly what it says, it's moderate
3 inflammation Grade 3 of 4. I don't know what pretty means,
4 but that's a pretty good --

5 Q Well, your --

6 A -- that's a good --

7 Q Give me the range.

8 A -- pathological description.

9 Q What does 3 of 4 mean?

10 A They grade it from zero to 4. This would be
11 considered moderate.

12 Q Okay. So what to you does -- if you have a
13 scale of 1, 2, 3, 4, and 3 is what we're looking at here, is
14 that significant inflammation?

15 A I would say that's moderate inflammation.

16 Q Is it significant?

17 A It's moderate. I can't answer that. I'm
18 sorry.

19 Q So when we look down here where it says
20 periportal fibrosis, what does that mean exactly?

21 A That means fibrosis or scar tissue that's
22 extending beyond the structures in the liver known as portal
23 tracts. So portal tracts are these areas all throughout the
24 liver where an artery and a vein and a bile duct can be found
25 that enter and exit the liver. And those areas, when you have

1 many types of hepatitis, not all, but many types of hepatitis
2 are the first areas that get inflamed. And this means --
3 periportal means it's beyond the portal tract, it's
4 periportal, extending beyond the portal tract.

5 Q Okay. This is still within the liver, though.

6 A This is within the liver. This is a
7 microscopic portion of the liver, right.

8 Q Now, you said, if I understood you correctly,
9 that you don't know that this was caused by hepatitis C; is
10 that correct?

11 A I can't say that all that fibrosis was caused
12 by hepatitis C, no. It would be very atypical.

13 Q You're familiar with the medical records of
14 Mr. Meana?

15 A Yes.

16 Q You've reviewed all the pre-2007 September
17 medical records available; correct?

18 A I've reviewed what I was given. That's what I
19 reviewed, yes.

20 Q Well, what were you given?

21 A I was given not that many medical records
22 prior to September 2007. There were a few medical records
23 from his primary care doctor, and there was maybe one or two
24 sets of labs in there. I don't have records going further and
25 further back.

1 Q In the medical records you saw, limited as
2 they were, did you see any evidence that he had fibrosis,
3 liver disease, anything like that? Any of his labs or
4 reports, anything like that?

5 A You can only tell that by liver biopsy, which
6 he hadn't had.

7 Q I'm asking you based on the liver studies,
8 whatever you saw as part of the medical records. Was there
9 any evidence at all that he had any kind of liver disease
10 prior to September 2007?

11 A There was evidence of liver disease, which
12 were these dilated extra hepatic bile ducts, or a process that
13 could affect the liver. Fibrosis you need a biopsy. I can't
14 say whether he had fibrosis or not.

15 Q So the extra hepatic ducts, and that was in --

16 A June.

17 Q -- June of 2007. I'm putting that up right
18 now. June 2007 report; correct?

19 A Yes, a report of a CT scan, I believe.

20 Q And do you see where it says CT scan of the
21 abdomen?

22 A Yes.

23 Q Now, the part that you mentioned that was
24 significant to you I've highlighted here. It says distended
25 extra hepatic bile ducts, distal obstruction is not excluded,

1 changes of cholecystectomy. Do you see that?

2 A Yes.

3 Q So extra hepatic means what? Outside the

4 liver; correct?

5 A Yes.

6 Q And bile ducts -- and it says distal

7 obstruction on this. Let me go briefly again. Distal

8 obstruction is not excluded. What -- what does that mean,

9 distal obstruction?

10 A That means an obstruction beyond where the

11 bile ducts are dilated. This scan cannot exclude that.

12 Q Okay. So that would be even further away from

13 the liver; correct? An obstruction potentially?

14 A In the bile ducts outside of the liver, yes.

15 Q Now, what would cause the bile ducts to

16 dilate?

17 A Oh, it could be a stricture, it could be a

18 stone, it could be a tumor, it could be things that are

19 unusual, it could be congenital, there could be many, many

20 causes.

21 Q But outside the liver; correct?

22 A But when you have bile ducts dilated outside

23 the liver, it's connected to the liver. You can't image the

24 interior hepatic bile ducts with this type of scan, so you

25 can't look at those.

1 Q Not my question. The obstruction was away
2 from the liver causing the actual dilation; correct?

3 A That would be most consistent with this, yes.

4 Q So the dilation didn't come from something
5 inherent within the liver according to this report; correct?

6 A Inherent within the liver? No. But it's part
7 of the biliary system that drains the liver.

8 Q Any indication from this report that there is
9 actual liver disease other than the dilation caused by an
10 obstruction away from the liver?

11 A Well, this is not the type of test you would
12 do to determine that, so I can't say.

13 Q So when I asked you if there was any evidence
14 of any liver disease or anything related to it before
15 September of 2007, you pointed to this. So I want to know
16 what part of this you're saying shows liver disease in Mr.
17 Meana.

18 A I'm saying that the extra hepatic duct
19 dilation suggests there's an obstruction. An obstruction can
20 cause, or a subclinical obstruction, damage to the liver over
21 time. But this test did not look for that specifically.

22 Q So there is no evidence that you reviewed and
23 had access to that showed any evidence of liver disease prior
24 to September of 2007?

25 MR. SANTACROCE: I'm going to object to his

1 categorizing that as evidence. It was a medical record. I
2 think he just misstated.

3 THE COURT: Well, no, he said he can -- he's --
4 that's overruled. He can answer if he's seen any evidence --

5 THE WITNESS: I can --

6 THE COURT: -- suggesting --

7 THE WITNESS: Sorry.

8 THE COURT: -- liver disease prior to 2007.

9 THE WITNESS: I can say I've seen evidence of a
10 process that can affect the liver.

11 BY MR. STAUDAHNER:

12 Q Later; correct? A process that could affect
13 the liver later?

14 A Later?

15 Q Than this.

16 A Or at this time. I don't know.

17 Q I'm going to ask you this the third time. Is
18 there any evidence at all of active liver disease at the time
19 before September of 2007?

20 A I'll answer it again just by saying I can see
21 evidence of a process that can affect the liver.

22 Q So the answer is no?

23 MR. SANTACROCE: Objection, Your Honor.

24 THE COURT: Overruled.

25 You can answer. Is the answer no?

1 BY MR. STAUDAHER:

2 Q Yes or no?

3 A And I think I've --

4 Q Yes or no?

5 A -- given my answer. You cannot look at the
6 liver itself with this test.

7 Q That isn't my question. Is there any evidence
8 of disease?

9 A Yes, of bile duct disease there is evidence.
10 Yes.

11 Q Now, have you -- have you heard of -- well, I
12 think you've mentioned them, benign cysts in the liver and the
13 kidneys and things like that?

14 A Yes.

15 Q And benign to you means what?

16 A Benign usually means it's not causing any
17 significant problem. In cancer it's not a cancer. It's a
18 mass that doesn't grow or metastasize.

19 Q In fact, in kidneys, over -- people over the
20 age of 50, typically half the people will have a cyst in their
21 kidney; correct?

22 A I don't know the number, but it's not uncommon
23 to have kidney cysts.

24 Q Nothing to do with any disease process, it
25 just happens; correct?

1 A It's an abnormal process, but it's not serious
2 and not significant.

3 Q What about the liver? Is that something that
4 happens congenitally? It just -- it just happens, it doesn't
5 cause any real problem?

6 A People may have benign liver cysts for sure.

7 Q You were asked about interferon. Do you
8 recall that? Interferon ribavirin, I think, was the
9 combination that you actually studied?

10 A Interferon-alpha, peg interferon-alpha is what
11 we use to treat hepatitis C, yes.

12 Q And you studied that back when?

13 A Oh, I mean, I've been using it clinically for
14 years. The clinical trials I did were probably in the very
15 late '80s to early '90s.

16 Q Have you done --

17 A I take that back. I take that back. I'm
18 sorry. It would have been the -- I was at Columbia in '95.
19 It would have been the late '90s to around 2000.

20 Q Because I've got your reports, your studies,
21 if you want to look at them. Would that help?

22 A No, the dates were in the late '90s where I
23 did interferon and ribavirin.

24 Q Okay. Late '90s. So as far as those studies
25 are concerned, what -- what were you studying? What were you

1 doing?

2 A Treating hepatitis C.

3 Q And -- and what did you find? When you --
4 when you said that you treated, I mean, are there different
5 effects on different genotypes of the virus, I mean, as far as
6 how well it works?

7 A Interferon-alpha and ribavirin, people with
8 genotype 2 and 3 respond more commonly than people with
9 genotype 1 infections or genotype 4 infections, which are
10 extremely rare.

11 Q Which, in the scheme of things, a 1, 2, or 3
12 is going to respond less effectively?

13 A Well, genotype 1 probably responds to that
14 treatment 40 to 50 percent of the type than genotype 2 and 3,
15 closer to 60 or 65 percent at a time.

16 Q Okay. So we've got Mr. Meana as genotype
17 what?

18 A He was 1a, I believe.

19 Q So he would fall under that 40 to 50 category?

20 A And looking at the general population for
21 chronic hepatitis C, yes.

22 Q So if I understand you correctly, 40 to 50
23 percent of the people that were -- had his genotype will
24 respond positively to interferon therapy; is that correct?

25 A With chronic hepatitis C, yes.

1 Q You mentioned acute. What is your definition
2 of acute hepatitis?

3 A Acute is hepatitis lasting less than six
4 months. That's a generally accepted definition.

5 Q So after six months we're at the chronic
6 phase?

7 A You call it chronic. It's somewhat arbitrary,
8 but that's the accepted term.

9 Q Now, within that time window, is that when
10 people usually will exhibit symptoms if they're going to
11 exhibit symptoms?

12 A Interestingly, most people with chronic
13 hepatitis C don't exhibit --

14 Q No, I'm --

15 A -- symptoms.

16 Q -- talking about acute. I'm sorry. The acute
17 phase.

18 A Oh. Interestingly, most people with acute
19 hepatitis C don't develop symptoms. But the ones who do, it's
20 roughly from a month or two after infection up to about six
21 months after infection.

22 Q So the window would actually -- for that acute
23 time, when you said would be the most effective at treatment
24 would be when people are exhibiting their symptoms then
25 primarily?

1 A Well, the truth is actually the sooner you
2 start treatment after an acute infection the better. There's
3 not a lot of data that looks at if you start seven months or
4 eight months or ten months or twelve months, but the general
5 consensus is the sooner you start treatment after an infect,
6 the better the chance of response.

7 Q So you, as a person who has studied this,
8 you're a hepatologist by trade, essentially; correct?

9 A Yes.

10 Q And that's what your specialty is?

11 A That's what I do clinically, yes.

12 Q Knowing that someone like Mr. Meana with Type
13 1a serotype virus, the response rate in the 40 to 50 percent
14 range for that, can you say that Mr. Meana would have
15 responded positively to that -- to that therapy if he had been
16 able to tolerate it?

17 A Okay. Just a correction, genotype virus, not
18 serotype.

19 Q I'm sorry. Did I say that --

20 A We don't serotype --

21 Q -- incorrectly?

22 A -- the virus. I can only say he would have
23 roughly a 50 percent chance perhaps if he were treated earlier
24 better because there just are data that suggest the earlier
25 the treatment the better. But I can't give an exact number.

1 Q So he's got maybe a 50/50 chance at even
2 having it have any effect at all on him?

3 A I think he has a chance of responding to
4 treatment that was -- I would put roughly in the 50 percent
5 range.

6 Q And there's clearly side effects related to
7 that treatment?

8 A Some people have side effects, some people
9 don't. Most people who are treated go through it without
10 having to stop the treatment.

11 Q Now, related to that, are neurologic
12 conditions -- I'm not talking about related to the end stage
13 liver failure that causes the toxins and the encephalopathy.
14 I'm talking about in general the virus itself and the
15 treatment, interferon with -- what was it, ribavirin?

16 A Ribavirin.

17 Q Ribavirin.

18 A That's okay.

19 Q With the treatment and -- and the actual
20 infection, were you saying that there is no mental component
21 to this that can be affected, that the virus doesn't affect
22 the brain at all?

23 A The virus doesn't affect the brain, no. And
24 also I was saying there's no dementia, was the question I was
25 asked.

1 Q Oh. I'm sorry. So -- well, let's -- let me
2 follow up with that. No dementia.

3 A No.

4 Q And the virus does not affect the brain?

5 A The virus itself does not affect the brain.
6 You cannot find hepatitis C in brain cells or in the central
7 nervous system.

8 Q I've got four articles here and I want to ask
9 you if you're familiar with any of them. The first one, it
10 was published in Metabolism and Brain Disease, and it's
11 entitled Hepatitis C Virus Infection in the Brain. Have you
12 ever read that article?

13 A I haven't read it. May -- may I see it?
14 You're asking me --

15 Q Sure.

16 A -- to comment on things --

17 Q Absolutely.

18 A -- I've never seen.

19 Q I'll give you a copy. Have you ever seen that
20 one?

21 A No, I haven't seen this.

22 Q Okay. I've got another one here called
23 Emerging Evidence of Hepatitis C Virus Neuroinvasion. And
24 I'll give you a copy of that one, too. I've got another one
25 here called Hepatitis C Virus Neuroinvasion Identification of

1 Infected Cells, Journal of Virology. And one last one. It's
2 entitled Hepatitis C Virus Infection and Health Related
3 Quality of Life.

4 Now, that last one was in the World Journal of
5 Gastroenterology. The next one was in the Journal of
6 Virology. The next one was in the Journal AIDS, and then the
7 last one was in the Metabolism and Brain Disease Journal, as
8 well. All of those related to actually infection in the
9 brain, virus getting into the brain. You say you're
10 unfamiliar with this at all?

11 A Hepatitis C virus does not infect brain cells.
12 You can show me all the articles like this you want. This
13 does not prove anything. These are publications that are
14 suggestive.

15 Q Suggestive. If we go to the one entitled
16 Hepatitis C Virus Neuroinvasion Identification of Infected
17 Cells, just look at the abstract. I know you haven't had a
18 chance to read the whole thing, but take a moment and read
19 that abstract and tell me again if you believe that that --
20 there's no evidence whatsoever in any peer reviewed journal
21 that there's evidence of an infection of the virus hepatitis C
22 into brain cells.

23 A I'm going to need a moment to --

24 Q Sure.

25 A -- read this.

1 Q Take a moment.

2 A [Witness complied]. Okay. I've glanced
3 through it.

4 Q Okay. And the other two, the one that says
5 Emerging Evidence of Hepatitis C Virus Neuroinvasion, and also
6 the one that says Hepatitis C Virus Infection of the Brain, if
7 you want to just look at the abstracts of those briefly
8 because it talks about the same neuro-cellular invasion in the
9 brain, all three papers, three different journals.

10 A Which was the other one you were talking about
11 now? I'm sorry.

12 Q Hepatitis C Virus Infection and the Brain, the
13 Metabolism and Brain Disease Journal, and also Emerging
14 Evidence of Hepatitis C Virus Neuroinvasion in the Journal
15 AIDS, 2008 and 2005 respectively. Actually, published in 2009
16 on the first one, 2005 on the second one.

17 A On this one I do not have the entire paper, I
18 don't believe.

19 Q Which is that?

20 A Hepatitis C Infection and the Brain.

21 Q I'll let you have my copy.

22 A Okay.

23 Q Okay. Do not all of those, all three of
24 those, those last three that I gave you, indicate the
25 astrocytes, macronuclear invasion of the virus into the brain,

1 actually into the brain?

2 A I would say these three papers prove nothing.
3 These are suggestive papers in second or third tier journals
4 that just point towards more research. This is not generally
5 accepted in the medical community.

6 Q So the Journal of Virology and AIDS and also
7 the -- what was it the, World Journal of Gastroenterology, the
8 -- what was the last one? Brain Metabolism -- Metabolism and
9 Brain Disease, you don't consider those peer reviewed journals
10 to be any evidence whatsoever of hepatitis C virus infection
11 in the brain or proof thereof?

12 A Any suggestive evidence whatsoever, or does
13 this conclusively prove that hepatitis C virus can damage the
14 brain by infecting it? Those are two very different questions
15 for me.

16 Q Well, does it revise your opinion at all --

17 A These papers --

18 Q -- seeing that there's some -- there's some
19 literature out there on this very subject?

20 A No. In fact, I --

21 Q Because you were fairly unequivocal that there
22 was no evidence whatsoever --

23 MR. SANTACROCE: Your Honor, I'm going to ask him to
24 finish his last answer.

25 THE COURT: Yeah, let him.

1 You can finish.

2 THE WITNESS: Well, may I read a few things from
3 these papers?

4 BY MR. STAUDAHER:

5 Q If you wish.

6 A Because you're asking me --

7 Q Go ahead.

8 A -- to look at abstracts and titles. In fact,
9 look at Hepatitis C Infection and the Brain, their last
10 paragraph. This still hypothetical scenario connecting HCV
11 infection and functional CMS changes could be summarized as
12 follows. This still hypothetical scenario. Okay. We're
13 dealing with hypothetical here. Okay.

14 In your prestigious journal Metabolism and Brain
15 Disease, which I've never heard of before, while the HRQL
16 reduction in depression may be discussed as caused by multiple
17 factors, blah blah blah -- here we go -- it is suggested that
18 alterations in brain function also play a role. I mean, these
19 are the type of literature that are small studies, suggestive,
20 oh, we did microcapture microscopy and we were able to amplify
21 hepatitis C virus RNA from a few brains.

22 That is a far cry from saying that hepatitis C virus
23 infects the brain. Now, I'm a peer reviewer for many
24 journals. I'm an editor of medical journals, an editor of a
25 scientific journal. There is a big jump from saying this

1 proves anything to that this is suggestive -- some suggestive
2 laboratory test.

3 Q Fair enough. So when it talks about detected
4 CD69 positive cells and HCV RNA also found in astrocytes which
5 are contained in the brain; correct? It's talking about the
6 HCV RNA is contained in the astrocytes within the brain. Does
7 that not mean that it's in the brain?

8 A Can I say that from this? Absolutely not. Do
9 I know he's actually looked at astrocytes? Do I know there
10 was no contaminating cells in the sample? This is just not
11 mainstream accepted medical stuff. This is suggestive stuff
12 from a few laboratory experiments. I can tell you that's how
13 the medical literature works. You make an observation, you
14 publish it, it needs further testing. You won't find this in
15 a review in a New England Journal of Medicine. You won't find
16 this in a textbook. This is very early suggestive stuff that
17 may very likely be wrong. That's all I can say about these
18 papers. I'm sorry.

19 Q Well, you did say just a moment ago that there
20 was no literature at all, isn't that fair?

21 A Well, we have to talk about literature at all,
22 or -- I'm sorry, maybe I'm saying is this literature that
23 makes people believe this to a reasonable degree of medical
24 certainty or probability?

25 Q So the public --

1 A This is just a paper describing some
2 experiments. That's different than proving cause and effect
3 or anything.

4 Q So the public medicine website, which is where
5 these came from, which is where a lot of journal articles
6 reside, you don't think that that's -- that's an outlet for
7 medical providers for people looking at this to see whether or
8 not there's any validity to it?

9 A I guess -- I'm sorry, sir. I guess you don't
10 understand peer review in the medical literature. I'm very
11 sorry. You publish things that are not necessarily facts.
12 You publish observations. This is science. You make an
13 observation. You amplify RNA from a cell from somebody's
14 brain. More people have to do it. Have I seen a bigger
15 series? Have I seen a paper in nature saying that hepatitis C
16 virus conclusively infects the brain? Based on observations
17 published in these small journals we have now proven. That's
18 how medicine works. Not you get a paper from --

19 Q Fair enough.

20 A -- this journal published in China and tell me
21 it's proof. I'm sorry.

22 Q Is that journal published in China?

23 A This is a Chinese journal, the World
24 Journal --

25 Q And you're familiar --

1 A -- of Gastroenterology.

2 Q -- with it?

3 A Yes, I am. I even was on the editorial board

4 for awhile or something.

5 Q Oh, you were even on the --

6 A Yes.

7 Q -- editorial board of that journal.

8 A That's right.

9 Q This obscure journal that is worthless --

10 A And I'm not saying --

11 Q -- as far as the scientific --

12 A I'm not --

13 Q -- community is concerned?

14 A And that does not mean everything is right in

15 there.

16 Q But you're on the editorial board; right? Or

17 you were.

18 A To help keep -- to try to help keep papers out

19 that weren't right, except I didn't review every one of them.

20 Q Okay. But you --

21 A Okay.

22 Q -- were on the editorial board of that very

23 journal that I brought up to you.

24 A The journal where I tried my very best to keep

25 papers out that were not based on solid science.

1 Q Fair enough. You -- not based on solid
2 science. I'm glad you asked -- you said that because in the
3 case that you -- that counsel asked you about that you
4 actually came in and testified in this -- gave a deposition in
5 this particular city; correct? Related to a non-genetically
6 matched patient?

7 A An alleged hepatitis C infection, yes. I
8 testified in one case of that.

9 Q Okay. And in that you said that the patient
10 didn't get hepatitis from the -- from his colonoscopy;
11 correct?

12 A As best as I was able to tell from looking at
13 all those records, I couldn't say to a reasonable degree of
14 medical certainty that it did.

15 Q What was your scientific basis for that
16 determination?

17 A I haven't looked at those records and I
18 haven't looked at that report in a long time.

19 Q I've got your deposition. Would you like to
20 see it?

21 A We can go through the deposition line by line
22 if you like. I mean --

23 THE COURT: Well, no --

24 MR. SANTACROCE: Your Honor --

25 THE COURT: -- we can't.

1 MR. SANTACROCE: -- I'm going to --

2 THE WITNESS: I mean, I just felt there was no
3 evidence.

4 THE COURT: But if Mr. Staudaher wants to ask you
5 look at it to refresh your recollection, he's welcome to do
6 that.

7 BY MR. STAUDAHER:

8 Q Specifically in that deposition did you not
9 say that you believed that there was no connection, that there
10 was no connection from a scientific or whatever your
11 perspective is, that the person had hepatitis derived from
12 that clinic?

13 A That person?

14 Q Yes.

15 A That person, if I remember correctly, there
16 was a large window where he may have contracted hepatitis, a
17 several month window where anything could have happened.

18 Q Well, was it not true that even a few weeks
19 before he had had a negative study or a negative test for
20 hepatitis C?

21 A I can't remember how many weeks before.

22 Q But you definitively said that he did not get
23 it from the clinic, did you not?

24 A I said to a reasonable degree of medical
25 probability I couldn't say he got it from the clinic.

1 Q And other than that clinic, according to the
2 records you reviewed, there was not a single other risk factor
3 that you identified, isn't that correct, other than the
4 clinic?

5 A I didn't identify the clinic as a risk factor.

6 Q Oh, I forgot. You didn't identify them, but
7 I'm saying there were no -- taking the clinic aside, there
8 were no other risk factors that you identified?

9 A In that case, I don't remember. I can look at
10 my report and see what I wrote in there.

11 Q Do you recall where it is in your deposition,
12 because I can help you with that.

13 A Yeah, I --

14 Q And I believe that if you go to page 13, and
15 you can read as much of it before and after as you need to get
16 context.

17 A Page -- I'm sorry?

18 Q 13.

19 A [Witness complied].

20 Q And then I want you to hop forward to 24.

21 A Well, it's kind of hard to hop forward.

22 MS. STANISH: Your Honor, may we approach?

23 THE COURT: Sure.

24 (Off-record bench conference.)

25 THE COURT: All right. Mr. Staudaher.

1 BY MR. STAUDAHER:

2 Q Now, when you said before that you did not
3 exclude that -- the person who had gotten hepatitis C at the
4 clinic on 13, do you actually say that you do not believe that
5 he got hepatitis C at the clinic?

6 A I think I say here he contracted it sometime
7 in a time span roughly six months before that time or from
8 going back a couple of weeks before that time and I think that
9 there's many possible ways he could have contracted because,
10 and I don't believe it was from a colonoscopy.

11 Q Okay. The colonoscopy is -- maybe I misspoke.
12 I guess it could have happened at the clinic, but not from a
13 colonoscopy according to you; correct?

14 A Well, it didn't happen from a colonoscopy. I
15 think I can say exactly what I said here. There are many
16 possible ways that it could have happened.

17 Q But not from a colonoscopy; correct?

18 A From an actual colonoscopy, no. I mean, I'm
19 sorry. I have to read.

20 Q Read. Feel free.

21 A I can't take a sentence out of context and --

22 Q That's why I said read as much as you wish.

23 A [Witness complied]. As far as I can tell, he
24 was not infected at the clinic.

25 Q Okay.

1 A That's all I can say.

2 Q And your scientific basis for that was what?

3 A The lack of any evidence that he was infected
4 at the clinic. Can you tell me evidence that he was? I
5 haven't seen any.

6 THE COURT: All right.

7 MR. STAUDAHER: All right. I'll move on, Your
8 Honor. I'll move on.

9 BY MR. STAUDAHER:

10 Q I want to move to a different case. Sears v
11 Foote Hospital, do you recall that case?

12 A Wow. That was quite some time ago, but I --

13 Q It dealt with --

14 A -- vaguely remember.

15 Q -- endoscopies; right?

16 A Yes, it did.

17 Q Okay. And scopes were -- people, at least
18 three, I think, or so were coming in complaining, or at least
19 alleging that they got their hepatitis C infections from the
20 scopes.

21 A As best as I can remember that, yes.

22 Q What was your opinion in that case?

23 A Well, I looked at a few cases, and one had a
24 blood transfusion as an infant. There was another cause of
25 hepatitis C. I cannot remember the other two. One was

1 somebody who was incarcerated and was injecting himself with
2 different dyes and sharing needles to tattoo people. I can't
3 remember the other case. But those cases there was no acute
4 hepatitis C and they all had other risk factors for hepatitis
5 C.

6 Q But you stated that it was not from the
7 scopes; correct?

8 A It absolutely wasn't from the scopes in those
9 cases.

10 Q You mentioned incarceration. Did you not
11 involve -- or were you an author on a paper involving whether
12 or not it was appropriate to give interferon therapy to
13 incarcerated persons or to wait because it doesn't -- I mean,
14 there's a window of time that you have that it's not going to
15 cause a problem?

16 A In chronic hepatitis C, yes.

17 Q Well, after --

18 A People --

19 Q -- six months you're into chronic; correct?

20 A No, no, no. You're playing with words a
21 little bit. I said the sooner you're treated, the better.
22 But if you're someone who has been in jail and you've been
23 infected for 10 or 15 years waiting a year or two isn't going
24 to matter. But if you're in jail and you're infected six
25 months, seven months, eight months, ten months, there may be

1 reason to do that. That -- that was dealing strictly with
2 people who were long term infected.

3 Q What about people that would have been in jail
4 that might be having some symptoms?

5 A I didn't comment on that in that paper.

6 Q Well, I'm asking you.

7 A Having symptoms or get acutely infected in
8 jail?

9 Q I'm talking about cirrhosis, things like that,
10 direct causes.

11 A Well, once you have cirrhosis, that's --
12 you're having symptoms from it, the treatment may not do that
13 much. The goal of treatment is to prevent getting
14 complications of cirrhosis.

15 Q So back to this exhibit, and this is the
16 defense exhibit. And I think it's DD whatever it was, DD-1.
17 In this particular case you say that once the cirrhosis or
18 fibrosis or whatever is onboard that it's not really effective
19 to have the treatment anymore; correct?

20 A Once you have established cirrhosis and
21 complications, the treatment doesn't help that much.

22 Q So we've gone from our 40 to 50 percent down
23 to what?

24 A Sorry, I don't understand.

25 Q Well, you said that in somebody with genotype

1 1a that they would have a 40 to 50 percent, 45, 50 percent.

2 You said, I think, 50 to be fair. 50 percent chance of
3 getting benefit from that therapy.

4 A Of being cured by that therapy, yes.

5 Q Okay. Somebody who starts to have cirrhosis
6 or signs of cirrhosis, where does it drop down to as far as
7 affectivity of any treatment?

8 A Oh, I don't know the exact numbers, but you
9 lose some efficacy once there is histological cirrhosis.

10 Q In this case there is histological cirrhosis
11 here, at least development of that; isn't that correct?

12 A No, that doesn't matter. I say when there is
13 established cirrhosis, whether there's Stage 2, that's not
14 going to really change the effectiveness that much. That's --

15 Q But this is histological result, is it not?

16 A Fibrosis. This is not cirrhosis. You were
17 asking me about cirrhosis.

18 Q Oh, that's good. That's good. Okay. So
19 fibrosis.

20 A Yes.

21 Q What's the difference between fibrosis and
22 cirrhosis?

23 A Oh, as I explained before, fibrosis is scar
24 tissue that forms in the live. Cirrhosis is a very advanced
25 stage of liver disease where you have regenerating nodules of

1 liver cells with scar tissue all around those nodules. So
2 fibrosis is just a scar tissue itself. Cirrhosis is very
3 advanced fibrosis with abnormal regeneration of the liver.

4 Q And you said -- when was the first time you
5 saw this document here?

6 A I don't remember.

7 Q Today?

8 A Oh, no. No, I saw this at least a few months
9 ago.

10 Q Those documents that are sitting right up
11 there, those medical records from the Philippines, when was
12 the first time you saw those?

13 A I saw those a few months ago. Although, I
14 should say I saw a clearer copy today. The copy I was
15 provided with was a little bit hard to read, but I had seen
16 those records before, too.

17 Q But you reviewed those literally before you
18 came and testified today; correct?

19 A No, no. I reviewed these records, I don't
20 remember the exact date, but one or two months ago. I just --

21 Q But most recently you reviewed them just
22 before you testified?

23 A Just to make sure that there was nothing
24 missing from the copies that I received, there was really
25 nothing significant missing.

1 Q In Defense Exhibit DD-1, you indicated that
2 what's listed there, the chronic hepatic -- hepatitis,
3 clinically hepatitis C with moderate activity, Grade 3/4 and
4 periportal fibrosis and mild microvesicular and macrovesicular
5 steatosis; is that correct?

6 A Steatosis, yes.

7 Q Steatosis, which is a --

8 A Fatty liver.

9 Q -- fatty liver. Right.

10 A Right.

11 Q Now, with regard to the next portion, I mean,
12 you said that the circle part, that there is no way to
13 determine that that -- the hepatitis C infection has anything
14 to do with that; correct?

15 A From -- I'm sorry. I didn't --

16 Q That the hepatitis C infection had anything to
17 do with that.

18 A Had anything to do with what? The --

19 Q What's listed there, the diagnosis.

20 A The steatosis?

21 Q No, all of it, any of it.

22 A I didn't say that.

23 Q Oh, I'm sorry.

24 A I said --

25 Q What did you say?

1 A I said he had chronic hepatitis that
2 clinically was hepatitis C. And then I said he had periportal
3 fibrosis, which may have been from hepatitis C or other
4 causes, and he has another insult in his liver, which is the
5 fatty liver.

6 Q Okay. And that one actually has -- is the
7 only one that says mild, is it not?

8 A It's mild.

9 Q Okay. It's mild. Now, when we go down here
10 to the lower portion of this under comments, pertinent
11 laboratory values found within Qwest Diagnostics Laboratory
12 are as follows. Do you see that?

13 A Yes.

14 Q And it's got a date, 6/3/2008. So that's
15 before this study on 7 -- it was -- I think the sample was
16 taken 7/25/2008; correct? Does it say that?

17 A This was 7/25/2008.

18 Q So go down there and look at that, each HCV
19 RNA PCR quantitation at, it looks like 8,850 international
20 units per mil; is that correct?

21 A Yes, I commented that when I talked about this
22 before. I said there was some data showing that he had
23 hepatitis C virus RNA at a low viral load, yes.

24 Q And it's PCR quantitation which means that
25 somebody did what?

1 A Oh, you want me to explain --
2 Q Sure.
3 A -- how PCR is done? So the virus is an RNA
4 virus. There's an RNA genome. We have DNA. The virus has
5 RNA. You have to take the RNA and convert it to DNA in one
6 reaction, and then there's a reaction called PCR where you can
7 amplify the DNA and you can semi-quantify how much virus is
8 present in the blood. And in this case this would be a
9 relatively or quite low value of 8,850, but the hepatitis C
10 virus RNA was present in his blood.
11 Q So when it says here quantitation 3.9 log,
12 what does that mean?
13 A That -- that's -- to the 10. 10 --
14 Q So it's 10 to the 10 --
15 A -- 10 to the 3.9.
16 Q -- to the 10 to the 10?
17 A No, 10 to the 3.9. So it's a little
18 different. I mean, if you take that, I don't know, that would
19 come out to maybe 10,000. No, it would come out to 8,850;
20 right? Because that's the same number.
21 Q And if you move across here, again, it says
22 genotype 1a.
23 A I think that's been established, yes.
24 Q Okay. No question that there's at least
25 genetic linkage in this particular case; correct?

1 A There's -- I can tell from this there's
2 genotype 1a virus. What do you mean by genetic linkage?

3 Q You're familiar that there was a genetic link
4 in this case for this particular patient?

5 A Can you ask me a more specific question?

6 Q Are you aware that there was a genetic link to
7 a source patient in this particular case --

8 A Oh, I'm --

9 Q -- with this -- with this particular patient?

10 A I'm aware looking at data from the Southern
11 Nevada Health District and the CDC that there were several
12 patients on that day that had genetically similar isolates,
13 yes.

14 Q Now, with regard to the -- the test here, I
15 mean, clearly there's evidence of disease that you even
16 acknowledge could be caused by hepatitis C; correct?

17 A Well, I don't think you can get Stage 2
18 fibrosis after just 10 months of hepatitis C.

19 Q In the medical records that you saw before
20 September 2007, did you see any evidence of anything that
21 could have led to this? We're talking about alcoholism,
22 infections of other kinds, whatever.

23 A No, the -- the bile duct obstruction and also
24 the fact that he had microvesicular and macrovesicular
25 steatosis here, he may have had that for quite some time.

1 Q And you're not a pathologist; right?

2 A I look at liver biopsies, but I'm not a

3 pathologist.

4 Q Okay. Do you feel competent to opine as to

5 cause of death when looking at records that two coroners, two

6 medical examiners looked at?

7 A I feel competent to opine on cause of death

8 because I've looked extensively at these medical records.

9 I've looked at their reports, and I've looked at the death

10 certificate, yes.

11 Q Extensively at medical records that -- which

12 medical records are we talking about?

13 A The ones that I mentioned when we began today.

14 Q Did you not say that it was relatively sparse,

15 the medical records that you had?

16 A I looked extensively at what I had, and it

17 was --

18 Q Okay.

19 A As far as I --

20 Q So even if you didn't have very much, you

21 looked at it really hard; is that right?

22 A As far as I know, it's the same medical

23 records that these pathologists looked at. If there's other

24 ones, I assume they would have been given to me. Are -- are

25 there other medical -- I guess I --

1 Q I don't know.

2 A -- can't ask questions, but --

3 Q I don't know what you actually looked at.

4 With regard to the kidney, I want to ask you about an issue
5 related to that that you testified. Already we've established
6 that little cysts, benign hepatic or renal cysts, they don't
7 really cause an issue; correct?

8 A The cysts in this place were not a major
9 contributing factor, if at all. I --

10 Q So the cysts don't cause any issue.

11 A That's true.

12 THE COURT: Let him finish.

13 MR. STAUDAHER: I'm sorry, Your Honor.

14 THE COURT: Did you finish?

15 MR. STAUDAHER: I'm sorry to the witness.

16 THE WITNESS: I said that's true, the cysts that
17 were found on the radiology scans were not major factors here.

18 BY MR. STAUDAHER:

19 Q You said that one of the concerns that you had
20 was the benign -- benign prostatic hypertrophy; correct?

21 A It could be a concern, yes.

22 Q That it might cause backing up of the urine
23 which might affect the kidneys, that kind of thing?

24 A Yes.

25 Q If you have backing up of the urine into the

1 kidneys, what do you get as a result, typically?

2 A You can get infections, which he possibly had,
3 but over long term you can get damage to the kidneys.

4 Q In what form? I mean, what do you usually see
5 as a harbinger before the damage occurs?

6 A Well, I'm not a kidney pathologist, so I don't
7 want to get into the details of what can happen, but as an
8 internist I know having chronic kidney obstruction you can get
9 kidney disease.

10 Q Do you see things like hydronephrosis?

11 A You might see hydronephrosis. You might --

12 Q And what is that?

13 A Hydronephrosis is when the -- the kidney where
14 the urine is collected expands, and you can see it perhaps on
15 an x-ray or an imaging study.

16 Q Okay. And there was no evidence in these
17 imaging studies?

18 A On that scan, no, but we don't have any
19 imaging since then, so I don't know.

20 Q Okay. Do you know what hepatorenal failure
21 is?

22 A I know what hepatorenal syndrome is.

23 Q Okay. Tell me about hepatorenal syndrome.

24 A So hepatorenal syndrome is when you have a
25 normal kidney. So your kidney has no structural kidney

1 disease. There is no damage to glomeruli. There is no
2 nephrosclerosis. There is no chronic kidney disease. So a
3 perfectly normal kidney in a person whose liver fails, that
4 kidney can stop working because the liver fails. Now, if you
5 changed a person's liver, the person gets a liver transplant,
6 that kidney works normally. If you take the kidney out of
7 that person and put into a normal person, and this is a dog
8 experiment, you don't do that in people, but that kidney works
9 normally. So that's when the kidney fails solely secondary to
10 the liver failing.

11 Q Isn't it true that approximately 40 percent of
12 patients with combination cirrhosis and ascites, which was the
13 case in this particular instance, will get renal failure as a
14 result, and that's what is termed hepatorenal syndrome?

15 A That's an interesting question because there's
16 two types of hepatorenal syndrome. So when you put that big
17 number on it, that sort of literature saying there is a low
18 grade renal insufficiency that some of them get, but the full
19 blown hepatorenal syndrome where your kidney completely fails,
20 that's a much, much, much smaller number.

21 Q But it's progressive renal failure caused by
22 liver cirrhosis; right?

23 A That -- that can happen in a structurally
24 normal kidney. Correct.

25 Q And that's what we actually have here is liver

1 failure; correct?

2 A We have a structurally abnormally kidney,
3 though.

4 Q And what are you basing that off of, again?

5 A I'm basing it on your -- your coroner and your
6 pathologist reports.

7 Q And which reports were those?

8 A Those would be --

9 Q And read me the grossly or structurally
10 abnormal results there.

11 A Okay. So this is the -- okay. This is the
12 autopsy report from the Philippines. And I see here
13 hypertensive nephrosclerosis kidney. I think the pathologist
14 from -- from here in Nevada -- I can't quite find that one. I
15 think I have it.

16 Q I've got a copy.

17 A Okay. So this is from the Clark County
18 Coroner. It says nephrosclerosis, but I think there's a more
19 extensive -- kidney, dissection shows mild to moderate
20 nephrosclerosis with associated interstitial fibrosis. There
21 also appears to be mesangial thickening within many of the
22 remaining glomeruli, as well as the presence of excessive
23 amounts of proteination and fluid within Bowman's space.
24 Occasional foci of interstitial chronic inflammation are
25 present. There is patchy parenchymal congestion, but no frank

1 hemorrhages observed. Occasional foci of arteriosclerosis are
2 present. So this is describing several structural kidney
3 lesions here.

4 Q Well, aside from the atherosclerotic issue,
5 the narrowing of the arteries in the kidney, isn't that --
6 doesn't that seem to match up with progressive renal failure
7 due to cirrhosis?

8 A No. I have nephrosclerosis here and
9 interstitial fibrosis and mesangial thickening. This is a
10 description of damage to the glomerulus itself. This is not
11 just arteries being hardening. This is the unit that filters
12 the blood in the kidney is damaged in this patient.

13 Q So how does cirrhosis cause renal failure.

14 A That doesn't cause it by doing that.

15 Q Well, I'm asking you.

16 A It causes it by hormonal and blood flow
17 problems. The kidney is structurally normal. If it was
18 purely hepatorenal syndrome and took the kidney out, the
19 kidney would not have any of these changes in it. Your
20 glomeruli look completely normal. It's because you get an
21 imbalance of hormones, such as renin, angiotensin,
22 aldosterone. These are hormones that control blood flow to
23 the kidney. You get problems with that and essentially you
24 get decreased perfusion of the kidney because the liver fails.
25 But once you start seeing these things, that's structural

1 damage to the kidney that probably resulted from years of
2 hypertension and perhaps resulted from years of low grade
3 obstruction.

4 Q But your opinion is that the liver had nothing
5 to do with that?

6 A I'm saying he had structural kidney disease.

7 Q I'm not asking you whether there was
8 structural kidney disease.

9 A I cannot --

10 Q I'm saying the findings in the kidney beyond
11 the structural disease, is there any --

12 MR. SANTACROCE: Your Honor, I'm going to object.
13 This is getting to the point of argumentative. It's been
14 asked and answered.

15 THE COURT: Well, let him -- no. He can --
16 BY MR. STAUDAHER:

17 Q Is there any portion of the cirrhosis, the
18 liver disease, that could have affected that?

19 A That could have? Yes. But can I say that
20 from looking at the history in this? I don't know.

21 Q Now, you mentioned in the -- in the -- I think
22 it was the -- gosh, the -- well, first of all, do you think
23 based on your review of the medical records that he had a
24 hepatorenal syndrome?

25 A I can't say he had hepatorenal syndrome from

1 the medical records, not with this degree of structural kidney
2 disease. Also, the necessary --

3 Q The --

4 A -- tests for hepatorenal syndrome --

5 THE COURT: Let him finish again.

6 MR. STAUDAHER: I'm sorry.

7 THE WITNESS: The necessary tests to diagnose
8 hepatorenal syndrome were not in the labs in the Philippines.

9 BY MR. STAUDAHER:

10 Q The medical records that you have up there,
11 specifically the 4/20 -- this is the second hospitalization,
12 the one where he died, 4/24/2012, a note indicating that he
13 was declared to be in hepatorenal syndrome -- in the
14 hepatorenal syndrome with associated hepatic encephalopathy.

15 A Can you show -- I -- I'm sorry. I can't find
16 that in here.

17 Q Well, I'm asking -- I've given you the date.
18 You've got the records in front of you.

19 A What was the date?

20 Q The date was 4/24/2012.

21 A You're going to have to help me a little more.
22 I have doctor's notes and nurse's notes here --

23 THE COURT: Mr. Staudaher --

24 THE WITNESS: -- and other notes.

25 THE COURT: I'm sorry. Now I'm interrupting you.

1 THE WITNESS: I'm sorry. It's okay.

2 THE COURT: If you're aware of where that is in the
3 record, can you --

4 MR. STAUDAHER: I know it's on that date. I don't
5 know if it's --

6 THE COURT: -- can you maybe --

7 MR. STAUDAHER: -- tabbed or not. I can try and
8 look.

9 THE COURT: -- try to kind of facilitate this.

10 THE WITNESS: There's doctor's and nurse's notes.
11 I'm sorry.

12 MR. STAUDAHER: Well, Your Honor, I've got the date,
13 but it may be the wrong -- wrong one here at the time. So
14 I'll look at that for later on.

15 THE COURT: Okay.

16 BY MR. STAUDAHER:

17 Q If the record had shown that, and we can look
18 at it another time, but if the record had shown that, would
19 you -- would that change your opinion at all?

20 A Well, it would depend how the record showed
21 that. If it's just a doctor writing a note, I did see a note
22 in here at one point that said diagnosis, question mark,
23 hepatorenal syndrome, that would not affect me at all. If I
24 saw laboratory evidence, that might affect me, but that's not
25 in here as far as I know.

1 Q What laboratory evidence would you need?

2 A Well, you need to check the urine sodium and
3 see if he had extremely low urine sodium.

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

5 THE COURT: All right. Thank you.

6 Redirect.

7 MS. STANISH: May I approach?

8 THE COURT: You may. You may move freely.

9 REDIRECT EXAMINATION

10 BY MS. STANISH:

11 Q I have the exhibit from the Philippines. Is
12 this -- from your review of this record, was it a complete
13 medical record in your experience? What's missing, I guess?

14 A Again, as I said, that's not at the standard
15 of medical records we would have at New York Presbyterian
16 Hospital or most U.S. hospitals. I didn't find good discharge
17 summaries. I didn't find detailed admission notes. And I
18 think some laboratory tests that you probably should have done
19 on a patient like this I didn't see in there.

20 Q Do you know if there was reference to labs in
21 -- if you recall, was there reference to labs, but the lab
22 reports themselves were not contained in these records?

23 A Not that I can recall, no.

24 Q Now, the -- Mr. Staudaher had indicated that
25 you just had to scurry to review these records before coming

1 to testify this -- in the morning today. You were -- when did
2 you first received these records?

3 A So I actually received two copies of those
4 records. One was a hard copy that I'm going to estimate about
5 six to eight weeks ago. Then I subsequently received a
6 scanned .pdf of the same records, and some of them were just
7 difficult to read. So the only thing I did today was
8 re-review them to see more clearly the pages that I couldn't
9 see in the scan copies and photocopies that I had.

10 Q If you recall, do you remember if the copies
11 you received had what we call little Bates stamps showing at
12 the -- it was discovery provided by the State?

13 A I believe that either you or your paralegal
14 sent a note that said these were provided by the State, but I
15 cannot be sure.

16 Q Do you know if you have reviewed all the
17 documents that the State of Nevada provided with respect to
18 Mr. Meana's medical records?

19 A I've --

20 MR. STAUDAHNER: Objection. Speculation. It's what
21 he was provided by defense counsel. He doesn't know what we
22 provided.

23 BY MS. STANISH:

24 Q Were you provided medical records that
25 indicate -- had Bates stamps on them?

1 A Some of them at least did, yes. And maybe
2 perhaps all of them, but there are Bates stamped records for
3 sure.

4 Q With regards to peer review articles versus
5 what you refer to as suggestive articles, can you explain why
6 the three articles that Mr. Staudaher gave you don't fall into
7 the category of what's accepted by -- in general by the
8 medical community? Maybe I need you to explain the standard,
9 to clarify that for us.

10 A Well, it's -- in biomedical research, it's
11 very typical that small interesting observations often get
12 published that are never followed up upon and never proven to
13 be conclusive. And I would consider these type of
14 publications in these type of, some of them highly
15 sub-specialized journals, and some of them even journals, you
16 know, that are not of even a middle caliber. I would say
17 these are at best suggestive.

18 I mean, these are certainly types of experiments
19 that you cannot hold to a reasonable degree of medical
20 certainty or a reasonable degree of scientific certainty.
21 These are suggestive findings and a few experiments. These
22 are not in textbooks. These are not in the New England
23 Journal of Medicine. They are not in nature. They are in
24 science. These are small suggestive findings. This is not
25 where I would base decisions of treating a patient, life and

1 death, or in a court determining, you know, causation or
2 problems.

3 Q But Mr. Staudaher seemed to think it was
4 significant that you were on the editorial board of one of
5 those. Can -- can you explain how these middle -- what did
6 you call them, middle range periodicals?

7 A Middle range journals. How'd they get me on
8 the editorial board?

9 Q I don't know. Were you on the editorial board
10 when it -- that was written?

11 A I was on the editorial board for awhile. I
12 was invited to give a lecture in China and I met the editor of
13 that journal, and he said would you be on the editorial board?
14 And I said, sure, I'll review a few papers a year. And my
15 only contribution to that journal was reviewing a few papers.

16 Q Did you review that one?

17 A Nope.

18 Q If you did, would you have let it into the --
19 recommended it be published?

20 A I haven't read it in its entirety, but I would
21 say I certainly have a lot of questions about it.

22 Q All right. Now, you're not a pathologist. So
23 are you sitting here today rendering an opinion as to what
24 caused Mr. Meana's death?

25 A Well, yes, I think as an internist and a

1 hepatologist I can review all these records and come to a
2 conclusion.

3 Q And explain to us why -- explain to us what
4 your conclusion is based on that review.

5 A Well, I think Mr. Meana had several underlying
6 medical problems. He had medical problems that were affecting
7 his kidneys from as early as 2006, 2007. He had medical
8 conditions that were chronic, that were to some degree
9 affecting his liver as manifested by biliary obstruction, and
10 also by fat in his liver. He got infected with hepatitis C on
11 top of that. He became quite sick with both kidney failure
12 and with liver disease and liver failure. But to look at all
13 these records and to say it was infection with the hepatitis C
14 virus on September 21, 2007, that led to his death, it's just
15 not possible.

16 Q Why? Isn't medicine a science of certainty?

17 A Medicine is a science of probability. There
18 may be some things that are 99.99 percent certain, but not
19 looking at a complicated patient with multiple problems who
20 had something happen to him four or five years ago and then
21 later say, oh, it's that that killed him. I just -- as a
22 physician and as a scientist, I cannot do that based on
23 everything I looked at here.

24 Q Thank you.

25 MS. STANISH: I have nothing further.

1 THE COURT: Mr. Santacroce.

2 MR. SANTACROCE: Thank you.

3 RECROSS-EXAMINATION

4 BY MR. SANTACROCE:

5 Q Doctor, Mr. Staudaher asked you about a case
6 many years ago that involved scopes where you ruled that out
7 as the mechanism of transmission of hep C. Can you tell me a
8 little bit more about that case, how long ago was it? I don't
9 need an exact date. Was it like ten years ago?

10 A It was -- it was roughly ten years ago, I
11 would say.

12 Q And in that particular case you ruled out the
13 scopes because the patients or the individuals that were
14 infected had other possible means of catching that disease.
15 For example, you said one had blood transfusion, one, I
16 believe, had some shared needles, and the other one you
17 couldn't think of; correct?

18 A I can't remember the other one, but I know all
19 those cases were -- there was no evidence of acute hepatitis C
20 infection, and they all had other risk factors for hepatitis
21 C.

22 Q And in that particular case you weren't making
23 a global determination that hepatitis C can't be transmitted
24 through scopes. That was just a fact specific case; correct?

25 A Correct. I was looking at those specific

1 cases that I looked at.

2 Q And, in fact, how long can hepatitis C virus
3 live in the environment outside of the human body?

4 A Oh, boy. I don't know the exact number.
5 There is some period of hours or something, but I don't know.

6 Q We had from 16 hours to four days. Does that
7 comport with your knowledge?

8 A I would not argue with that, but I don't know
9 for sure.

10 Q And it's a blood-borne pathogen; correct?

11 A Yes.

12 Q So that means it passes through blood, blood
13 to blood contact?

14 A Blood-blood is the only way to really get it,
15 yes.

16 Q And blood lives in fecal matter; correct? Or
17 can be present in fecal matter?

18 A Can be. I would say that would be a quite
19 low, low, low, low risk way of transmitting this virus, but
20 it's theoretically possible.

21 Q Okay. And it can be passed through -- well,
22 first of all, you're not here to make a determination as to
23 mechanism of transmission in this case; correct?

24 A Correct. I was asked to look at Mr. Meana's
25 medical records and comment on his medical history and medical

1 condition and how he ended up.

2 Q So when Mr. Staudaher asked you about the
3 scopes, you weren't opining in this particular case the
4 mechanism of transmission of the disease?

5 A All I did when he asked me that is read what I
6 had said in my deposition from two to three years ago in a
7 different case.

8 Q Okay. And your -- your testimony is emphatic
9 that hepatitis C does not cause dementia; correct?

10 A It does not cause dementia.

11 Q If I was a neuropsychologist and I did a study
12 of 19 people and I have had that some sort of correlation
13 between hepatitis C virus and that these 19 individuals had
14 some sort of neurological damage, and then I concluded that
15 one of them, at least, had dementia, would that be a valid
16 study?

17 A That would probably not even get published in
18 some of these journals. There is no controls, there is no
19 methodology, there is -- it's never been peer reviewed as far
20 as I know, so, no.

21 Q Thank you.

22 THE COURT: Mr. Staudaher.

23 MR. STAUDAHER: No redirect, Your Honor.

24 THE COURT: Counsel approach.

25 (Off-record bench conference.)

1 THE COURT: Doctor, I have a couple of juror
2 questions up here.

3 THE WITNESS: Okay.

4 THE COURT: A juror would like to know if Mr. Meana
5 had not been infected with hepatitis C on September 21, 2007,
6 can you say that he would probably have died from liver -- I'm
7 sorry, from liver complications in 2012?

8 THE WITNESS: Boy. It's just really not possible to
9 say that based on the records. I mean, I would say probably,
10 maybe not from liver disease. From kidney maybe, but I -- I
11 just can't say. That would be speculating.

12 THE COURT: Okay. And then another juror would like
13 to know can hepatitis C accelerate existing kidney disease or
14 liver disease or does it have no effect?

15 THE WITNESS: Well, obviously, if there is more than
16 one insult to your liver, it can accelerate it. So a classic
17 example is people who have hepatitis C and also drink alcohol.
18 They do progress faster. So having two or three different
19 diseases can make your liver worse than having one disease.
20 Kidney disease, hepatitis C rarely affects the kidney. There
21 are rare circumstances where you can get something called
22 cryoglobulins where hepatitis C can affect the kidney, but
23 there's no evidence that he had that and it's, you know, not
24 really common.

25 THE COURT: Ms. Stanish, do you have any follow up

1 to those last juror questions?

2 MS. STANISH: Court's indulgence.

3 THE COURT: I guess that would be no.

4 MR. WRIGHT: I'm shaking my head no.

5 MS. STANISH: Can we approach, Your Honor?

6 THE COURT: Sure.

7 MS. STANISH: Thank you.

8 (Off-record bench conference.)

9 THE COURT: Ms. Stanish. Oh, I'm sorry. We need to
10 wait for everybody to get back to their seats.

11 FURTHER REDIRECT EXAMINATION

12 BY MS. STANISH:

13 Q Dr. Worman, did you review all the medical
14 records that our office forwarded to you?

15 A Yes.

16 MS. STANISH: And, Your Honor, may the record
17 reflect that the medical records forwarded to Dr. Worman were
18 provided by the State of Nevada and we forwarded all that we
19 received from them to Dr. Worman.

20 THE COURT: Okay.

21 MR. STAUDAHER: State will -- will take the
22 representations of counsel, Your Honor.

23 THE COURT: All right. Then that will be reflected
24 in the record.

25 MS. STANISH: Nothing further.

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1 THE COURT: Mr. Santacroce, anything else?

2 MR. SANTACROCE: No, Your Honor.

3 THE COURT: Mr. Staudaher, anything else?

4 MR. STAUDAHER: No, Your Honor.

5 THE COURT: All right. Doctor, thank you for your
6 testimony. You are excused at this time.

7 THE WITNESS: Thank you.

8 THE COURT: And I'm sorry. We didn't have any other
9 juror questions? I forgot to ask.

10 All right. Thank you, Doctor. You're free to
11 leave.

12 All right. Ladies and gentlemen, in a moment we'll
13 be taking our evening recess. We will not be in session
14 tomorrow. On Thursday we will resume. I anticipate that we
15 will have the closing arguments on Thursday, and following
16 that the case will be submitted to you.

17 Now, trial is not over, so obviously the prohibition
18 about discussing the case or anything relating to the case is
19 still in effect. You are additionally reminded that you are
20 not to read, watch, or listen to any reports of or
21 commentaries on the case, any person or subject matter
22 relating to the case. Do not do any independent research by
23 way of the internet or any other medium, and please do not
24 form or express an opinion on the trial.

25 If you would all please place your notepads in your

1 chairs. And I forgot to tell you when to come back. We'll
2 see you back here at 9:00 a.m. on Thursday morning. 9:00 a.m.
3 Thursday morning.

4 (Jury recessed at 4:39 p.m.)

5 THE COURT: All right. How about 10:30 for us
6 tomorrow, or is that too early?

7 MS. WECKERLY: No, that's not too early. I'm just
8 hoping we can get the proposed defense ones tonight so we can
9 look at them.

10 MS. STANISH: I believe so. You know, we have 15
11 special jury instructions. Many of them are evidentiary right
12 out of the Ninth Circuit pattern book. And then it's really
13 the elements of the offense relating to the negligent charges
14 that I think they want to focus on, but we will get those to
15 them.

16 THE COURT: Well, they may want to focus on the ones
17 from the Ninth Circuit, which by virtue of the fact that you
18 say --

19 MS. WECKERLY: We're in State Court.

20 THE COURT: Well, we're in the -- under the -- by
21 virtue of the fact that you say they're from the Ninth Circuit
22 book suggests we normally, and I'm sure we normally don't give
23 them, so, I don't know, they may have objections on those, as
24 well.

25 MS. STANISH: I understand.

1 THE COURT: All right. We'll see you back here
2 tomorrow at 9 -- I'm sorry, 10:30.

3 MS. STANISH: Thank you.

4 (Court recessed for the evening at 4:41 p.m.)
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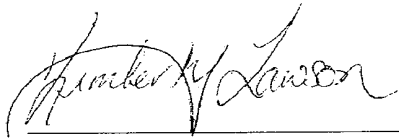
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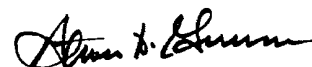
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DISTRICT COURT
CLARK COUNTY, NEVADA

* * * * *

STATE OF NEVADA,

Plaintiff

vs.

DIPAK KANTILAL DESAI,
RONALD ERNEST LAKEMAN,

Defendants

CASE NO. C265107-1,2
CASE NO. C283381-1,2
DEPT. NO. XXI

Transcript of
Proceedings

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 45

THURSDAY, JUNE 27, 2013

APPEARANCES:

FOR THE STATE:

MICHAEL V. STAUDAHER, ESQ.
PAMELA WECKERLY, ESQ.
Chief Deputy District Attorneys

FOR DEFENDANT DESAI:

RICHARD A. WRIGHT, ESQ.
MARGARET M. STANISH, ESQ.

FOR DEFENDANT LAKEMAN:

FREDERICK A. SANTACROCE, ESQ.

RECORDED BY: JANIE OLSEN, COURT RECORDER
TRANSCRIBED BY: JULIE POTTER, TRANSCRIBER

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JRP TRANSCRIPTION

1 LAS VEGAS, NEVADA, THURSDAY, JUNE 27, 2013, 9:06 A.M.

2 (Court was called to order)

3 (Outside the presence of the jury.)

4 THE COURT: All right. Excuse me. We're still
5 missing two jurors. I wanted to finish up on the last
6 remaining matters before we bring the jury in. As I said,
7 there are two jurors who are not here, so we can't start with
8 the jury anyway.

9 Ms. Weckerly, did you make all of the changes to the
10 jury instructions that we talked -- we went over the last copy
11 yesterday?

12 MS. WECKERLY: Yes, and I emailed them to everybody,
13 including the Court.

14 THE COURT: All right. And did Mr. Santacrocce, Ms.
15 Stanish, did you both have an opportunity to review the jury
16 instructions with the final revisions that we had discussed?

17 MR. SANTACROCE: Yes, Your Honor.

18 THE COURT: All right.

19 MS. STANISH: Yes, Your Honor. We were just trying
20 to refresh our memory on the ultimate ruling on the
21 instruction dealing with the term petty larceny.

22 THE COURT: I thought we were pulling the grand
23 larceny instruction and we were just going to do theft under
24 250 and obtaining money under false pretenses under 250, and I
25 thought the agreement had been that that's just obvious.

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1 I had suggested giving a lesser included, but then
2 my understanding was between the attorneys the feeling was
3 that it was just obvious, they either meet the 250 or they
4 don't meet the 250 and they could choose the appropriate
5 verdict on the verdict form. That was my understanding of how
6 we had left it yesterday afternoon.

7 MS. WECKERLY: Okay. Well, that's fine. That can
8 just be pulled out --

9 THE COURT: Okay.

10 MS. WECKERLY: -- that instruction.

11 MS. STANISH: And that was the only thing we saw,
12 Your Honor.

13 THE COURT: And I don't believe we went through and
14 numbered that in our numbering.

15 MS. WECKERLY: No, I just think it's in the -- you
16 know, the blank number. You know, it's just in the packet, so
17 it probably isn't in the Court's packet if you pulled it out.

18 THE COURT: Okay. And then you made the changes
19 onto the verdict form; correct?

20 MS. WECKERLY: I did, and I dropped it off.

21 THE COURT: All right.

22 MR. SANTACROCE: And when you're done with that,
23 there's one other matter.

24 THE COURT: I still have to go over their rights to
25 testify.

1 MR. STAUDAHER: And the State has a couple of other
2 matters, as well, Your Honor.

3 THE COURT: Okay.

4 MR. STAUDAHER: Minor matters.

5 THE COURT: All right. Did the defense receive
6 copies of the revised verdict form?

7 MS. WECKERLY: It should have been on the last email
8 that I sent in the Word format.

9 MR. SANTACROCE: Was it at 6:30 last night or
10 something?

11 MS. WECKERLY: Yes.

12 MR. SANTACROCE: Yes.

13 MS. STANISH: Yes, we received that.

14 THE COURT: Okay. The theft, the one I just was
15 handed, does not have the misdemeanor, the theft under 250,
16 and the obtaining under 250.

17 MS. WECKERLY: I think that --

18 THE COURT: Do you have a different one, Denise?

19 THE CLERK: This is what Sharry gave me.

20 THE COURT: Oh, okay. All right. So this is -- she
21 gave me a different one.

22 All right. And, Defense, your copies have the --
23 yes, okay, this is correct. It reflects what we had discussed
24 yesterday.

25 All right. Just to make sure that everyone has the

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1 correct jury instructions from the completed packet that Ms.
2 Weckerly has emailed to everyone and my JEA just printed out,
3 shall we go through and number them again together?

4 MR. WRIGHT: Yes.

5 THE COURT: All right. Instruction No. 1, members
6 of the jury.

7 2, if in these instructions.

8 3, an indictment is but.

9 And, State, you've omitted the count relating to the
10 Veteran's Administration?

11 MS. WECKERLY: Yeah, correct. It just says omitted.

12 THE COURT: Okay. 4, you are here only to
13 determine.

14 5, a separate crime.

15 MR. WRIGHT: Wait. I've got it is the duty.

16 THE COURT: That is part of Instruction 3.

17 MR. WRIGHT: Okay.

18 THE COURT: Just when it was printed out it went to
19 a new page.

20 All right. So 5, a separate crime is charged.

21 6, a conspiracy is an agreement.

22 7, it is not necessary.

23 8, each member of.

24 9, evidence that.

25 10, where two or more persons.

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1 11, mere presence.
2 12, any person who.
3 13, a person who.
4 14, you have heard.
5 MR. WRIGHT: Just a minute. I'm on 13. 14, you
6 have heard.
7 THE COURT: Everybody on the same page as the Court?
8 15, a professional caretaker.
9 16 -- 15 goes to a second page.
10 Then 16 is a certified registered nurse anesthetist.
11 17, both the reckless endangerment.
12 18, as used in these instructions.
13 19, count 25 charges.
14 20, counts 26 and 27.
15 21, if you find.
16 22, the term intent to defraud.
17 23, murder is.
18 24, malice as.
19 25, murder of the second degree.
20 26, murder in the second degree.
21 27, the second degree felony murder.
22 28, in regard to the crime.
23 29, as to an offense.
24 30, as to the element.
25 31, to constitute the crime charged.

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1 32, the defendant is presumed innocent.
2 33, it is a constitutional right.
3 34, you are here to determine.
4 35, the evidence which.
5 36, the credibility or believability.
6 37, you have heard testimony.
7 38, you have heard the testimony of.
8 39, certain charts and summaries.
9 40, a witness who.
10 41, although you are to consider.
11 42, in your deliberation.
12 43, when you retire.
13 44, if during your.
14 And 45, now you will listen.
15 Is that what everyone has?
16 MS. STANISH: Yes, Your Honor. And for the record,
17 I had given your clerk a complete copy of our jury
18 instructions.
19 THE COURT: All right. All right.
20 All right, Mr. Staudaher, you indicated the State
21 had some matters.
22 MR. STAUDAHER: Yes, just a couple of items, Your
23 Honor.
24 THE COURT: All right.
25 MR. STAUDAHER: First of all, the charts that are

1 the -- I know that the charts we're talking about that are in
2 evidence, the smaller versions of those, we have larger
3 versions of those that we wish to -- I know they're not going
4 to be for --

5 THE COURT: To use as demonstrative evidence?

6 MR. STAUDAHER: And that goes back -- can go back to
7 the jury so that they can actually see a larger version of the
8 small chart, those right there, which are mirror copies of
9 them. I'm talking about the large charts that were -- that
10 would be displayed in court, so that they can have those
11 instead of all of them poring around a small version of that.
12 So we're asking --

13 THE COURT: Are you talking about the charts that
14 have the detailed information?

15 MR. STAUDAHER: Yes. Yes.

16 THE COURT: All right. Does the defense have any
17 objection to the large copies of the charts that we've been
18 using throughout the trial going back to the jury? That's the
19 breakdown by the days --

20 MR. WRIGHT: Yes.

21 THE COURT: -- and the rooms?

22 MR. WRIGHT: Yes. I don't want replaced blown-up
23 charts of the State's exhibits after we rest the case. I
24 would have blown up all of my exhibits to big charts that they
25 can carry around and prop up. The evidence is in and closed.

1 THE COURT: All right. The jury will get the
2 smaller evidence. Obviously, you can use whatever blowups,
3 whatever demonstrative evidence you want to use. And however
4 you choose to blow up or enlarge the evidence that's been
5 presented is fine.

6 MR. STAUDAHER: And the ones that the Court has
7 comply with all the orders so far --

8 THE COURT: Okay.

9 MR. STAUDAHER: -- and our corrections.

10 THE COURT: And those are all admitted --

11 MR. STAUDAHER: Yes.

12 THE COURT: -- the graphs and everything that have
13 been revised according to the Court's orders.

14 MR. STAUDAHER: With regard to -- we both, as the
15 Court had ordered earlier with regard to any PowerPoints or
16 whatever, we have lodged as Court's exhibits copies of both
17 presentations as we anticipate providing them today. Also, we
18 have provided as -- and I think those are going to be Court
19 Exhibits 24 and 27.

20 There's also Exhibit 26, Court's Exhibit 26, which
21 is the basis of the location of the seizure document related
22 to the affidavit, which was the center of discussion
23 yesterday. Although, we know that that has been removed as a
24 Court's exhibit, we wanted to have at least a record of where
25 it came from, specifically what computer it came off of, all

1 of that kind of stuff. So that has been lodged and that is
2 Exhibit 26.

3 25 --

4 THE COURT: Right. And just to reiterate so it's
5 clear in this portion of the record, the Court did find that
6 there was nothing to suggest that the police had acted
7 inappropriately or anything like that in obtaining that
8 document.

9 MR. STAUDAHER: Right. And as far as the -- early
10 in the trial there was some discussion about R&R Partners and
11 -- and some meetings and so forth and whether attorneys were
12 present and who had hired them and that kind of thing.

13 We went back through some of those records. We
14 compiled emails and so forth from the -- and this was all
15 discovered and it was provided to defense counsel. And we
16 just want to make this a Court's exhibit, a record of that,
17 which was Exhibit 25 related to the meetings and so forth. No
18 argument about it. I just want it for the appellate record in
19 case they want to review what the basis was on that issue.

20 With regard to -- well, I know that there are a
21 couple of outstanding exhibits that have -- the clerk and I
22 have been working with trying to identify that they are --
23 they're not a major issue. But two of them, I believe, are
24 Court's exhibits, or would be a Court's exhibit. One is
25 actually an admitted exhibit that apparently has gotten lost

1 in the process.

2 THE COURT: Okay. Do we --

3 MR. STAUDAHER: I've tried to reproduce that.

4 THE COURT: Okay. I'm not concerned about the

5 Court's exhibit at this point. I am concerned about the trial

6 exhibit that needs to go back to the jury.

7 MR. STAUDAHER: Yes, it's one single --

8 THE COURT: So are we missing a trial -- I mean, a

9 trial exhibit that would go back to the jury or --

10 MR. STAUDAHER: Yes.

11 THE COURT: Okay.

12 MR. STAUDAHER: There is one page of -- it's one

13 memo related to, I believe, Ms. Rushing's testimony when those

14 documents came in. The clerk has identified it to me. I'm

15 going to try and go back and find a replacement copy of it.

16 It is not something we intended to argue at all today --

17 THE COURT: Okay.

18 MR. STAUDAHER: -- in court. So I just wanted to

19 make sure the Court was aware of that. Also --

20 THE COURT: All right. Just to -- so we all

21 understand, what -- do you know what exhibit number that is?

22 THE CLERK: 202.

23 THE COURT: 202? Okay. And you'll make sure you

24 get that and get with the --

25 MR. STAUDAHER: Correct.

1 THE COURT: -- clerk and obviously show the defense
2 what it is that you're adding or putting in as the exhibit.

3 MR. STAUDAHER: Sure.

4 THE COURT: Okay.

5 MR. STAUDAHER: And it's my understanding it would
6 be a replacement of one that was already shown and admitted --

7 THE COURT: Okay.

8 MR. STAUDAHER: -- at one point. With regard to one
9 other document, there was, and I've shown this counsel, the
10 only witness who did not come in and actually physically
11 testify or present on a video demonstration -- or video
12 deposition was that of Carole Grueskin.

13 THE COURT: Ms. Grueskin.

14 MR. STAUDAHER: I displayed in opening with Court's
15 and with counsels' approval her picture, and I intend -- and
16 it may be coming up, it will come up again in closing here.
17 So I wanted to make sure that we had at least as a Court's
18 exhibit a copy of that -- that picture that would be used so
19 that we're not just displaying things to the jury that are not
20 evidence that didn't come into the case. So I've shown that
21 to both counsel. It's my understanding that they are not --

22 THE COURT: No objection --

23 MR. STAUDAHER: -- have no objection to --

24 THE COURT: -- to him displaying --

25 MR. STAUDAHER: -- it and we can --

1 THE COURT: -- the picture of Ms. Grueskin?
2 MS. STANISH: Correct, as demonstrative evidence.
3 THE COURT: Right. It won't go back to the jury.
4 It's a Court's exhibit as part of the -- a Court's exhibit, as
5 well as part of the PowerPoint that has also been made a
6 Court's exhibit.
7 Is that correct --
8 MR. STAUDAHER: That's correct, Your Honor.
9 THE COURT: -- Mr. Staudaher?
10 MR. STAUDAHER: Yes.
11 THE COURT: All right. Is that all that the state
12 needed to clear up?
13 MR. STAUDAHER: Yes.
14 THE COURT: All right. We're going to go over the
15 right to testify and the right not to testify, which we did
16 not do yesterday. I'm going to begin with Mr. Lakeman.
17 Mr. Lakeman, would you please stand. Mr. Lakeman,
18 do you understand that you have the right to take the stand
19 and testify on your own behalf? Are you aware of that right?
20 THE DEFENDANT LAKEMAN: I do. I understand.
21 THE COURT: All right. Do you understand that if
22 you choose to take the stand and testify on your own behalf,
23 the deputy district attorneys will have the opportunity to
24 cross-examination you and anything you say, whether it be in
25 response to a question on direct examination,

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1 cross-examination, or a question from one of the jurors or the
2 Court will be the subject of fair comment by the deputy
3 district attorneys in their closing arguments? Do you
4 understand that?

5 THE DEFENDANT LAKEMAN: I understand.

6 THE COURT: All right. Conversely, you have the
7 right not to take the stand and testify. Should you avail
8 yourself of your right not to testify, the deputy district
9 attorneys are precluded from commenting upon this in their
10 closing arguments. Do you understand that?

11 THE DEFENDANT LAKEMAN: I understand.

12 THE COURT: All right. Also, if you choose not to
13 take the stand and testify, the Court will give an instruction
14 if asked to by your attorneys, and they have requested the
15 instruction.

16 The instruction essentially says it is the
17 constitutional right of a defendant in a criminal trial that
18 he may not be compelled to testify, thus the decision as to
19 whether or not he should testify is left to the defendant on
20 the advice and counsel of his attorney. You must not draw any
21 inference of guilt from the fact that he does not testify, nor
22 should this fact be discussed by you in your deliberations in
23 any way. That will be the instruction, and Mr. Santacroce, I
24 understand, would like that instruction given.

25 Is that correct?

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1 MR. SANTACROCE: That is correct.

2 THE COURT: All right. Do you understand all of
3 that?

4 THE DEFENDANT LAKEMAN: Yes, Your Honor.

5 THE COURT: All right. Also, if you choose to take
6 the stand and testify and you've been convicted of a felony
7 crime within the past ten years or you have discharged your
8 sentence of parole, probation, or imprisonment within the past
9 ten years, the deputy district attorneys would be permitted to
10 question you about that.

11 And I don't believe that there are any prior
12 convictions as to Mr. Lakeman that could be used for
13 impeachment; is that correct?

14 MR. SANTACROCE: That's correct, Your Honor.

15 THE COURT: All right. Have you had a full and
16 ample opportunity to discuss your right to testify, as well as
17 your right not to testify with your attorney Mr. Santacroce?

18 THE DEFENDANT LAKEMAN: Yes, Your Honor.

19 THE COURT: All right. Do you have any questions
20 that you would like to ask the Court about either of these
21 rights?

22 THE DEFENDANT LAKEMAN: No, ma'am.

23 THE COURT: All right. And it is my understanding,
24 Mr. Santacroce, that your client does not wish to testify; is
25 that correct?

1 MR. SANTACROCE: That is correct.

2 THE COURT: All right. Did I cover that to your
3 satisfaction?

4 MR. SANTACROCE: Yes.

5 THE COURT: To the State's satisfaction?

6 MR. STAUDAHER: Yes, Your Honor.

7 THE COURT: All right. Thank you.

8 Mr. Lakeman, you may be seated.

9 Dr. Desai, I need you to stand up. I'm going to
10 cover the same rights that I just covered with Mr. Lakeman.
11 All right?

12 You have the right to take the stand and testify on
13 your own behalf. If you choose to take the stand and testify
14 on your own behalf, the deputy district attorneys can
15 cross-examine you and anything you say in response to any
16 questions, regardless of who asked it, whether it's your
17 attorneys, the deputy district attorneys on cross-examination,
18 the Court, or one of the jurors, will be the subject of fair
19 comment by the deputy district attorneys in their closing
20 arguments.

21 Also, if you choose to take the stand and testify
22 and you have been previously convicted of a felony crime
23 within the past ten years or discharged your sentence of
24 parole, probation, or imprisonment within the past ten year,
25 the deputy district attorneys can question you about that.

1 And I don't believe that pertains to Dr. Desai; is
2 that correct?

3 MR. STAUDAHER: That is correct, Your Honor.

4 THE COURT: All right. Conversely, you have the
5 right not to take the stand and testify. And should you
6 choose not to testify, the deputy district attorneys are
7 forbidden from commenting upon that in their closing
8 arguments.

9 Also, and I believe Mr. Wright and Ms. Stanish have
10 asked the Court to give this instruction, and the Court will
11 do it if requested, that tells the jury that it is a
12 constitutional right of a defendant in a criminal trial that
13 he may not be compelled to testify. That's the decision, as
14 to whether he should testify, is left to the defendant on the
15 advice and counsel of his attorney. You must not draw any
16 inference of guilt from the fact that he does not testify, nor
17 should this fact be discussed by you or enter into your
18 deliberations in any way. Do you understand those rights that
19 I've just gone over with you?

20 MR. WRIGHT: Yes.

21 THE COURT: Okay. And Mr. Wright, to the best of
22 your ability, you have discussed those rights with your
23 client, Dr. Desai, along with your co-counsel, Ms. Stanish; is
24 that correct?

25 MR. WRIGHT: That is correct.

1 THE COURT: All right. And I understand that Dr.
2 Desai is not going to be testifying; is that correct?

3 MR. WRIGHT: That's correct.

4 THE COURT: All right.

5 MR. WRIGHT: The [inaudible].

6 THE COURT: That's fine. Just one final thing. And
7 just, I think it's already clear on the record, but to the
8 extent that it may not be, you are requesting that the Court
9 give Instruction No. 33, inform the jury that it's the
10 constitutional right of a defendant in a criminal trial that
11 he may not be compelled to testify; is that correct?

12 MR. WRIGHT: That's correct.

13 THE COURT: All right.

14 MR. WRIGHT: Okay. Do the -- on the determination
15 not to testify, after Monday, maybe it was Tuesday -- yeah,
16 Tuesday noon when you were mentioning the -- right before the
17 noon hour, I started to address Dr. Desai about -- and I told
18 him this morning to look at you and I would like to explain
19 throughout the course of the trial what has transpired, and at
20 my instructions after jury selection commenced.

21 It is clear to me, I'm just telling you my
22 representations from me. I'm not getting into whether it's
23 right, wrong, as the Court says exaggerated or not
24 exaggerated, he has difficulty taking in if he multitasks,
25 look, listen, speak. If you just do one thing, like

1 concentrate on listening and not looking and mixing it up,
2 only listen, it goes in better was my understanding that we
3 worked out during jury selection.

4 And so he would sit either eyes closed, looking
5 down, or whatever. It's not that he can't see or anything.
6 He is simply concentrating exclusively on listening, and then
7 we would discuss it with him. Even with that, and those --
8 those efforts, like at the -- on Tuesday at the noon hour when
9 I discussed with him what had occurred here.

10 He was mixed up as to Dorothy Sims, a witness I had
11 called for the defense, you know, and why she testified that
12 syringes were used patient to patient at the clinic. Well, of
13 course, it wasn't at the endoscopy clinic. The testimony was
14 about a Maryland Parkway clinic. But the -- that didn't get
15 in by -- by -- I mean, that wasn't fully comprehended by Dr.
16 Desai.

17 And then there were discussions in the court about
18 the alternate jurors and who is still available, who may --
19 may -- who have pressing issues that may be a sitting juror,
20 may need to be excused. And all he -- he thought certain
21 jurors had been excused and replacements had taken place and
22 didn't understand. I am pointing that out because that's the
23 most recent efforts of me explaining to him and understanding
24 what was going on.

25 Based upon all of that, in my judgment, he is

1 incapable of testifying. His memory is not good for the five
2 and a half year ago past. He mixes up what has happened here
3 in the courtroom when I've talked with him. I do not have
4 transcripts of the proceedings to go over with him. It
5 probably wouldn't make any difference anyway, to tell you the
6 truth.

7 But his condition in assisting me, he's not able to
8 testify, his assistants, at times he has given me
9 misinformation is the way I would characterize it as opposed
10 to useful information that I am able to use. And essentially
11 his ability to assist has been the equivalent of him being
12 tried in absentee.

13 THE COURT: All right. Well, Mr. Wright, we're not
14 going to, you know, re-litigate the competency --

15 MR. WRIGHT: I understand.

16 THE COURT: -- issue here. More than an ample
17 record has been made on this issue before the case even was
18 transferred into this department. You know, what I noted when
19 we began, the admonishment the other day is that Dr. Desai's
20 posture was markedly different from the posture that I had
21 observed throughout the weeks of this proceeding, meaning, you
22 know, he was stoop shouldered and hanging his head in a manner
23 that I had not seen previously, and that suggested to me that
24 he was exaggerating through a physical manifestation, his
25 ability to comprehend, and that's what I said. And I still

1 believe that.

2 Now, today his posture is good. He is standing up
3 and he's looking at me. I've also, you know, looked over at
4 him in the trial. From time to time, you know, I catch his
5 eye, he catches mine, and then he immediately looks down.
6 Your -- you know, I believe that your representations that
7 you're making here today are well intentioned. But as I've
8 said in the past, your representations are only as good as the
9 information that's being imparted to you by your client.

10 And so you've made your representations on the
11 record. Again, we're not going to re-litigate this whole
12 competency issue. The Court has, in its view, made whatever
13 accommodations have been requested in terms of taking
14 recesses, you know, if we need to break so that you can confer
15 privately with your client, we've made the vestibule room
16 available so that you and Ms. Stanish can confer privately
17 with your client where we can't witness the discussions and
18 whether or not your client is communicating with you. I would
19 note that's not something that's ordinarily done in murder
20 trials or any other kind of criminal trials.

21 So I just -- I think the record is already clear as
22 to the numerous accommodations that the Court has made that
23 the Nevada Supreme Court indicated should be made, and we were
24 happy to make them. So I think -- you know, I just wanted to
25 put that on the record again, but I think that the record

1 already is abundantly clear and beyond what I've already said
2 we're not going to visit the competency issue again. I don't
3 know if the State wants to place anything on the record at
4 this time.

5 MR. STAUDAHER: No, I think I would submit it, Your
6 Honor.

7 THE COURT: All right. Is there any --

8 MR. WRIGHT: I was just -- I was just giving an
9 explanation. He was caught cold Thursday after -- before the
10 noon hour. I had not discussed with him the issue even coming
11 up. So, I mean, when he did get up he was caught by surprise.

12 THE COURT: Okay.

13 MR. WRIGHT: Thank you.

14 THE COURT: All right. The final issue, then,
15 concerns Juror No. 1. And I will give the defense the option
16 because of some of the concerns that were expressed mid-trial
17 by Juror No. 1 that had not been expressed during jury
18 selection. If you would like Juror No. 1 to be made an
19 alternate, as I previously said, the Court is not going to
20 shuffle the alternates. The alternates come in order. So the
21 next alternate would be, I believe, the gal in Chair 14.

22 MR. SANTACROCE: Your Honor, I'm going to -- if I
23 have made an objection to Ms. Pomykal in the past, I'm going
24 to withdraw it. I think her other issues are moot at this
25 point.

1 THE COURT: Right. Her other issues are moot and --
2 the health -- meaning the health issues. And as you know, we
3 made it quite plain to her, and my bailiff has been, I think,
4 attentive not just to her but to all of the jurors to make
5 sure that there were no problems that she would need a break
6 or need to see a physician or anything like that. So there
7 haven't been any further problems in that regard.

8 MR. SANTACROCE: So we will withdraw any objection
9 if we made one. I think she should sit as a regular juror.

10 THE COURT: All right. Is that also true for the
11 defense, Mr. Wright?

12 MR. WRIGHT: Yes. Knowing who the alternate is, I
13 think the medicine is worse than the cure. So --

14 THE COURT: That's your -- that's your decision. As
15 I said, you know, we knew at the outset of jury selection that
16 the alternates would be placed in numerical order and we don't
17 change the order of the alternates, unless there is some new
18 issue with a health issue or something like that with an
19 alternate.

20 Those are the only remaining matters that I can
21 recall. Is there anything that we need to address from the
22 State's perspective?

23 MR. STAUDAHER: No, Your Honor, at this time.

24 THE COURT: Is there anything else we need to
25 address from the defense perspective?

1 MR. WRIGHT: No, Your Honor.

2 THE COURT: Mr. Santacroce?

3 MR. SANTACROCE: No, Your Honor.

4 THE COURT: All right. What we're going to do, as I
5 believe all the jurors are now here, we'll take just a couple
6 of minutes for a break. And then when we come back in Kenny
7 will bring in the jury and the defense can rest, and we'll
8 proceed with reading the jury instructions.

9 (Court recessed at 9:34 a.m., until 9:41 a.m.)

10 (Inside the presence of the jury.)

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

16 Defense, Mr. Wright?

17 MR. WRIGHT: We rest.

18 THE COURT: All right. Thank you.

19 Mr. Santacroce?

20 MR. SANTACROCE: Defense rests.

21 THE COURT: All right. Does the State have any
22 rebuttal evidence?

23 MR. STAUDAHNER: No, Your Honor.

24 THE COURT: All right. Ladies and gentlemen, that
25 concludes the presentation of evidence in this case. As I

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1 told you at the outset, that is followed by the instructions
2 on the law, which I shall read to you in a few moments. After
3 the instructions on the law are read to you, the attorneys
4 have the opportunity to make their closing arguments. Because
5 the State has the burden of proving this case, they both open
6 and close the closing arguments.

7 It is important that I read to you these written
8 instructions exactly as they are written. I am precluded from
9 trying to expound upon them or clarify them in my own words in
10 any way. You will have a number of copies of these written
11 instructions back in the jury deliberation room with you so
12 that you can refer to the written instructions during your
13 deliberations. You will also have all of the exhibits that
14 were admitted into evidence back in the jury deliberation room
15 with you. The instructions are all numbered for your
16 convenience.

17 (Jury instructions read by The Court.)

18 THE COURT: Ladies and gentlemen, that concludes the
19 instructions on the law.

20 Is the State ready to proceed with their closing
21 argument?

22 MS. WECKERLY: Yes, Yes.

23 MR. WRIGHT: May we approach for a moment?

24 THE COURT: Approach?

25 MR. WRIGHT: Yes, Your Honor.

1 THE COURT: Sure.

2 (Off-record bench conference.)

3 STATE'S CLOSING ARGUMENT

4 MS. WECKERLY: Good morning. The crimes that are
5 charged that relate to patient care in this case, which are
6 performance of an act in reckless disregard of persons or
7 property or criminal neglect of patients, those are crimes
8 that are actually classified under the Nevada revised statutes
9 as crimes against the public health or crimes against public
10 safety because the County or the State has an interest in
11 ensuring that the public doesn't get reckless treatment from
12 the healthcare providers.

13 No one in this courtroom is on trial for not
14 following the highest gold standards of the CDC. The
15 Endoscopy Center of Southern Nevada certainly fell far below
16 that on several fronts. There was bad scheduling, there was
17 bad charting, patients were rushed through that were not here
18 because someone didn't get a blanket in recovery, that are not
19 here because someone had to wait a long time before their
20 procedure happened, and were not even here because of bad
21 charting or bad care overall.

22 We're here because nine people were the victims of a
23 gamble taken by the healthcare providers at the center. And
24 the people that lost the gamble were the seven named victims
25 in this case and the two other individuals that you heard

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1 about that contracted hepatitis C on September 21, 2007. The
2 defendants gambled and the victims lost.

3 They fell below the lowest standard of care in
4 providing care to those individuals and they did it knowingly
5 and they did it recklessly. And when that happens the case
6 moves into a criminal realm.

7 Now, when you get into a criminal investigation,
8 things change a little bit. Things open up. With a criminal
9 investigation you no longer have the anonymity that might be
10 available in a Health District investigation. That anonymity
11 veil is pierced and people have more at stake once things are
12 out in the open.

13 Compromises people might have made you know, come to
14 light. Ethical breaches are inquired about. And maybe
15 behavior that people weren't that proud of because --
16 essentially becomes known. And criminal cases are conducted
17 on the record and out in the open, so they're different than a
18 healthcare or a Health District investigation.

19 And there's no doubt that the police were justified
20 in conducting an investigation in this case. We had nine
21 people in our community contract a communicable disease from a
22 healthcare provider, and that never, never should have
23 happened. The police investigation was thorough. It took
24 months and months.

25 They interviewed a bunch of people. They went back

1 and interviewed some if people wanted to offer additional
2 information. And that's to be expected. We shouldn't expect
3 our detectives to do any less than always interview, always
4 try to be collecting information, always be working on the
5 case. And they did that in this -- in this case.

6 Because this case sort of has two facets of
7 investigation, the healthcare investigation by the Southern
8 Nevada Health District, and the investigation conducted by the
9 police department, you will actually kind of see and assess
10 the -- the information that you know as a result of those two
11 investigations. And you're actually in a unique position in
12 this case because you see if there are any differences in what
13 people are willing to say anonymously versus what people are
14 willing to say to the police, if there's any difference at
15 all.

16 You will assess whether people are worried about
17 protecting their professional licenses, and you will be able
18 to assess if that is relevant at all. And you can weigh all
19 these motivations and all these factors of all the witnesses
20 that you heard throughout the presentation of this case.

21 Now, Ronald Lakeman and Keith Mathahs are the only
22 CRNAs who were charged criminally. They were the only CRNAs
23 who each treated a source patient, someone with known
24 hepatitis C, and they are the only CRNAs that perpetuated it
25 to the victims that you've come to know in this case. In that

1 regard they're unique among the CRNAs in terms of the lowest
2 quality of care they provided.

3 Now, Dr. Desai is the only doctor charged in the
4 case, as well. He's not being charged because he was a
5 capitalist or because he made a lot of money through his
6 clinic. He set the standards at the endoscopy center. He
7 made the environment at the endoscopy center what it was. He
8 directly advised to -- advised the CRNAs to engage in risky
9 behavior.

10 All of the treatment was done according to his
11 vision. He was in control. And there was a risk associated
12 in his methods administering healthcare. And that risk, you
13 know, ended up being very costly to nine individuals in 2007.
14 And he has to answer for that. And he's no longer able to
15 duck out of a press conference. He's in criminal court with
16 criminal charges with a jury assessing the charges against
17 him.

18 Now, when you go back to deliberate, you will have
19 all of the evidence that has been admitted in this case, and
20 it's all going to be available to you. You'll have all the
21 propofol log books. You can count up how much propofol was
22 checked out every day for the year. You'll have the procedure
23 log books. You can count up all those procedures. You'll
24 have the patient files of everybody, even the non-named
25 victims you'll have patient files.

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1 And you can look at all of that evidence and go
2 through it all and make sure you understand what happened in
3 this case and make sure you understand that the -- that the
4 evidence is what we're all saying it is and you can make your
5 own assessment as to the value you assign each piece of
6 evidence.

7 Now, in terms of the procedure log books there's
8 been some discussion about how many procedures were actually
9 conducted each day, what was the count? And a lot of the
10 employees came in and said, 'wow, there were like 80 procedure
11 that day or there were 70 procedures that day.

12 And whether that is accurate, whether it was 65 and
13 they remember 70, or whether, you know, it was 82 and they
14 remember, you know, 60 really doesn't matter. The point of
15 their recollections and the point of their testimony was they
16 felt really, really busy. They felt really busy at the place.
17 They had to cut corners on their charting. They had to move
18 people through quickly, and they had concerns about how
19 quickly people were being moved throughout the clinic.

20 The second consideration with the -- with the number
21 of patients that were treated each day relates, of course, to
22 the insurance counts. With that type of clinic and that type
23 of busy practice, it seems extremely unlikely that someone is
24 doing some leisurely interview in pre-op before a patient goes
25 under the anesthesia or is spending a particularly long time

1 with a single patient in recovery. So it relates to that, as
2 well.

3 Now, you heard about a lot of poor documentation and
4 poor charting, and that certainly is reflective of the number
5 of patients that were moved through and the inability of the
6 staff to sort of keep up with the case load. And it also sort
7 of coincides with the actual experiences of the victims in
8 this place.

9 Remember Stacy Hutchison? On the -- on the day of
10 her procedure she wakes up in the recovery room and no one is
11 around her and so she gets up and gets herself dressed and
12 gets to her car before someone tells her, hey, you need to
13 come back in here. So no one was watching her terribly
14 closely.

15 Or remember Mr. Sharrieff Ziyad? He was dizzy and
16 put in a chair, you know, moved off of his gurney because
17 apparently it was needed for someone else. And so he was left
18 to sit and let the medication wear off.

19 The overall point of this evidence was to show you
20 or illustrate for you that this was an assembly line where
21 profits were important, and it was volume over patient care.
22 So the question of do the doctors who weren't charged in this
23 case bear some responsibility regarding what happened? And
24 the answer is, yes, they do. But there is limitations and
25 constraints in every type of case and it's an imperfect

1 system. So the bottom line is they will not be prosecuted for
2 their -- their share of the responsibility.

3 Now, you heard from in this case literally the
4 world's expert on hepatitis C transmission, and Dr. Alter had,
5 in my view, a personality consistent with her credentials.
6 She was -- she had a big personality. But this wasn't just a
7 CDC investigation.

8 This case was also investigated by Detective Whitely
9 who was with us during the trial, and he doesn't have
10 necessarily the same personality as Dr. Alter, but both of
11 these investigations were extremely important in terms of what
12 evidence was presented to you during this trial. The case is
13 an epidemiological investigation, but it's coupled with a
14 regular general criminal investigation, as well.

15 And the evidence came to you that way in two forms.
16 Criminal investigations are a little broader. The Metro
17 detectives interviewed all employees, not just nurses, not
18 just doctors. They interviewed GI techs, they interviewed
19 people who were working in the office area to get a broader
20 sense of what was going on at the clinic.

21 And Detective Whitely sort of had to dig through all
22 the documentation, determine what was relevant, and untangle
23 it to a certain extent. And as jurors you'll have that same
24 -- same role, in a sense. You'll be assessing the evidence,
25 fitting it into different pieces, seeing how it corresponds to

1 the crimes that are charged.

2 Another difference is, of course, in a criminal
3 investigation it's sort of presented in a multifaceted way.
4 It's presented witness by witness by witness. It's a little
5 tedious. Each witness has a tiny piece of information, and
6 you hear it sometimes in a little bit of a disjointed manner.
7 And now you're called upon to look at it cohesively, put all
8 the pieces together.

9 Now, the Southern Nevada Health District and the CDC
10 and Miriam Alter explained that their focus when they came out
11 to investigate what happened at the clinic was on public
12 health, and rightly so. That is their responsibility. They
13 are charged with the public health.

14 And they go out, they identify the problem, they try
15 to figure out what's causing, they try to stop it, and they
16 want people to get tested as soon as possible. And all of
17 those people had substantial credentials in terms of disease
18 outbreak investigation. Certainly Dr. Alter did. And the two
19 -- the two doctors from the CDC, in her view, conducted the
20 epidemiological investigation in an appropriate way.

21 So they go out and they make an assessment about the
22 mode of transmission and they get their response together from
23 a public health perspective, and that is to make this
24 notification to people. But their -- their conclusions are
25 drawn very quickly.

1 And Brian Labus from the Southern Nevada Health
2 District, he's the one who was primarily in charge of the
3 investigation locally with the CDC. And this case,
4 interestingly or fortuitously or not fortuitously, sort of
5 plucked Mr. Labus from relative anonymity. Because nine cases
6 from a single clinic is something that wouldn't happen in
7 years. I mean, they could go years without someone getting
8 hepatitis C.

9 So this was an event that was going to garner a lot
10 of media attention one way or another. But the medical
11 attention was focused on Mr. Labus. He had a lot of scrutiny
12 over his results and how he was going to -- or how he did the
13 investigation. But he would have because of that scrutiny no
14 motivation whatsoever other than protecting the public health
15 and getting it right. He knew there was going to be scrutiny.
16 He had every reason to be very careful about the conclusions
17 that he drew during his investigation as to the source of
18 transmission.

19 And all of these years later, after all of the
20 review, his conclusions are the same. And Dr. Alter reviewed
21 his work and his conclusions, and she is -- concurs with his
22 findings that it was the unsafe injection practices with the
23 propofol that caused the transmission. And you all saw Dr.
24 Alter testify. She seemed like kind of a tough grader to me,
25 and if she didn't agree with something she would certainly not

1 hold back her opinion.

2 In fact, when she was testifying on the stand, she
3 did mention one statistic Mr. Labus had in his report that she
4 thought didn't make any sense, and she said so on the stand.
5 But overall she said the investigation was appropriate and
6 that she concurred with the conclusions of the investigation.

7 Now, the -- the sort of concurrent or complimentary,
8 you know, Metro investigation started a little bit after the
9 CDC and the Health District left the clinic in 2008. And some
10 of the premises or some of the aspects of the -- of both of
11 the investigations rely on some common facts or some -- some
12 factual givens that have to be present in order for the -- in
13 order to understand the mode of transmission.

14 And one of these is that the two source patients on
15 each day, on July the 25th and September the 21st both got
16 over 100 milligrams of propofol injected into them. And the
17 reason why that's important, as we all have learned, that only
18 10 cc syringes were used at the clinic. So if those two
19 individuals got more than 100 milligrams, at least another
20 syringe or at least another dose of propofol had to have been
21 given to them from a re-accessed vial.

22 If either of those people, Mr. Rubino or Mr. Ziyad
23 had only received 100 milligrams of propofol, there wouldn't
24 necessarily be any contamination of the vial, would there?
25 Because they would pull it out, it would have all fit in one

1 syringe, it would have been injected into the patient, and
2 there would be no possible means of contamination of the vial
3 because it would never be re-accessed.

4 And this is similar, actually, to -- to saline
5 injections which have been mentioned quite a bit through this
6 trial. There is no reason to ever re-access a saline vial.
7 Once the saline -- once the vein is flushed, no one goes back
8 and reflushes it again. But with the propofol it's different
9 because during the procedures patients need to be redosed as
10 the procedure moves along.

11 The other -- another give of both investigations is
12 how the -- I guess the scientific facts of how the disease
13 itself is transmitted, that it's a blood-borne disease. And
14 so there's a limited number of ways at the endoscopy center
15 that -- that it could have been transmitted. It had to be
16 through some sort of blood transmission.

17 So first, let's talk about the scopes. The scopes
18 were certainly eliminated by the CDC. And they did what they
19 called an epidemiological comparison between different
20 procedures on people and found no distinction between those
21 who got the disease and didn't get the disease based on the
22 scope, so it was eliminated as a factor for the CDC in terms
23 of a mode of transmission.

24 Now, the Metro investigation -- and, well,
25 incidentally, though, the defense expert that you heard from

1 two days ago, he also said a scope would be a really low, low,
2 low chance of causing transmission of hepatitis C. So we may
3 -- we may get agreement on that.

4 Now, the Metro investigation is maybe more fact
5 based, maybe more common sense. If you look at the patient
6 charts on September the 21st, and I'm sure you can all see
7 that really clearly, Mr. Rubino up here is the first patient.
8 The next patient is the Lakota Quannah and he gets infected.
9 We know he gets infected that day.

10 So unless the exact same scope was used, like
11 literally pulled out of Mr. Rubino, not taken to any cleaning
12 room and immediately used on Lakota Quannah, it can't be the
13 scopes. It wouldn't have been enough time to even clean the
14 scope to use it on Mr. Meana because the timing is just so
15 short and their process took so long.

16 So it wasn't effective cleaning of the scopes. They
17 were -- these -- these individuals didn't have the scope and
18 the cleaning wouldn't have been short enough in time to have
19 been used on the same people. So that can be eliminated from
20 sort of a fact based perspective, a little bit different than
21 how the CDC analyzes things.

22 And you also know from the testimony of Jeff
23 Krueger, and the review of the records of the clinic that the
24 Medivator was actually working on the infection days and there
25 was no indication that they were doing the hand washing or any

1 of those things before. So the scopes are pretty much
2 eliminated as a source of transmission.

3 So let's talk about biopsy forceps. This was one
4 thing the CDC also eliminated. And what they did was, of
5 course, compare people who got biopsies and people who didn't
6 get biopsies and see, well, you know, is there any difference
7 in who contracted it and who didn't based on biopsy forceps,
8 which is appropriate for an epidemiological investigation.
9 And they found no connection between the use of the biopsy
10 forceps and someone contracting hepatitis C. So from an
11 epidemiological perspective, that was eliminated.

12 Now, from a police prospective or from a more, I
13 guess, common sense perspective, if you look at -- this is a
14 close up view of July the 25th. We know Mr. Sharrieff Ziyad
15 was the first patient of the day. And Michael Washington
16 isn't the next person who actually got a biopsy. If you pull
17 patient file 3 and 4 you will see and you'll have those in the
18 deliberation room that they also got a biopsy, and they were
19 treated before Michael Washington and they didn't contract
20 hepatitis C. So the biopsy forceps can be eliminated as a
21 source of transmission, as well.

22 This was Dr. Carrol's idea, a rogue employee was
23 responsible, at least it was his theory at one time, for
24 infecting the people at the clinic. This one, this idea, was
25 pretty much eliminated early on because of the genetic link

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1 between the source patients on both days and the people that
2 ultimately got infected. It's sort of an impossibility that
3 someone could have gotten Mr. Rubino or Mr. Ziyad's blood and
4 randomly injected people. And the genetic relatedness
5 certainly dispels any idea that this could have been caused by
6 -- by a rogue employee.

7 So then here was the saline flush. Now, for the CDC
8 and the Southern Nevada Health District, their observations of
9 the pre-op area were enough to eliminate that as a source of
10 transmission. Because when they observed the nurses in pre-op
11 they didn't find any breach of aseptic technique. Everything
12 was done appropriately.

13 So what did the police bring to the table? What was
14 the result of the police investigation? Well, you saw and you
15 heard the testimony of Lynette Campbell. She -- the woman who
16 administered the hep-lock on several of the people who ended
17 up getting infected on September the 21st. And you heard her
18 describe step by step by step how it is that she administers
19 the hep-lock and what process she goes through.

20 You also heard her testify that she never breached
21 aseptic technique and that she never flushed the hep-locks
22 twice. And you can take -- you can, I guess, put whatever
23 weight you want as to her testimony. She was a brand new
24 nurse. This was her first job. She had every reason in the
25 world to want to do things correctly. And when she was

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 Moreover, there was the mailing that you saw from
18 the CRNA professional association which was the warning, don't
19 engage in this practice, do not do this, this is a dangerous
20 practice that Mr. Lakeman should have gotten. That was in
21 2002 that that came out. These individuals also historically
22 lived through the identification of hepatitis C
23 scientifically.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 I mean, Ralph McDowell testified that in 2008 it was

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And you also know from his conversations with Tonya

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 Ladies and gentlemen, before we move into the
22 closing arguments for the defense we're going to take a brief
23 recess. Obviously, the case is not over so I must, again,
24 remind you of the admonition not to discuss the case or
25 anything relating to the case with each other or with anyone

1 else. You're not to read, watch, or listen to any reports of
2 or commentaries on the case, person or subject matter relating
3 to the case. And do not form or express an opinion on the
4 trial.

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

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

8 (Inside the presence of the jury.)

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

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

13 MR. WRIGHT: Yes.

14 THE COURT: All right. Thank you.

15 DEFENDANT DESAI'S CLOSING ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 wrongdoing.

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

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

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

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

1 minutes.

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

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

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

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

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

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

10 And Lawrence Preston testified that if you hired
11 anesthesiologists, if you can get some that would come to work
12 there like for a salary, anesthesiologists get to bill more.
13 CRNAs have a reduced factor. I think he testified it was like
14 85 percent. So if you hired anesthesiologists, their bills
15 get paid higher. The question would be would they work
16 independently and put in their own bills and keep the money,
17 or should the clinic hire them and bill them out and just pay
18 them a salary?

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

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

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

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

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

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

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

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

12 And so Tonya Rushing set up the billing company,
13 taking over for Lawrence Preston. And Tonya Rushing was like
14 90 percent owner, and this lady did it for 18 months and then
15 she said this is -- I'm not doing it anymore. And Tonya took
16 it over and said I will do it all myself, and she hired
17 individuals and the billing company continued as it had -- as
18 it had been doing on their merry way.

19 And it -- and it continued on their merry way up
20 until what we've heard was the Rexford case, and that's the
21 testimony of Dr. Clifford Carrol. Because what happened in
22 2007 was there was civil litigation. A patient named Rexford
23 sued Dr. Carrol because of whatever happened on the procedure.
24 And during the discovery, in the fall of 2007, in
25 January/February of 2008, and it just so happened to coincide

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

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

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

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

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

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

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

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

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

6 Because at that point Tonya Rushing said she
7 researched it and looked into it. Whether she called the
8 insurance companies or who, I don't know. But from that day
9 forward, the billings changed. And this is like in February
10 2008 is the testimony of, I think, Dr. Carrol and Tonya
11 Rushing. However you recall it, it is.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 If we use those times in brown, brown would be
16 Lawrence Preston, yellow would be ultra conservative billing
17 purposes, like face to face time, ignoring everything else, if
18 we use Lawrence Preston time, you can see it's 26, 29, 20, 34,
19 32, 45, 41, 39, and 36 minutes. Those are the actual times.

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

1 should be the correct way.

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

11 Doing the same for each of these, Mr. Meana, one,
12 \$32.80, or \$16.40. These will be the amounts that go right to
13 a specific count in the indictment alleging a false fraudulent
14 overbilling.

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

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

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

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

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

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

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

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

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

4 MR. STAUDAHNER: That's what it would be.

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

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

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

20 THE COURT: All right.

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

25 THE COURT: Can I see counsel at the bench.

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1 (Off-record bench conference.)

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

8 Do not discuss this case or anything relating to the
9 case with each other or with anyone else. Do not read, watch,
10 or listen to any reports of or commentaries on this case, any
11 person or subject matter relating to the case. Don't do any
12 independent research by way of the internet or any other
13 medium. And do not form or express an opinion on the trial.

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

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

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

19 (Off-record bench conference.)

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

21 (Outside the presence of the jury.)

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

24 THE COURT: It was wrong.

25 MS. STANISH: Yours was changed.

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

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

6 THE COURT: -- fine with the change.

7 MS. STANISH: I just wanted to make sure.

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

10 MS. STANISH: Good cover.

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

15 (Pause in the proceedings.)

16 (Inside the presence of the jury.)

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

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

21 MR. WRIGHT: Thank you.

22 DEFENDANT DESAI'S CLOSING ARGUMENT (Continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

1 how does that cause the transmission of hepatitis C?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 caregivers.

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

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

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

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

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

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

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

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

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

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

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

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

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1 inspections.

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

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

14 THE COURT: All right. Yeah.

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

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

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

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

1 All right. Go on, Mr. Wright.

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

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

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

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

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

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

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

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

1 them what their choices are.

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

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

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

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

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

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

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

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

1 in here contrary to her statement.

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

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

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

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

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

4 And of course her problem was she fabricated this
5 story about 50 cc vials, and she specifically remembered and
6 told the police that Ron Lakeman would take and fill up from a
7 50 cc vial with a spike and that's the way he did it. And
8 this all took place when she went to work in August of 2005.

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

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

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

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

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

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

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

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

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

8 Here -- here are the witnesses that have testified
9 and the number -- number of procedures per day. Every one of
10 these, you go by your recollection of these, but daily patient
11 numbers per witnesses. Jean Scambio said 65 to 70 patients
12 per day through Shadow Lane. Keith Mathahs, 65 to 80 per day.
13 Daniel Sukhdeo, 65 to 80 per day. Dr. Eladio Carrera, 70 to
14 80 per day. Marion Vandruff, 70 to 72 minimum per day.
15 Pauline Bailey, 60 to 70. Vince Micne, 70 to 80. Ralph
16 McDowell, 60 to 70. Vince Sagendorf, 70 to 75. Johnna Irvin,
17 80 to 90.

18 And all of this while we're having this
19 orchestration, this drumbeat of assembly line out of control,
20 too many patients, how many can you do in an hour? And the
21 entire time they have every -- every single record book, every
22 single patient on every single day. And they have done the
23 math and they knew the numbers. And they knew for 2007 it is
24 59 patients per day average. They know that the highest
25 number that had ever been through the clinic was 76 on a day.

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

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

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

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

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

3 Is that her name, Marie?

4 MS. STANISH: Ann Marie.

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

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

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

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

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

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

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

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

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

7 And then once again, they -- the State has the
8 evidence. They have all of the computers. They subpoenaed
9 all of the records. They know what every vial of propofol
10 costs. And they know from 2004 until the clinic closed in
11 2008 that the price never varied at all between 20s and 50s.

12 A 50 costs two and a half times a 20, right to the
13 10,000th of a cent. Well, on two occasions 50s were cheaper.
14 So there was absolutely none of this motive to save money by
15 going to 50s that the State said in their opening. And then
16 they affirmatively put on evidence by which you could infer
17 that.

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

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

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

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

25 Mr. Mione absolutely always denied that and even

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

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

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

10 A Uh-huh.

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

13 A The specifics of each step?

14 Q Uh-huh.

15 A No, I could not repeat them to you.

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

19 A No.

20 Q You're not aware of that?

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

25 Q Are you anticipating where I'm going?

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

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

8 A Yes, I am.

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

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

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

18 A I can't.

19 Q -- of the article.

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

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

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

24 MR. SANTACROCE: She was trying to dispute --

25 THE COURT: Well, okay --

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

2 THE WITNESS: No, I am not.

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

5 THE WITNESS: Sorry.

6 THE COURT: That's okay.

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

12 THE WITNESS: I'm sorry. Okay.

13 THE COURT: All right.

14 BY MR. SANTACROCE:

15 Q Have you read the background information?

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

18 Q Well, let me --

19 A The importance --

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

22 A No, I don't remember.

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

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

1 page.

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

4 A Yes.

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

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

9 Q What does it say on the bottom.

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

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

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

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

21 A Two.

22 Q And a source patient; correct?

23 A Presumably. I didn't get that far.

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

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

3 A If that's what it says.

4 Q Well, ma'am --

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

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

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

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

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

21 Q Are you saying these investigators weren't
22 competent?

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

25 Q Well, you said only according to these

1 investigators.

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

13 And I will tell you that when we went to New York in
14 2001, the New York Times, before we even arrived had already,
15 of course, heard about it. And the first thing they -- they
16 interviewed somebody, an expert, whatever, and whose first
17 comment was they're not disinfecting the scopes properly, it's
18 the scopes, it's the scopes. I heard that for a year before
19 we were convinced, you know. So there actually is no
20 documentation that the scopes are directly associated with
21 infection. It has occurred in that setting, but that does not
22 in any way -- as the authors themselves admit, they can't
23 distinguish between the two. They just buried it in the
24 discussion.

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

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

11 MR. STAUDAHER: Diathermic.

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

14 BY MR. SANTACROCE:

15 Q The loop were not autoclaved after each use.

16 A Autoclaved? They're never --

17 Q Now, it says --

18 A -- autoclaved.

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

24 A Yes, I do.

25 Q And you disagree with the authors of this

1 article?

2 A No. Read the discussion.

3 Q I have read --

4 A I'm sorry.

5 Q -- the discussion.

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

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

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

13 Q Okay.

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

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

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

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

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

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

10 A Okay.

11 Q Okay.

12 A Uh-huh.

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

21 A I didn't say that.

22 Q Okay. What did you say?

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

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

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

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

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

17 A No.

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

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

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

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

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

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

7 Q I'm talking about reusable ones.

8 A Well, I understand it was --

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

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

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

16 BY MR. SANTACROCE:

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

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

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

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

8 A Well, you're saying --

9 Q I said reused.

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

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

14 A No, you said reusable biopsy forceps --

15 Q Okay.

16 A -- were being reused.

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

19 A I saw it stated --

20 Q -- came to your conclusion?

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

23 Q Were you --

24 A So I saw it in the report.

25 Q Were you aware as to how those biopsy forceps

1 were being cleaned?

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

4 Q How do you know that?

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

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

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

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

16 A Uh-huh.

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

19 A Uh-huh. Yes.

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

23 A Yes.

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

1 A It was in the report.

2 Q And so you were aware of that?

3 A Yes.

4 Q Okay. Were you --

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

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

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

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

13 A I don't know.

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

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

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

21 A Biopsy --

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

23 A Anything --

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

1 mean?

2 THE WITNESS: That's correct.

3 THE COURT: Okay.

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

7 BY MR. SANTACROCE:

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

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

11 Q Okay.

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

13 Q How do they need to be cleaned?

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

18 MR. SANTACROCE: Well, the jury can --

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

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

24 THE COURT: Okay. Just ask your question.

25 BY MR. SANTACROCE:

1 Q How are reusable biopsy forceps cleaned?

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

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

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

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

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

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

13 A Yes, it is.

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

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

19 Q Okay.

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

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

1 THE COURT: I -- and --

2 THE WITNESS: I won't even -- okay. I won't go
3 there.

4 THE COURT: No, I was just going to say this --
5 you're not the first witness in this trial that I've told this
6 to, but you don't get --

7 THE WITNESS: It's okay.

8 THE COURT: -- you don't get to ask questions.

9 THE WITNESS: Okay. My purpose is looking at the --
10 not only that information, but the epidemiological stuff.

11 BY MR. SANTACROCE:

12 Q No, I didn't ask you a question.

13 A Yes, of course you didn't.

14 THE COURT: And Mr. -- I know this is your first
15 time testifying. Mr. Staudaher has an opportunity after Mr.
16 Santacroce is done to come back on redirect examination. And
17 at that point he can -- you know, if he thinks you need to
18 clarify something, expound on an answer you've given to either
19 Mr. Wright or Mr. Santacroce, Mr. Staudaher will, you know --

20 THE WITNESS: Okay.

21 THE COURT: -- ask you to do that at that time.

22 THE WITNESS: Thank you.

23 BY MR. SANTACROCE:

24 Q Now, when Dr. Fischer and Langley testified,
25 after reviewing all of the evidence that's been -- well, I'm

1 not going to say she reviewed all of the evidence, but she
2 reviewed Exhibit 156. And after reviewing this chart, her
3 conclusion was that in order for their theory that the
4 infection was transmitted through unsafe injection practices
5 that the propofol bottle, the infected one, had to be moved
6 from room to room to room. Now, what I'm going to show you,
7 do you know what this chart represents?

8 A Yes, I think so.

9 Q Okay. Well, tell me what your understanding
10 of this chart is.

11 A The line listing of the patient procedures for
12 that day.

13 Q Okay. Do you know what the orange color is?

14 A There's a key at the top of the page.

15 Q I didn't notice that before.

16 A A legend.

17 Q Thank you.

18 A Yeah, well, it's usually helpful when reading
19 a chart.

20 Q It is. Okay. What is it?

21 A They're known hepatitis -- they were known to
22 be infected with hepatitis C virus before they were a patient
23 in this procedure.

24 Q Okay. So -- and you testified earlier you
25 didn't know how many rooms -- procedure rooms were at the

1 clinic at the time you reached your conclusion. I'll
2 represent to you there were two. Okay? So the orange colored
3 guy is the source patient; correct?

4 A He is known to be HI -- he is known to be HCD
5 positive --

6 Q Okay.

7 A -- prior to his -- he's a potential source
8 patient, yes.

9 Q Okay. And he is in Room 1. Okay?

10 A Uh-huh.

11 Q And then we go down to Room 2, it's divided by
12 this line here, and we some more infected patients. Okay?
13 Are you with me so far?

14 A Uh-huh.

15 Q Now, what I want to ask you is -- and we'll
16 have to go by the color of the lines here because this machine
17 isn't big enough to get it all in. But can you tell me,
18 according to the nurse's log, what time the procedure started
19 for the guy in orange?

20 A Well, I didn't generate this chart, and the
21 times are, in my understanding, is inaccurate. If I could
22 read it, I would tell you. But I also know the times overlap
23 and they couldn't possibly be accurate because all of those
24 times together make up more than 24 hours.

25 Q Okay. Can you just --

1 A That's the only thing --
2 Q -- tell me --
3 A -- I can answer.
4 Q -- the answer to the question I asked you?
5 What time, according to the nurse's log, did the guy in orange
6 start the procedure? Can you see it?
7 A I can -- I can see the screen, I just --
8 THE COURT: Can you read it? Is it big enough for
9 you to read?
10 THE WITNESS: It's big enough for me to read. I
11 have not focused on this chart because it wasn't --
12 THE COURT: I have a question. Was this chart given
13 to you ahead of time for you to look at?
14 THE WITNESS: A few weeks ago.
15 THE COURT: A few weeks ago.
16 THE WITNESS: Yes, it was.
17 THE COURT: Okay.
18 THE WITNESS: It was given to me in early May.
19 THE COURT: Okay.
20 THE WITNESS: But I really didn't look at it because
21 my expertise was really based on what had -- this is just
22 revisiting it in a visual form.
23 THE COURT: In a different format.
24 THE WITNESS: That's right.
25 THE COURT: Okay.

1 THE WITNESS: And it was already based on the
2 epidemiological studies that have been done. Now, the issue
3 is, let's see, the earliest time seems to be --

4 BY MR. SANTACROCE:

5 Q The nurse's log --

6 A -- nurse --

7 Q -- what time --

8 A -- 9:49.

9 Q -- does that say.

10 A Is that what you're talking about?

11 Q And what time did the procedure end?

12 A 10:00.

13 Q And drop down to Ms. Hutchinson. What time
14 did her procedure start?

15 A Is that 9:55.

16 Q And what time did it end?

17 A 10:04.

18 Q So at least according to the nurse's log, the
19 source patient was undergoing a procedure in a different time
20 in a different room at the same time an infected patient was
21 infected in a different room by a different CRNA.

22 A If I -- according to that, yes.

23 Q Okay. Now, I want to talk about the
24 preoperative procedures that you reviewed in coming to your
25 conclusion. What was the preoperative procedures at the

1 clinic regarding the starting of heplocks?

2 A They usually were started by nurses in the
3 pre-op room before the patient went to the patient bay for
4 movement into the procedure room --

5 Q And were that --

6 A -- and --

7 Q I'm sorry. If you weren't done, I apologize.

8 A And my understanding from the report, the
9 report stated that after they inserted the heplock, the
10 nurses, these are not the CRNAs, but the nurses who usually
11 put in the heplocks would flush the heplock to make sure it
12 was clear with saline from a multi-dose vial.

13 Q Okay. And were you aware -- you obviously
14 were aware because you said it was a multi-dose vial; correct?

15 A Yes.

16 Q So you were aware that they were reusing that
17 saline on multiple patients?

18 A Yes.

19 Q Which is a practice you've already testified
20 to is a no-no.

21 A We -- yes, that is correct. However, not in
22 that vacuum.

23 Q Okay.

24 A You're doing it --

25 Q What's the --

1 A -- in a vacuum.

2 Q -- vacuum?

3 A The vacuum is they didn't reuse their needles
4 or syringes. They only did one flush.

5 Q How do you know that?

6 A They said so and they were observed to do so.
7 And unless you don't believe that's accurate --

8 Q Was Lynette Campbell observed?

9 A I don't know the names of anyone.

10 Q Well, let's show you Exhibit 166. This is the
11 chart -- this is the Endoscopy Center of Southern Nevada
12 hepatitis C transmission, September 21, 2007. These are the
13 -- this is the source patient, infected patients in Room 1,
14 and infected patients in Room 2. And this is the person that
15 started the heplock on source patient, and Mr. Meana,
16 Orellana, Martin, and Huynh. She also started the heplocks on
17 Aspinwall and Grueskin. She shared the pre-opinion room on
18 that day with Nurse Jeff Krueger who testified that they used
19 multi-dose vials of saline in the same room. Okay?

20 A Uh-huh.

21 Q Were you aware of this information when you
22 reached your conclusion?

23 A Yes, I was aware they were using multi-dose
24 vials of saline, which is not the --

25 Q Are you aware of any studies that link

1 contaminated saline to hepatitis C outbreaks?

2 A Yes.

3 Q Can you tell me about those?

4 A In one case the individual responsible for
5 administering the saline would draw blood for collection for
6 laboratory testing from the -- from the person's IV or
7 heplock, and then using the same syringe, maybe change the
8 needle, I can't remember, would go into a 500 cc in this case,
9 it was a large bag of saline, and withdraw saline to flush the
10 heplock, and then went on. So the bag of saline was
11 contaminated by the blood in the syringe from use on that
12 person's heplock. So that's one instance.

13 Q And you --

14 A There's another one. I'd have to think.

15 Q You already testified that you don't need to
16 actually see the blood for it to be contaminated; correct?

17 A That's correct.

18 Q Are you -- are you familiar with the CDC's
19 report of hepatitis B and C outbreaks in 2008?

20 A Have I seen this particular chart?

21 Q No, I said are you aware of the outbreaks that
22 they --

23 A Yeah. Yes.

24 Q Let's look at the bottom one here.

25 A Okay.

1 Q Are you aware of this study in North Carolina,
2 or this outbreak in North Carolina?

3 A I'm aware that it occurred

4 Q 1200 people notified, 5 people contaminated,
5 and what the CDC declared or determined was the mechanism of
6 transmission was reuse of syringes which contaminated 30 cc
7 saline vials -- whoops -- saline vials for IV catheter
8 flushes.

9 A Uh-huh.

10 Q Are you aware of that study?

11 A It's occurred on other occasions.

12 Q So contaminated saline is certainly a possible
13 mechanism for transmission?

14 A It certainly is. Any vial containing -- how
15 did they infusate? Is that the word that was used in the
16 report, infusate?

17 Q I'll have --

18 A I know it's --

19 Q -- to defer to --

20 A -- a funny word.

21 Q -- Mr. Wright --

22 A But it's liquid.

23 Q -- because he uses --

24 A Liquid in a --

25 Q -- those big words. I don't.

1 A -- vial. Liquid in a vial. That becomes
2 contaminated, can serve as a source for transmission. It
3 doesn't have to be propofol. It can be anything.

4 Q Anything.

5 A That's right. That's why you have to do a
6 very good epidemiological investigation. And the problem is
7 that when you only -- if you only have one or two infections,
8 determining how that might have occurred can be very difficult
9 to link a specific source because you don't have the numbers
10 to analyze. So you have to look at all the possible ways.
11 And the issue here is the protection of public health and not
12 your trial.

13 Q Thank you.

14 A You're welcome.

15 Q When Mr. Wright asked you about the two
16 infection dates and don't they stand alone, and I don't know
17 what his exact question -- I don't remember the exact
18 question, but do you remember that line of questioning where
19 he talked about July 25th being separate and how do you link
20 the two dates or something of that nature? Do you remember
21 that testimony?

22 A That's not quite how I remember it, but I do
23 remember the general area of questioning.

24 Q Okay.

25 A Like there were 362 other days.

1 Q Okay. So I believe you testified that because
2 the clinic was using unsafe practices on the 21st of
3 September, 2007, it can be inferred that that was the
4 mechanism of transmission for July 25th. Is that accurate?

5 A Yes.

6 Q Finally we agree. Then you said something,
7 and I wrote down in quotes, you can't prove it. What did you
8 mean by that?

9 A I can't show you that the virus was in the
10 vial and transmitted to the infected patient, newly infected
11 patient because you only have the source and the patient, the
12 one infected patient. However, we've seen that on multiple
13 occasions. And --

14 Q I'm done with that. Let's move on. Let's
15 talk about the effect that hepatitis C has on -- on the liver
16 itself, okay. And I didn't get an answer to this question.
17 Mr. Wright asked you -- talked to you about Mr. Perrillo. I
18 don't think he was a medical doctor, but I think he was a
19 neuropsychologist. And then he did 19 cases and said that
20 there was hepatitis C caused dementia in -- in people. And I
21 think Mr. Wright asked you do you agree with that theory, and
22 I didn't actually get an answer to that. Can you tell me if
23 dementia is caused --

24 A Well, I don't agree with it based on the
25 information that was provided to me, and I'm unaware of any

1 other literature, you know, looking -- evaluating that
2 relationship.

3 Q So it's your opinion that hep C doesn't
4 cause --

5 A I have no data to show. I know of no data to
6 show that hepatitis C causes dementia.

7 Q Does hep B cause cirrhosis of the liver?

8 A It can, but -- it can.

9 Q And I believe you testified as to the range of
10 time the onset of cirrhosis can occur; right? I think you
11 said the average was 20 years.

12 A Yes.

13 Q And I believe you made probably the most
14 profound statement of the day. Bad data in, bad data out. Is
15 that accurate?

16 A That is very accurate.

17 Q That's all I have, ma'am. Thank you.

18 THE COURT: All right. Mr. Staudaher, redirect.

19 REDIRECT EXAMINATION

20 BY MR. STAUDAHER:

21 Q Based on your review of everything, does it
22 look like bad data in?

23 A No.

24 Q Based on all of those questions that were
25 provided to you, the reports you've looked at, have you

1 changed your opinion at all?

2 A No.

3 Q Now, I want to show you the article that
4 counsel referenced, and this is the one that you talked about
5 the New England Journal of Medicine article. And this is back
6 in '97; correct?

7 A Yes.

8 Q So 20 years ago?

9 A Yes.

10 Q Okay. Go ahead and look at that section that
11 you were talking about. And this is, if I understood you
12 correctly, a sample size of two patients.

13 A And one source.

14 Q And one source.

15 A Uh-huh. The possibility that HCV was
16 transmitted because of inadequate procedures and the use of
17 anesthesia should also be considered. To be fair, they go on
18 to say we believe this route of transmission is less likely.
19 Because the intravenous tubing and all the syringes containing
20 the anesthetic drugs were changed after the first procedure.
21 But they did not -- they don't refer to the vial of
22 medication, only the tubing and the syringe and needles, which
23 in most -- all of the outbreaks that were investigated, all of
24 them -- well, not all of the outbreaks. Some were reused
25 between patients. But in most instances the needle and

1 syringes are discarded, but the contamination of the vial has
2 already occurred.

3 But then they go on to say, however, inadequate
4 procedures were followed during -- inadequate procedures were
5 followed during the other two procedures. Only the
6 intravenous tubing and the needles were changed between the
7 endoscopies of Patients 2 and 1. They -- so they go on for an
8 entire paragraph about the potential of unsafe injection
9 practices as a -- as a potential reason for this to have
10 occurred, even though they focus and feel it's less likely,
11 these authors, they focus on the scope as the mechanism, a
12 poorly disinfected scope.

13 Q Now --

14 A But if you read the discussion, to me, they
15 were unable to evaluate either of them. Both of them were
16 bad. They had problems. There were deficiencies in both
17 procedures, the intravenous administration of anesthetic, and
18 the high level disinfection of the scopes.

19 Q Now, with regard to the article that Mr.
20 Wright asked you about, and that was the injection practices
21 among clinicians in the United States, that one.

22 A Yes.

23 MR. STAUDAHNER: And I'm going to move for admission
24 of this document based on doctrine of completeness at this
25 point. Sections -- whole sections were read out of the

1 document.

2 MR. WRIGHT: Objection.

3 THE COURT: That's -- the document is not admitted.

4 You certainly, Mr. Staudaher, are free to ask questions from
5 that document as the defense did.

6 BY MR. STAUDAHER:

7 Q The sample size in this was much larger than
8 that other study; correct?

9 A Well, this isn't an outbreak. This is a
10 survey.

11 Q Oh.

12 A I didn't get the number -- isn't it? It's a
13 survey of practices?

14 Q Well, let me bring it up to you.

15 A Sorry. I'm sorry.

16 Q It's okay.

17 A Maybe I misunderstood --

18 Q I want to make sure.

19 A -- what you were talking about.

20 Q It's the first time I've seen it, too.

21 A Oh, yeah. It's a survey, and there are
22 several of them that have been done now, one by CMS. Those
23 are the -- you know, it's the old -- CMS, Center for Medicare
24 and Medicaid.

25 Q Services.

1 A Yeah, services. What did it used to be
2 called? I can't remember. So this was a survey of -- oh,
3 they had 8,000 respondents. That's pretty good, actually. A
4 fairly high response rate. That's what I wasn't sure of. And
5 they asked them, you know, the questions about how they --
6 about their injection practices.

7 Q Now, specifically on the other side here where
8 it breaks down who responded, do you see that?

9 A Uh-huh. Yes.

10 Q How many CRNAs responded out of all those
11 8,000?

12 A 49.

13 Q Okay. So there -- where the sample size of
14 CRNAs out of this was -- it says 1 percent --

15 A Uh-huh.

16 Q -- roughly.

17 A Yes.

18 Q I'm not sure how they -- they quite get that
19 when it's only an 8,000 sample size.

20 A Because not 8,000 people responded.

21 Q Oh, okay.

22 A The survey they -- oh, well, no. It says
23 8,000 respondents. Oh, they had to have answered yes to the
24 first item in the survey in order to be considered for the
25 rest of the survey.

1 Q Okay. What was the first item?

2 A The first item. I knew you were going to --
3 that was coming next. Okay. Actually, they don't know how
4 many people -- I don't know the denominator. So they don't
5 know the number. It was published on the web, and individuals
6 were -- professionals were asked to respond to the survey. It
7 was anonymous, and so they don't know how many. It was the
8 combined membership of ten collaborating organizations and
9 they had a total of 8,000 responses. All respondents were
10 asked three general questions. In your current practice do
11 you prepare or administer parenteral medications, injectable
12 medications. You had to answer yes to that in order to then
13 be analyzed for the other.

14 Q So if I understand correctly, at least from
15 that large --

16 A That's right.

17 Q -- 8,000, we drop it down almost in half just
18 by that -- answer to that question; is that correct?

19 A I guess that's what --

20 Q Is it 49 out of --

21 A I'm surprised they don't have the n in the
22 title.

23 Q If 49 nurse anesthetists responded and that's
24 1 percent, that means the total of respondents that actually
25 fall in this category would be 4,900, would it not?

1 A Oh, don't you just love scientific articles?
2 They have very long footnotes. Total frequencies vary. Some
3 respondents did not answer all questions, etcetera, etcetera,
4 etcetera. So the actual number, the total number who answered
5 the question, like the 49 out of the number of people who
6 answered the question and were considered eligible and
7 answered the question.

8 Q And the section where Mr. Wright asked you
9 under this -- under -- under the title for this heading in
10 this --

11 A Uh-huh.

12 MR. STAUDAHER: And this is, for counsel, page 791.

13 BY MR. STAUDAHER:

14 Q Question, basically, did you enter a single
15 vial more than once for the same patient? And they're talking
16 about how many respondents reported that that had been done.
17 In this case it was a total of 30.2 percent of 1599
18 respondents. When asked why they did that, they gave some
19 examples in italics as to why they did that. Can you see
20 that?

21 A Yes.

22 Q Okay.

23 A Uh-huh.

24 Q And was the -- what was the -- what was the
25 reason why they responded to even just doing that?

1 A Cost, using multiple dose vials supplied by
2 the healthcare entity to use up what was in there as long as
3 the vial was only kept for a certain period of time. My
4 understanding about heparin is it is a multi-dose. It has a
5 bacteriostatic agent in it.

6 Q Now, with regard to the heading, which was
7 entitled use of multi-dose vial for more than one patient, the
8 very last comment on that section, what did it say, one of the
9 respondents as an example?

10 A I use a new syringe for each entry and we date
11 the vials after opening.

12 Q Now, does that sound like a practice that
13 would be -- I mean, I know that it may not be optimal.

14 A That would be the practice. That would be the
15 appropriate practice.

16 Q Okay. So somebody who answered to that in
17 that category, that was even a quoted response by one of the
18 people, is that correct, in this article?

19 A That's what they're trying -- that's the
20 example of one of the responses.

21 Q Where it says practice is not considered
22 appropriate consistent with current guidelines, one of the --
23 the heading there on the same page is use of single-dose vial
24 for more than one patient. Do you see the reasoning why on
25 that particular one was used by some of the respondents?

1 A As a cost saving measure.

2 Q Okay. So two costs involved there. Let's see
3 if there was any others that I could see. Okay. So it
4 varies, at least the information that was provided; correct?
5 I mean, by these different respondents, who they responded to,
6 which questions and the like?

7 A Yes.

8 MR. STAUDAHER: Court's indulgence, Your Honor.

9 BY MR. STAUDAHER:

10 Q Since that -- that article written 20 years
11 ago with a subset -- a sample population in the sample -- or
12 in the study of two people, 20 years, are you aware of a
13 single article that's connected scopes to infection?

14 A No.

15 MR. STAUDAHER: Pass the witness, Your Honor.

16 THE COURT: All right. Recross, Mr. Wright.

17 MR. WRIGHT: Nothing.

18 THE COURT: Mr. Santacroce.

19 RE CROSS-EXAMINATION

20 BY MR. SANTACROCE:

21 Q In the New England Journal of Medicine article
22 that we were referring to, are you aware of a study that was
23 done as to the degree of adherence to guidelines for cleaning
24 and disinfection of gastrointestinal endoscopes?

25 A Can I see what you're referring to?

1 Q Absolutely.

2 A Thank you. Well, it was performed in 1988,
3 and I can't say I'm surprised. I don't know what the
4 percentage was, but there's been a lot of progress made. I'm
5 not saying that people do it right all the time and it's
6 ideal, and I'm not suggesting it's perfect. But I haven't
7 seen an example -- an instance of transmission that could be
8 attributed epidemiologically or otherwise to reprocessed
9 scopes.

10 Q According to this survey 30 to 100 percent
11 were inadequately using disinfectant procedures to clean
12 gastrointestinal equipment. 30 to 100 percent were not
13 following guidelines.

14 A Do you know where the survey was done?

15 Q Well, there's a footnote.

16 A I -- no, there's a reference.

17 Q Would you like to see the reference now?

18 A I saw the reference, but I still don't know
19 where the survey was performed, in what countries.

20 Q Well, I can show you. Do you want to see the
21 reference?

22 A Certainly. Again, that survey was done in
23 1988, 11 years prior to the publication of these -- of this --

24 Q Then why did you print it out and bring it to
25 court?

1 A Excuse me?

2 Q Why did you print this out and bring it to --
3 provide it?

4 A I said the --

5 MR. STAUDAHER: Objection. She didn't bring it to
6 Court, Your Honor. Mr. Santacroce did.

7 THE COURT: Well, he changed his phrasing, provide
8 it.

9 BY MR. SANTACROCE:

10 Q If it was so old, outdated, had no relevance
11 to transmission of disease, why did you download it three days
12 ago, provide it to the district attorney who then, in turn,
13 provided it to us?

14 A My comment about it being interpreted as being
15 out of date was the 1988 survey of disinfection procedures,
16 not this particular episode that was published in 1999.

17 Q So the conclusion about the cleaning methods
18 of the endoscopic equipment is still relevant?

19 A It's relevant to the fact that they -- that
20 they found deficiencies, yes. But it does not show -- they
21 found other deficiencies that in my -- that they could not
22 distinguish one from the other as causing infection.

23 Q After they --

24 A Or contributing to the transmission of
25 infection.

1 Q After they cite those statistics, the 30 to
2 100 percent, they say failure to follow the recommended
3 procedures can have an important role in the endoscopic
4 transmission of microorganisms.

5 A That's very true, all microorganisms. This is
6 true.

7 MR. SANTACROCE: Nothing further. Thank you.

8 THE COURT: Mr. Staudaher.

9 MR. STAUDAHER: No redirect, Your Honor.

10 THE COURT: Counsel approach.

11 (Off-record bench conference.)

12 THE COURT: Ma'am, I have a couple of juror
13 questions up here.

14 THE WITNESS: Okay.

15 THE COURT: The juror would like to know would best
16 practice be to use 20 cc syringes with 20 cc vials so that the
17 entire contents of the vial are pulled up all at once?

18 THE WITNESS: Only if that syringe was used on a
19 single patient. Otherwise, it would have the same -- there
20 wouldn't be any difference in your ability to contaminate a
21 vial by using the syringe.

22 THE COURT: Okay. Another juror would like to know
23 if in this case the injection practices were bad and the
24 cleaning of the scopes was equally bad, would that lessen your
25 belief that the cause was the injection practices only?

1 THE WITNESS: No. And the reason is because the
2 analysis of -- as I -- one of the -- the epidemiological study
3 compares the frequency of exposures, like through the scope or
4 a procedure or an injection in those who got infected or even
5 a staff member, for example, those who got infected compared
6 with those who didn't. And for these procedures, what type of
7 procedure, when they occurred, whether or not they had
8 biopsies, were all -- were not different between -- this is --
9 this is how you look at it, this is how you study it. We're
10 not different between those who became infected and those who
11 did not. And if you have selected your patient population to
12 be representative of those at risk, which they did, every one
13 they could possibly get to get tested, and they had a fairly
14 good -- they had a high percentage of the patients tested on
15 the days in question, then that is what speaks to be most
16 strongly.

17 Also, knowing that their practices were so --
18 their injection practices were so deficient, faulty, and is --
19 is also very telling that they continue to do those even in
20 front of the CDC investigators. So you've got two different
21 -- you know, you've got multiple ways in which people could
22 have been infected. But the epidemiological analysis did not
23 show that there were no differences between infected patients
24 and uninfected patients in those who -- in the type of
25 procedure they had. And that, when a good study is done, is

1 the conclusion that they're not associated. That's how we
2 make that conclusion. That's how you decide a drug is
3 effective or not effective --

4 THE COURT: Mr. --

5 THE WITNESS: -- for example.

6 THE COURT: I'm sorry.

7 Mr. Wright, any follow up?

8 MR. WRIGHT: Yes.

9 RECROSS-EXAMINATION

10 BY MR. WRIGHT:

11 Q It's very -- you said it's very telling that
12 like Mr. Mathahs --

13 THE COURT: Keep your voice up.

14 BY MR. WRIGHT:

15 Q Very telling -- I think you said it's very
16 telling they continued to do this even right in front of the
17 inspector; right?

18 A Yes.

19 Q Okay. Like -- like Mr. Mathahs knows the
20 inspector is there watching what he is doing, he knows the
21 purpose of the inspection, and he goes ahead and performs a --
22 does his thing in a manner which is not best practices;
23 correct?

24 A Correct.

25 Q And the person who was actually there and

1 observed him interviewed him right at the moment and stated
2 that she believed he was sincere in that he did not understand
3 the risks of the procedure. So why is that telling? All that
4 shows is that he didn't understand that he couldn't do what he
5 was doing when he sat there and proudly put on a new needle.

6 A I'm not -- I know I'm not allowed to ask a
7 question and I'm not really asking a question, it's --

8 Q Go ahead and try one.

9 A -- rhetorical. If you break the law, like
10 driving while intoxicated or going over the speed limit and
11 you say, oh, I didn't know I wasn't supposed to do that, isn't
12 there some kind of --

13 Q No. You can ask the question. We don't have
14 strict liability.

15 A -- ignorance is no excuse?

16 Q No, we have -- this is a criminal case, as you
17 pointed out. This isn't --

18 A I'm using science.

19 Q Right.

20 A Okay.

21 Q I understand that.

22 A Right. So then --

23 Q But here, in order to commit an offense it
24 must be a --

25 MR. STAUDAHER: Objection. Calls for a legal

1 conclusion.

2 THE WITNESS: I'm not --

3 MR. STAUDAHER: That's what we're doing now, so --

4 THE WITNESS: I'm not going there. It's so routine,
5 whether or not this person -- this person should know, number
6 one.

7 BY MR. WRIGHT:

8 Q Just a minute, you're going to bait me into
9 responding.

10 A Oops.

11 Q You're not the only one who gets to preach.

12 A Sorry.

13 THE COURT: Is what you're saying it's telling
14 because it's -- you know, that suggests to you that it's a
15 practice, at least with respect to that person, Mr. Mathahs,
16 that he routinely engaged in; is that what you mean?

17 THE WITNESS: Yes.

18 THE COURT: So he --

19 THE WITNESS: That's what I mean.

20 THE COURT: -- wouldn't think, oh, they're here, I'm
21 doing something wrong and dangerous, I better not do it.

22 THE WITNESS: Right. And, in fact, there is --

23 THE COURT: Okay. Is that what you meant?

24 THE WITNESS: That's what I meant.

25 THE COURT: Mr. Wright.

1 BY MR. WRIGHT:

2 Q But normally if someone like knows they're
3 doing something wrong and the highway patrolman is sitting
4 there, they don't do it; correct?

5 A I don't know.

6 Q You don't?

7 A I don't know.

8 Q If you see --

9 A Do they step --

10 Q -- the highway patrolman --

11 A -- on their brakes and hope the radar gun
12 didn't get them? I don't know what people do --

13 Q Okay.

14 A -- actually. I can't --

15 Q Well, wouldn't --

16 A -- attest to that, but --

17 Q -- you presume, as an investigator who looks
18 at these things, that normally when a person being watched,
19 observed, and knows it is an investigation to see how
20 hepatitis may have transmitted --

21 A Did you know there's a scientific --

22 Q -- that --

23 A -- term for that?

24 Q -- that --

25 A Sorry.

1 Q -- that he is going to, if he knows something
2 he is doing is wrong, he is going to change his behavior?

3 A Is some instances you're correct.

4 Q Okay.

5 A But --

6 Q And in the --

7 A -- not all --

8 Q -- in the study --

9 MR. STAUDAHER: Objection. If he could at least --
10 she could at least be allowed to finish her answer.

11 BY MR. WRIGHT:

12 Q Okay. Finish your answer.

13 A You're so -- you're so right in some ways that
14 they have a name for it. It's called the Hawthorne Effect.

15 Q Okay.

16 A It's the very act of observing, someone
17 changes their behavior because they know they're being
18 observed. Actually, people who routinely perform a procedure,
19 tend to routinely do it even when observed. It can be an
20 issue in some research, but in my -- in much of -- in my
21 experience, in healthcare related outbreaks, the procedures
22 are not changed when the investigators come in to investigate.

23 Q In the studies I've read there was some type
24 of -- it says in there bear in mind, we weren't there six
25 months ago, and all we are doing is observing people right now

1 who know they are watching us, so there was an obvious bias.

2 There is some word or --

3 A Well, there could be a limitation. One of the
4 -- usually what the article says -- sorry, I interrupted. I
5 apologize.

6 Q You're good at that.

7 A I know. I am not good at this. I apologize.
8 Should I wait? Finish, please.

9 Q What is -- that is a bias that takes place
10 because if a person normally knows they are doing something
11 wrong, they don't do it in front of the constable; correct?

12 A No.

13 Q They do it?

14 A They can still -- they will still do it in
15 some instances. I cannot tell you how often someone might
16 change their behavior in this situation. In science it's very
17 important to point out what limitations might exist in your
18 study, no matter how fabulous you think it might be, or how
19 flawed, you want to point out what the limitations could be,
20 and that's a limitation on any study that -- particularly one
21 that occurs well after the event.

22 Q Okay. But I take it you would put a great
23 deal of credence in the testimony and observation of Dr.
24 Fischer who actually interviewed Mr. Mathahs --

25 A You mean that he --

1 Q -- and -- and gave her opinion about whether
2 he was genuinely surprised and had believed he was engaging in
3 safe practices.

4 A She may -- she -- I'm not saying I disbelieve
5 her. It's just not relevant to me or to my conclusions from
6 this -- the cause of this --

7 Q It's not relevant --

8 A No.

9 Q -- whether -- well, see --

10 A To you it might --

11 Q -- in a criminal case -- see, we're in a
12 criminal case.

13 MR. STAUDAHER: Objection, Your Honor. This is not
14 an instruction on law.

15 THE COURT: Okay. So is what you're saying it's not
16 relevant to you from an epidemiological --

17 MR. STAUDAHER: From the source of the cause of the
18 outbreak.

19 THE COURT: Because you're not concerned with
20 liability, civil or other -- criminal or otherwise; is that
21 correct?

22 THE WITNESS: Yes, not in a hardhearted sense,
23 but --

24 THE COURT: Okay.

25 THE WITNESS: -- from a scientific point of view.

1 THE COURT: You're just concerned scientifically
2 with understanding --

3 THE WITNESS: That's what I've been asked to do.

4 THE COURT: -- the -- the genesis, if you will, of
5 the infection and determining how to prevent future infection,
6 is that fair?

7 THE WITNESS: That's right. That's right.

8 THE COURT: Not with respect to placing blame or
9 anything like that in terms of civilly or criminally, is that
10 fair?

11 THE WITNESS: Yes.

12 THE COURT: Okay.

13 MR. WRIGHT: The end.

14 THE COURT: I thought that was a preface for a
15 question.

16 MR. WRIGHT: No.

17 THE COURT: Mr. Santacroce, do you have any follow
18 up.

19 MR. SANTACROCE: Just a couple.

20 FURTHER RECROSS-EXAMINATION

21 BY MR. SANTACROCE:

22 Q When the juror asked you if the injection
23 practices were bad and cleaning practices were equally as bad
24 would it change your opinion, you said no. What I need to ask
25 you is you read the MMWR report from the CDC regarding this

1 case?

2 A Yes.

3 Q They use words in that report like the likely
4 transmission, possible, likely, words like that. Okay? Why
5 do scientists use words like likely and probable and possible?

6 A Because we cannot directly show that that
7 event caused that infection. We can do a -- that's why.

8 MR. SANTACROCE: That's all I have. Thank you.

9 THE COURT: Mr. Staudaher?

10 MR. STAUDAHER: Nothing further, Your Honor.

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

13 All right. Ma'am, I see no additional questions.
14 Thank you for your testimony.

15 THE WITNESS: Thank you.

16 THE COURT: You are excused at this time.

17 And the State may call its next witness.

18 MR. STAUDAHER: State calls Dr. Lewis, Your Honor.

19 THE COURT: I'm sorry?

20 MR. STAUDAHER: Dr. Lewis.

21 THE COURT: All right. Dr. Lewis.

22 Is everybody okay without a break?

23 Doctor, just right up here, please, by me. No, this
24 one. And it's just right up those couple of stairs, and then
25 just remain standing facing that lady right there and she'll

1 administer the oath to you.

2 DANIEL LEWIS, STATE'S WITNESS, SWORN

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

5 THE WITNESS: Daniel Lewis; D-A-N-I-E-L L-E-W-I-S.

6 THE COURT: All right. Thank you.

7 Mr. Staudaher.

8 DIRECT EXAMINATION

9 BY MR. STAUDAHER:

10 Q Doctor, what do you do for a living?

11 A I'm an internist.

12 Q And how long have you had that position or
13 done that work?

14 A Since 2001.

15 Q Where did you go to school?

16 A University of Nevada Medical School.

17 Q Did you do a fellowship or training after your
18 medical degree?

19 A I did my residency through the University of
20 Nevada.

21 Q So all your -- all your training has been here
22 locally?

23 A Up in Reno, Nevada.

24 Q I want to ask you about a specific patient. I
25 mean, you know why you're here exactly; correct?

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1 A Yes.

2 Q Can you tell us if you were involved with a
3 patient by the name of Carole Grueskin at some point?

4 A Yes.

5 Q What relation did you have with her?

6 A I was her primary care provider.

7 Q Now, as far as that's concerned, I mean, go
8 back in time. When was the first time that you came in
9 contact with her as a patient provider sort of situation?

10 A February 2007.

11 Q What was the reason for her coming to see you
12 at that time?

13 A The first visit was to establish care, but she
14 was also complaining of kind of bronchitis symptoms.

15 Q Was -- was she establishing care in the sense
16 that you were going to be her primary doctor?

17 A Correct.

18 Q So after that happens, I mean, when she comes
19 to you for that particular problem, do you do the whole sort
20 of first evaluation physical and lab work and the like?

21 A Sometimes, yes. On the first -- that -- on
22 that visit, no, because she was sick and we just addressed the
23 immediate problem of her being -- having bronchitis.

24 Q Did she return to you at a later time?

25 A She did.

1 Q Have you seen her multiple times?
2 A Yes.
3 Q Now, during the times that you saw her, were
4 one of those at least an evaluative type of physical with lab
5 work and the like?
6 A Yes, in July of 2007.
7 Q When you did that in July of 2007, was there
8 any indication that she had any kind of a liver problem or
9 liver condition based on her labs and your assessment of her?
10 A No.
11 Q Did she exhibit any symptoms of cognitive
12 impairment, dementia, anything like that at those times?
13 A No.
14 Q Moving forward, did you continue to see her
15 for other problems during the time?
16 A Yes, I did.
17 Q At some point down the road did you refer her
18 for a colonoscopy?
19 A Yes, I did.
20 Q What was the reason you did that?
21 A She had blood in her stool. In her -- on the
22 physical exam -- or on the -- her annual physical, she had
23 microscopic blood on the stool test that we did on that test.
24 Q Okay. So what -- that was the reason to send
25 her?

1 A Yes.

2 Q Now, what kind of a procedure or procedures
3 did you send her for?

4 A I really sent her to be evaluated by the
5 gastroenterologist for what could be causing the source of
6 bleeding from the stool test.

7 Q And where did you send her?

8 A The referral went through Southwest Medical
9 Gastroenterology Department, and then I think they then sent
10 her to Gastroenterology's -- Dr. Desai's GI practice.

11 Q So she eventually ends up at Dr. Desai's
12 practice?

13 A Yes.

14 Q Does she undergo procedures there?

15 A Yes.

16 Q Now, I want to back up from that point. When
17 did that all happen?

18 A She thought she had a colonoscopy on September
19 21, 2007.

20 Q So prior to September 21st, I think you said
21 the first time you came in contact with her was in February.

22 A Correct.

23 Q So you had seen her how many times between
24 February and September of that year?

25 A I saw her once in February, twice in July of

1 2007.

2 Q So a total of three times?

3 A At that point, yes.

4 Q Now, during any of those times, any indication
5 that she came in with -- with jaundice or any kind of overt
6 liver function problem?

7 A No.

8 Q Any of the lab work you had done during any of
9 those times came back with any problem related to her having
10 hepatitis, anything like that?

11 A No.

12 Q Now, from a cognitive impairment, you've seen
13 her a few times, any indications in the records you had or
14 your direct observations that she had any kind of a mental
15 condition or problem?

16 A No.

17 Q And when I say that, I'm talking about
18 something like dementia, you know, Alzheimer's, anything like
19 that.

20 A No, she did not.

21 Q Now, when she goes to the clinic, tell us what
22 happens after that from your perspective.

23 A I -- at that point she saw me in November of
24 2007. She presented with jaundice. Her skin was yellow and
25 she had no pain, abdominal pain. We did stat labs that day,

1 which then we got the results of the following day.

2 Q And what did they show?

3 A They showed her liver enzymes were extremely
4 high. The cutoff is -- the lab values are usually around 30
5 or 40. Hers were in the 3,000 to 4,000 range.

6 Q So this is in November. Roughly, when in
7 November?

8 A The -- I think the first part of November.

9 Q So at least at that time, was that the first
10 time you had seen her since she had her colonoscopy procedure?

11 A Yes.

12 Q Did she have just a colonoscopy, or did she
13 have something else also?

14 A As far as --

15 Q Endoscopic procedures at the clinic?

16 A An upper GI, as well.

17 Q So she had both?

18 A She had both.

19 Q When she gets actually to you on -- before the
20 November date, and the window of time I'm talking about, I
21 just want to make sure you're clear on this, is after the
22 colonoscopy and upper endoscopy in September --

23 A Uh-huh.

24 Q -- to the November date when you see her at
25 the beginning of November --

1 A Uh-huh.

2 Q -- were there any calls to you, any further
3 visits, any time that you interacted with her other than time
4 when she follows back up?

5 A Not that I know of.

6 Q When you see her at that time, is she
7 noticeably jaundiced at the point when you see her?

8 A Yes, extremely.

9 Q Once you get that information from her and you
10 order the lab work, I mean, do you assess her in any other
11 way? Do you try to look her?

12 A I examined her.

13 Q Were there any other problems that you noted
14 at that time?

15 A No.

16 Q Was she having any cognitive impairment at
17 that point?

18 A No.

19 Q So let's move forward from the November date.
20 You send her for the lab work. I assume you get this back?

21 A Uh-huh.

22 Q What happens next?

23 A I immediately sent her -- well, called her. I
24 truly don't know if I spoke to her or if one of our staff
25 members spoke to her and told her to go to the hospital.

1 Q Okay. So does that happen?
2 A Yes.
3 Q Do you follow up with her after that?
4 A Yes.
5 Q Did you see her in the hospital?
6 A No, I did not.
7 Q When was it that you saw her again after --
8 after the hospitalization?
9 A A week after she was discharged from the
10 hospital.
11 Q When was that, if you know?
12 A I don't know the exact dates. She was in the
13 hospital for approximately three days. It was towards -- it
14 was in the month of November.
15 Q Still?
16 A Yes.
17 Q So all of this, the jaundice to the
18 hospitalization to you seeing her afterward, the month of
19 November?
20 A Right. It spanned approximately three to ten
21 days.
22 Q When you saw her in follow up after that, had
23 her mental status changed at all?
24 A No.
25 Q What do you with her or for her at that stage?

1 A At that point it was still unclear what caused
2 her to have hepatitis, and so we repeated some lab work that
3 had been done in the hospital, which included a hepatitis
4 panel.

5 Q Did it come back?

6 A It came back positive for the antibodies for
7 hepatitis C.

8 Q Now, at this point what do you do?

9 A At this point I told her that she needed to
10 follow up with the gastroenterologist that saw her in the
11 hospital.

12 Q To your knowledge -- I mean, do you get a
13 report back at some point? Do you know if she did that or
14 didn't do that?

15 A I did get a report back that she did.

16 Q So when is the next time that you actually see
17 her?

18 A The next time I saw her was in December and
19 she had seen -- she had seen the gastroenterologist who said
20 -- well, in his reports said that he was unclear of what --
21 how she had hepatitis C.

22 Q And who was this?

23 A Dr. Weisz.

24 Q Okay. And --

25 A So I -- I was frustrated because the lab work

1 showed that she had hepatitis C, you know, that her antibody
2 came back positive for hepatitis C. And so I told her that
3 she, you know, she probably has hepatitis C and she needs to
4 follow back up with the gastroenterologist.

5 Q Now, did you do any kind of treatment of her
6 for her hepatitis C?

7 A No, that's out of the realm of internal
8 medicine.

9 Q Do you know if she underwent any treatment,
10 like interferon therapy, Ribavirin, anything like that?

11 A Not at that time. Not at that initial visit,
12 no.

13 Q Okay. So let's -- let's move forward. What's
14 -- and, again, at this point, what month, where are we talking
15 about?

16 A We're talking about December of 2007, now
17 probably in January of 2008.

18 Q Any issue with cognitive impairment at that
19 time?

20 A No. No.

21 Q So still we don't have an issue there?

22 A No.

23 Q Move forward in time to the -- to the next
24 visit or the next time you've interacted with her.

25 A I got a -- well, okay, I got a call from the

1 Health District stating that she had hepatitis C and that they
2 were going to contact her. And at that point -- at that point
3 we -- she came back in. At this point hepatitis C outbreak
4 was, you know, on the news every day and she came back in
5 extremely, extremely upset, distraught, angry, anxious to the
6 point where she just was having a hard time functioning.

7 Q So that's after she gets the news about her
8 condition and the news is --

9 A Right.

10 Q -- in the media.

11 A So she had a -- she had a test in February
12 2008, which did confirm that she had the virus for hepatitis C
13 and the genotype of that virus.

14 Q Did you continue to see her after that?

15 A Yes.

16 Q During the times that you see her in follow
17 up, when was the next time, if you can --

18 A March of 2008.

19 Q So now we're well in -- we're into the next
20 year.

21 A Yeah, I pretty much saw her once a month
22 throughout the entire year of 2008.

23 Q Do you know if she did ever undergo any kind
24 of treatment, therapy, interferon, specifically.

25 A She did eventually.

1 Q And when was that?

2 A November of 2008.

3 Q So at least the anxiousness or at least the
4 condition you talked about, when -- and let's talk about that
5 initially. You say she comes back in after the results are
6 given to her. The way that you described her just in court a
7 moment ago, is that what we're talking about as far as
8 anxiousness, or something else?

9 A She was extremely anxious and she was
10 extremely depressed, and she -- at that point in March one of
11 her complaints was that she was forgetting things, that she
12 was forgetting her keys, she was forgetting to do things, meet
13 appointments, certain things, that type of stuff.

14 Q Had she disclosed to you during any of the
15 evaluations you had done as her primary, any kind of family
16 history of dementia, Alzheimer's, anything like that?

17 A No, she did not.

18 Q Had you seen any signs or symptoms in
19 retrospect, now that you're dealing with her later on, of
20 those kinds of signs or symptoms?

21 A I saw signs of memory loss, yes. And what was
22 confusing about it is depression can cause memory loss. You
23 know, you can become so depressed or so anxious that you
24 forget things. So -- so at that point that's what I felt was
25 going on. I felt that it was due to her overall emotional

1 state that was causing her to forget things.

2 Q Related to the hepatitis infection?

3 A Related to having -- acquiring hepatitis C.

4 Q Okay. So those symptoms don't occur until
5 after that -- that event?

6 A Yes.

7 Q Now, moving forward, you said you still saw
8 her every month.

9 A Uh-huh.

10 Q Does -- does that cognitive issue, the
11 depression, the things you mentioned, does it change over
12 time?

13 A It -- it actually -- it -- it got worse. In
14 March she was reluctant to go on any type of medication for
15 depression. She refused to go see a psychiatrist or a
16 psychologist. It was in June that we were -- that I pretty
17 much convinced her to try an anti-depressant. We then
18 increased the dose of that anti-depressant in August of 2008.
19 Again, there was a lot of stress in Spring of 2008 because at
20 that point we were trying to find another gastroenterologist
21 to treat her, which was extremely difficult because all of the
22 sudden no gastroenterologists were taking patients, you know,
23 and so it became a -- it just became an ongoing thing that
24 just wasn't moving forward as far as to get treatment.

25 Q Did she eventually start interferon therapy at

1 some point?

2 A She did. She started interferon therapy in
3 November of 2008.

4 Q And how did she respond to that?

5 A She had some complications from that. The
6 interferon caused her to -- her white blood cell count to go
7 very low and her red blood cells to go very low.

8 Q Did you notice any difference in her cognitive
9 situation once she started the interferon therapy?

10 A She became more confused.

11 Q Was it a correlation between that, I mean,
12 before versus after?

13 A I don't know if it -- I mean, I don't know if
14 it was related to the treatment. I'm not sure.

15 Q But after she started the interferon she got
16 worse?

17 A Yes.

18 Q Would you classify that as mildly worse,
19 medium, markedly?

20 A I would say mildly worse.

21 Q Now, how far did you continue with her?

22 A Last time I saw her was in January 2009.

23 Q So at that time what was her situation?

24 A She was -- I think they had stopped the
25 treatment and that's about -- that's all I remember.

1 Q Do you know why the treatment was stopped?

2 A Because of the complications of her becoming
3 so anemic from the treatment.

4 MR. SANTACROCE: I'm going to object as to
5 foundation.

6 MR. STAUDAHER: Well, he's the -- you're the
7 physician, you have the --

8 THE COURT: That's overruled.

9 BY MR. STAUDAHER:

10 Q So it was because of complications what?

11 A It was because of complications of -- of her
12 unable to -- to handle or be treated by that medication
13 because it caused her to become anemic.

14 Q And you mentioned red and white blood cell
15 counts?

16 A Right. It required blood transfusions and --
17 and she still wasn't able to tolerate it.

18 MR. STAUDAHER: Pass the witness, Your Honor.

19 THE COURT: All right. Ms. Stanish.

20 CROSS-EXAMINATION

21 BY MS. STANISH:

22 Q Good afternoon, Dr. Lewis.

23 A Hi there.

24 Q Let me start with Ms. Grueskin's medical
25 history. I assume when you met with her first you collected

1 her medical history?

2 A Yes.

3 Q And is it the case that she was a heavy
4 smoker, smoking one to two packs a day?

5 A That's correct.

6 Q Do you know for what duration she had done
7 that?

8 A I don't know.

9 Q Okay. Do you recall that it was for over 20
10 years?

11 A Yes.

12 Q And by the way, how old was she when you first
13 visited with her?

14 A She was born in 1939, so 2007 I would say
15 that's 69, 68.

16 Q How old is she now since you're good at math?

17 A Let's see here, 39 --

18 THE COURT: Not to put you on the spot or anything.

19 MS. STANISH: No, I know he's going to get it right.

20 THE WITNESS: 74 -- or 72. No, 74. Sorry.

21 BY MS. STANISH:

22 Q See, that's what I thought. All right. And
23 did she also have issues with breast cancer?

24 A Yes, she did.

25 Q And did she receive radiation for that?

1 A Yes, she did.

2 Q Were -- did she also have to have an operation
3 in connection with that?

4 A I don't recall.

5 Q All right. Do you -- did she also suffer from
6 diabetes?

7 A No, she did not.

8 Q Okay. Do you recall any other health issues
9 that she was dealing with when you first visited with her?

10 A No, other than she was having back problems.

11 Q And as far as her GI issues, ultimately what
12 was determined to be her problem with GI issues when you
13 referred her in 2007 for the colonoscopy?

14 A She had -- she had black positive stools on
15 her stool test.

16 Q Meaning what?

17 A Microscopic blood within the stool, meaning
18 that there is possibly some sort of bleeding going on
19 internally.

20 Q And as I under -- as I understand it, you had,
21 prior to her going to the -- for the colonoscopy, you had done
22 the -- the normal labs that you would give to a patient who is
23 getting their annual or physical?

24 A That's correct.

25 Q And those blood tests, they test for liver

1 enzyme levels; is that correct?

2 A That's correct.

3 Q I assume you did not give any specific blood
4 tests relating to the hepatitis?

5 A No, I did not. Not at that time.

6 Q And let's jump now when, as I understand it,
7 she became symptomatic in November of 2008 and you referred
8 her to the hospital.

9 A Uh-huh.

10 Q And the --

11 MR. STAUDAHER: Your Honor, to correct that, just
12 for counsel. 2007, I think, was the year.

13 MS. STANISH: Oh, did I say '08?

14 MR. STAUDAHER: Yes.

15 THE COURT: Okay. 2007.

16 MS. STANISH: I bet you're a good proofreader.

17 MS. WECKERLY: I heard it, Margaret.

18 MR. STAUDAHER: Actually, it was my co-counsel.

19 BY MS. STANISH:

20 Q What year did -- November 2007 she becomes
21 symptomatic and you refer her to the hospital?

22 A That's correct.

23 Q And at some point you refer her to Dr. Sood?

24 A Yes.

25 Q And do you know when that was?

1 A That was in 2008, March of 2008.

2 Q And, you know, I read your deposition, so I
3 understood that there was an issue with whether it was
4 yourself or Dr. Sood trying to determine if she had autoimmune
5 hepatitis.

6 A Right.

7 Q First what was -- put that on a timeline for
8 me relative to her becoming symptomatic in November of 2007.

9 A Uh-huh.

10 Q When were -- when were her providers
11 struggling with this issue?

12 A During -- because -- Dr. Sood was. Dr. Sood
13 ordered the test to determine whether or not she had anything
14 that would contraindicate being on interferon therapy. If she
15 had autoimmune hepatitis, that -- which would then probably be
16 treated with steroids, that would make the hepatitis C worse.
17 If the hepatitis -- if she had -- or likewise. But basically
18 the reason why is so she -- they did a blood test. It was
19 positive for ANA. Her ANA was positive, which kind of could
20 point in that possible direction that she had autoimmune
21 hepatitis.

22 Q So the next question is what the heck is
23 autoimmune hepatitis?

24 A From what I know is it's the -- like any type
25 of autoimmune disease it's when your body produces antibodies

1 that attack against itself. And in this case, your body
2 produces antibodies that are attacking certain proteins within
3 the liver causing inflammation of the liver.

4 Q It sounded like you had expressed some
5 frustration that she wasn't getting the -- the treatment for
6 hepatitis C, the drug regimen.

7 A I don't recall exactly. I mean, that was
8 three or four years ago. But I think in general I think I was
9 frustrated that all the hoops that we had to go through to get
10 her treated, yes.

11 Q And she wasn't -- she actually didn't get the
12 treatment until September 2008, almost a year after the
13 colonoscopy?

14 A That's probably correct.

15 Q And can you explain -- well, you're not the
16 one making the decision. That's Dr. Sood making the decision.

17 A Uh-huh.

18 Q Or -- or was Dr. Sood working with some other
19 specialist that you're aware of?

20 A Not that I'm aware of.

21 Q Okay. So Dr. Sood was the one who was dealing
22 with the hepatitis issue?

23 A Dr. Sood is a gastroenterologist specialist.
24 That's what he would -- yeah, he would be the one that would
25 do any type of treatment for hepatitis C.

1 Q And can you tell from your review of the
2 medical records why there was such a long delay getting her
3 that treatment?

4 A I think a couple things. One, again, there
5 was the question of autoimmune hepatitis, and two was her
6 mental state at the time.

7 THE COURT: Ms. Stanish --

8 I'm sorry. Were you done with your answer?

9 THE WITNESS: Yeah. Yes.

10 THE COURT: I didn't mean -- I have a bad habit of
11 interrupting people.

12 Ms. Stanish, we're going to take a quick break.

13 MS. STANISH: Okay.

14 THE COURT: So I am going to interrupt you.

15 MS. STANISH: All right.

16 THE COURT: Ladies and gentlemen, during the quick
17 break you're reminded you're not to discuss the case or
18 anything relating to the case with each other or anyone else.
19 You're not to read, watch, or listen to any reports of or
20 commentaries on this case, any person or subject matter
21 relating to the case, or do any independent research. Please
22 don't form or express an opinion on the trial.

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

25 And, Doctor, during the break, please don't discuss

1 your testimony with anyone.

2 THE WITNESS: No problem.

3 THE COURT: All right. Thanks. And you're free to
4 sit there, or if you want to take a break you can exit through
5 the double doors.

6 THE WITNESS: Thanks a lot.

7 (Court recessed at 4:26 p.m., until 4:34 p.m.)

8 (In the presence of the jury.)

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

11 And Ms, Stanish, you may resume your
12 cross-examination.

13 MS. STANISH: Thank you, Judge.

14 BY MS. STANISH:

15 Q Going back to the autoimmune deficiency, you
16 noticed that at one time period?

17 A At what time period what?

18 Q On the timeline.

19 A In the summer of 2008.

20 Q And is that suggestive of the beginning stages
21 of lupus? Did she --

22 A I truly don't know if -- the reason why she --
23 I was involved with the whole scenario of possible autoimmune
24 hepatitis is because of the way her insurance was set up she
25 had to go back to her primary doctor for referrals. And it

1 was recommended by the gastroenterologist that she be referred
2 to the rheumatologist. And so she came back and saw me for a
3 referral to go see the rheumatologist.

4 Q And what exactly is a rheumatologist?

5 A A rheumatologist is a specialist in conditions
6 like rheumatoid arthritis, lupus, autoimmune diseases of that
7 nature.

8 Q Do you know if memory problems are associated
9 with lupus or other autoimmune diseases?

10 A Not that I -- I don't know.

11 Q You don't know. And your -- from the time you
12 -- you're seeing her, November of 2007 when she's diagnosed
13 with hepatitis C to mid-September 2008 when she's not getting
14 the hepatitis treatment, the drug regiment, during that time
15 frame are -- are her -- are her viral loads stable or what's
16 going on there?

17 A I do not know.

18 Q You don't know. Do you even know as -- today
19 if -- if the -- if the hepatitis C has cleared her system?

20 A The last time I was in contact with her was in
21 January of 2009.

22 Q Okay. So you don't know. All right.

23 A I know nothing after that visit.

24 Q Well, then I guess I can't ask you much more,
25 so thank you.

1 THE COURT: All right. Mr. Santacroce, any cross?

2 MR. SANTACROCE: Yes, thank you.

3 CROSS-EXAMINATION

4 BY MR. SANTACROCE:

5 Q Doctor, you said that you noticed some
6 cognitive impairment after the procedure or after the
7 diagnosis of hepatitis C?

8 A She came in with the initial complaint of
9 having memory loss in March of 2008.

10 Q Okay. And is that when you noticed some
11 cognitive impairment?

12 A Yes. I ordered an MRI of the brain at that
13 time and it was normal. And I thought that it was probably
14 due to the amount of anxiety, depression that she was
15 undergoing at that -- having at that point.

16 Q Do you have an opinion as to whether or not
17 hep C causes dementia or Alzheimer's?

18 A I don't have an opinion. I leave that up to
19 the gastroenterologist.

20 Q Okay. So you can't say to a reasonable degree
21 of medical certainty what, if anything, caused dementia or
22 Alzheimer's?

23 A What causes Alzheimer's dementia?

24 Q In her.

25 A No, I do not know.

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1 Q Did she have a -- is there a formal diagnosis
2 for dementia? I mean, who do you go see to be diagnosed with
3 dementia?

4 A A neurologist.

5 Q Do you know if she saw a neurologist?

6 A I do not know if she saw a neurologist.

7 Q Could memory loss or dementia be caused by
8 treatment, chemotherapy, radiation, things of that nature?

9 A Yes, it can.

10 Q And your testimony was that she had undergone
11 radiation prior to her procedure at the clinic?

12 A That is correct. She did have radiation
13 treatment for breast cancer, yes.

14 MR. SANTACROCE: I have nothing further. Thank you.

15 THE COURT: Redirect?

16 MR. STAUDAHER: No, Your Honor.

17 THE COURT: Any juror questions for this witness?
18 No juror questions?

19 Doctor, thank you for your testimony. Please don't
20 discuss your testimony with any other witnesses, and you are
21 excused at this time.

22 And the State may call its next witness.

23 MS. WECKERLY: Yereny Duenas.

24 THE COURT: Ma'am, just right up here, please, next
25 to me. And then face this lady right there and she will

1 administer the oath to you.

2 YERENY DUENAS, STATE'S WITNESS, SWORN

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

5 THE WITNESS: My name is Yereny, Y-E-R-E-N-Y, last
6 name Duenas, D-U-E-N-A-S.

7 THE COURT: All right. Thank you.

8 Ms. Weckerly.

9 DIRECT EXAMINATION

10 BY MS. WECKERLY:

11 Q Ms. Duenas, how are you employed?

12 A I'm employed.

13 Q How?

14 A Through my employer. No. I'm employed
15 through Zenith American Solutions. I'm a participant service
16 coordinator.

17 Q And what does that mean you do?

18 A We are the third party administrator for a
19 bunch of the unions in town. For example, Culinary, we pay
20 their claims, we handle their eligibility, we handle self-pays
21 and things like that.

22 Q And how --

23 A On the insurance side, medical insurance side.

24 Q How long have you done that type of work.

25 A 18 and a half years.

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1 Q And was the company that you work for always
2 known as Zenith American?

3 A No, we've had different name changes through
4 the years. It was previously ABPA, and then we had a merger
5 with Zenith, so we're now Zenith American Solutions.

6 Q Okay. And were you someone who was
7 specifically involved in handling claims for under Culinary
8 insurance back in 2007?

9 A Yes, I was a claims team leader.

10 Q And as a team leader do you handle claims
11 personally and do you supervise or how does that work?

12 A I distribute the work, if there's any
13 questions, I help the examiners, any provider calls, customer
14 -- escalated customer calls, I handle all those type of
15 issues, go to contract meetings, and so on.

16 MS. WECKERLY: Your Honor, may I approach the
17 witness?

18 THE COURT: You may.

19 MS. WECKERLY: And I've shown these to counsel.

20 BY MS. WECKERLY:

21 Q Ms. Duenas, I'm showing you what's been marked
22 as State's 209, and there's actually several documents. And
23 there's 209A, B, and C. And if you could just look through
24 all those --

25 A Okay.

1 Q -- and then let me know when you're done.

2 A Okay. Okay.

3 Q Are all of those documents related or all they
4 all business documents related to an insurance claim that was
5 processed by your company, I guess, based on Culinary
6 insurance back in 2007?

7 A Yes, but it looks like there's statements in
8 there that the patient received from the actual doctor's
9 office.

10 Q Okay.

11 A Like the explanation of benefits, that has our
12 name on it as ours, but like these invoices --

13 Q Uh-huh.

14 A -- they look like they are from the doctor's
15 office. Those are not from our office.

16 Q Okay. You didn't generate these --

17 A No, we did not --

18 Q --- at the insurance company --

19 A --- generate those.

20 Q -- but you're familiar with this type of --

21 A Yes.

22 Q -- document being submitted?

23 A Yes.

24 Q Is that fair?

25 A Yes.

1 Q Okay. Are all of the documents in here
2 something that you would be familiar with from working --
3 A Yes.
4 Q -- for 17 years?
5 A Yes.
6 Q Okay.
7 MS. WECKERLY: Your Honor, the State moves to admit
8 209, and then 209A, B, and C.
9 THE COURT: Any objection?
10 MS. STANISH: No, Your Honor.
11 THE COURT: All right. Those are all admitted.
12 (State's Exhibit 209, 209A, 209B and 209C admitted.)
13 BY MS. WECKERLY:
14 Q Okay. Can you -- is your screen on up there?
15 A Yes, it is.
16 Q Okay. Perfect. I am showing you -- this is
17 209C, and it looks like -- well, you tell me. What are we
18 looking at here?
19 A Okay. These are our internal processing
20 guidelines based as how the claim was processed in 2007.
21 Q Okay.
22 A It's just an internal document that we have
23 that we provide for the examiners so they know when they
24 receive their certain claim type how -- kind of like what is
25 loaded in the system and what the background information is.

1 Q Okay. And in 2007 through Culinary insurance
2 for a -- for a claim for the anesthesia associated with the
3 colonoscopy, how is that measured or how is it determined?

4 A Our anesthesia claims are based on base units
5 plus time, times the RVU units.

6 Q Okay. And it looks like on here there's an
7 RVU unit price.

8 A Correct.

9 Q And was that the price in 2007?

10 A Yes, for a CRNA. Yes, it was.

11 Q Okay. So this is the price. Sorry. This \$34
12 is the price that you pay per unit for the procedure?

13 A Correct.

14 Q And you said the price is determined by
15 calculating the number of units associated with the procedure?

16 A Yes.

17 Q And then just timing it by this 34?

18 A Yes.

19 Q Okay. And the other kind of information on
20 this document, I guess, defines the -- sort of the conditions
21 of what can be billed or what counts or what doesn't?

22 A That is correct.

23 Q I'm going to flip to -- well, it's the second
24 to the last page. Okay. And this -- this box right here,
25 which is the -- the second box on the page, can you explain to

1 us what information is contained in that box?

2 A Okay. In this box it's basically how the
3 system calculates anesthesia time. For example, if the
4 anesthesia time billed is, for example, 45 minutes, the system
5 looks at that. The system is programmed to look at it every
6 15 -- every -- every unit, every 15 minutes equals one unit.

7 Q Okay.

8 A So anything over 15 minutes gets rounded up to
9 the next unit. So, for example, if 16 units were billed, that
10 rounds up to two units.

11 Q Okay. And if it's 12 minutes, how many is
12 that?

13 A That's one unit.

14 Q And if it's 32 minutes, how many units is
15 that?

16 A That's -- 32 units is three units.

17 Q I'm sorry. 32 minutes.

18 A Oh. 32 minutes is three units.

19 Q Okay. So if you go at all into --

20 A Round up. Anything above 15 increments is --
21 rounds up to two units.

22 Q Okay. And I think you said that you have a
23 base number of units associated with a procedure and then you
24 add on those 15 minutes depending on how long the procedure
25 is?

1 A Correct.

2 Q And in 2007, what was the base unit assignment
3 to a colonoscopy?

4 A It was six units.

5 Q Six units. So it would be six plus whatever
6 15 minute increments?

7 A Correct.

8 Q Times the 34?

9 A Correct.

10 Q Okay. So let's look at her claim detail. And
11 maybe I'll zoom in just a little. Can you see that?

12 A Yes.

13 Q Okay. So this -- this page of the document
14 shows the claim is for anesthesia; correct?

15 A Correct.

16 Q And this would be -- this 560, would that be
17 the charges --

18 A Submitted. Those are the bill charges.

19 Q By the provider?

20 A Yes.

21 Q Okay. And it looks like there was -- is that
22 like a discounted rate?

23 A That's considered a PPO discount where we
24 don't pay for it and the patient is not liable for it.

25 Q Okay. So that's because of the agreement that

1 you had, you discount the 560 by 254?

2 A Correct.

3 Q Just off the top?

4 A And that would be the allowable.

5 Q Okay. And then it looks like this was the
6 eligible amount on the claim, which is 306?

7 A Correct.

8 Q And was there -- can you tell on this document
9 whether the patient had to pay a copay or whether you paid the
10 whole thing?

11 A We pay the -- we paid the whole thing. Over
12 here where it has a percentage co-insurance.

13 Q You can actually write on the screen with your
14 fingernail.

15 A Oh.

16 Q Yeah.

17 A Okay.

18 Q If you want to just show us where that is.

19 Okay.

20 A Right there, that is -- shows that the
21 allowable, what's considered at 100 percent, so the patient
22 had no out of pocket.

23 Q Okay. And so this is how much Culinary and
24 the insurance company paid for her procedure?

25 A Correct.

1 Q And so this was \$306

2 A Yes.

3 Q Now, are you able to tell -- I'm showing now
4 the last page of -- can you tap the bottom right of that with
5 your finger there. Thank you. This is the last page of 209,
6 and it looks like there is time entered on this document; is
7 that fair?

8 A Yes.

9 Q And what -- what is the time that's entered?

10 A This is the time that the -- that the provider
11 submitted that the patient was under anesthesia, and it's
12 11:45 to 12:18.

13 Q And how many units would that be?

14 A That would be three units.

15 Q Okay. And so with a base unit of six that's
16 associated with the procedure, and then you add three more
17 units, so it was nine.

18 A Uh-huh. Times the 34 -- \$34 per RVU.

19 Q Okay. And then we times that by this 34 RVU?

20 A Is a 306.

21 Q And that's the 306 that was paid on the claim?

22 A That's correct.

23 Q So let me ask you. If this time were lower,
24 like one less unit, would less have been paid on this claim?

25 A Yes.

1 Q How much less?
2 A \$37 less.
3 Q Or 34?
4 A 34. I'm sorry. 34.
5 Q 34.
6 A Yes.
7 Q And if it was one -- if it was a procedure
8 that lasted under 15 minutes, how many units could have been
9 billed?
10 A Just the one.
11 Q Okay. So it would have been seven times the
12 34?
13 A Correct.
14 Q So each unit that was added on in terms of
15 anesthesia time increased how much was paid by the insurance
16 company by \$34, is that fair?
17 A That is correct.
18 Q And in this particular claim, \$306 was paid,
19 meaning nine units were billed?
20 A Yes.
21 MS. WECKERLY: I think that's all I have.
22 THE COURT: Thank you.
23 Cross.
24 CROSS-EXAMINATION
25 BY MS. STANISH:

1 Q Good afternoon.

2 A Hi.

3 Q Just a few clarifying points, and I mean just
4 a few because you're really an expert. You know how this
5 works. And I did have this nice chart prepared, and I think
6 that given what you've already testified you can click right
7 through this. This column right here, as I understand your
8 testimony, a total of nine units were paid and do you multiple
9 that by 34?

10 A Yes.

11 Q Did that work?

12 A It's exactly how you have it, plus, plus, and
13 then times.

14 Q So I got it right?

15 A [Nods head yes]

16 Q Okay. And so if we wanted to, all we had to
17 do is subtract \$34 from this and it'll be the amount that
18 would be \$34. I won't even go through the math, even though I
19 have my calculator. But from 16 to 30, all we have to do is
20 subtract 34 from -- well, I guess I will do it. What the
21 heck. 306 minus 34, you say? Oh, what did I do?

22 MS. WECKERLY: You had an error message. I saw it
23 on your -- you did.

24 MS. STANISH: Yeah, it's hard to use a calculator
25 often, I know, but you can see why I have this problem.

1 MS. WECKERLY: That's all right.

2 BY MS. STANISH:

3 Q So 306 minus 34 equals 272. So if the
4 anesthesia services was between 16 minutes and 30 minutes, the
5 insurance company would have paid 272 and the patient would
6 not have to pay anything?

7 A Correct.

8 Q And then minus another -- by the way, if it's
9 zero to 15, if there's -- if I'm at zero, I still get -- do I
10 still get the one unit?

11 A Yes.

12 Q So if there was no time --

13 A Well, if there was no time the claim wouldn't
14 have been submitted.

15 Q Well, no, I mean, you get the base; right?

16 A Right.

17 Q You automatically get --

18 A Right.

19 Q -- the base.

20 A Right.

21 Q And so -- and by the way, your competitors are
22 only giving five units. But just to clarify, it's automatic
23 that they get six for having the colonoscopy procedure. I
24 guess my question is, as I understand the timing permits, if
25 it's zero to 15 you're going to get one point?

1 A Correct.

2 Q So just meaning if there was -- if they just
3 didn't report any time, left the time unit blank, they would
4 get seven?

5 A Right.

6 Q All right.

7 A If they left time blank, we would always send
8 for the medical records to see actually what time was used.

9 Q Sure. And so to -- so if we minus 34 from --
10 if we were at the zero to 15, the amount paid would be \$238;
11 correct?

12 A [Nods head yes].

13 Q All right. That's all I have.

14 THE COURT: All right. Thank you, Ms. Stanish.
15 Mr. Santacroce.

16 CROSS-EXAMINATION

17 BY MR. SANTACROCE:

18 Q Good afternoon. Can you tell from the
19 documents you have who the provider is that you pay?

20 A Yes.

21 Q Who is that?

22 A Do you want to bring it back up?

23 MS. WECKERLY: It's -- it's right there.

24 MR. SANTACROCE: Why don't you just hand her those,
25 Margaret?

1 MS. STANISH: Anything for you.

2 THE WITNESS: Oh. Thank you. Based on the
3 explanation of benefits, the provider was Keith H. Mathahs.

4 BY MR. SANTACROCE:

5 Q And who was the patient?

6 A The patient is Sonia E. Alfaro Orellana.

7 Q And who did you make the check out payable to?

8 A Check payable to -- there's no copy of the
9 check in here, but based on the provider that's on the
10 explanation of benefits it would have been made to Keith
11 Mathahs.

12 Q Are you sure about that?

13 A No, I'm not 100 percent sure without the copy
14 of the check.

15 Q Okay. So you're not sure. It might have been
16 made to Gastroenterology Center of Nevada?

17 A I don't -- it probably would have -- it should
18 have been made to Keith Mathahs based on Box, probably, 31 of
19 the HCFA.

20 Q But as you sit here today you can't testify as
21 to who the check went to?

22 A Let me look at the image in here to see what
23 was billed in Box 31. The check was made to Keith Mathahs
24 based on the information on 209B.

25 Q Okay. So we're starting -- the check wasn't

1 made out to Ronald Lakeman; correct?

2 A Correct.

3 Q Now, you -- you testified that the allowable
4 amount was \$306?

5 A Correct.

6 Q Do you administer a lot of these claims for
7 anesthesia?

8 A We process --

9 Q For your company.

10 A We process a lot of anesthesia claims, yes.

11 Q Okay. And other than the Gastro Center of
12 Nevada or Endoscopy Center of Nevada, other -- other
13 providers?

14 A Yes.

15 Q And is this amount a customary amount in the
16 industry about, roughly?

17 A Yes. I mean, the base units are always the
18 same for that procedure for CPT Code 00810.

19 Q And what is that code for?

20 A That is for anesthesia for gastrointestinal
21 issues.

22 Q Okay. So --

23 A So the base units for that on our plan, no
24 matter who the provider is, is always six units. So that
25 stays the same. The only thing that would change is how the

1 provider bills the time that the patient was under anesthesia.

2 Q Okay.

3 A So it all depends on how we receive the claim.

4 Q So no matter what they're getting six base
5 units.

6 A Correct.

7 Q And the only thing that varies is the minutes?

8 A Correct, depending on what the patient was
9 under.

10 Q And I want to know from your experience is a
11 \$306 payment for that provider code customary in your business
12 for that type of procedure?

13 A It depends on what -- how we get the claim. I
14 -- the examiners don't look at a claim and be like, oh, this
15 seems -- these minutes don't seem appropriate. We process the
16 claim based on good faith. I mean, it could have said five --
17 it could have said five units and we would have paid it
18 because we process based on good faith that the claim we're
19 getting is correct with the information. And we have the
20 screen that shows the to and from time.

21 Q Okay. And from -- from the provider code, if
22 I had billed \$1,000 for a procedure that was for this provider
23 code, would your machine kick it out?

24 A No, it would not kick it out.

25 Q You would pay \$1,000?

1 A We would not pay \$1,000. The system is set up
2 according to that base plus time, times the RVU. So depending
3 on how many units were in there, then we would have -- we pay
4 according to that.

5 Q Okay. So there was nothing out of the
6 ordinary about paying \$306 for that procedure code?

7 A Not to -- to a normal processing claims
8 examiner, no.

9 Q Okay.

10 MR. SANTACROCE: Nothing further.

11 THE COURT: Redirect.

12 MS. WECKERLY: Nothing else. Thank you.

13 THE COURT: Any juror questions for this witness? I
14 see no juror questions.

15 Thank you for your testimony. Please don't discuss
16 your testimony with anyone else who may be called as a witness
17 in this case, and you are excused.

18 THE WITNESS: Okay. Thank you.

19 THE COURT: Thank you.

20 THE WITNESS: Do I just leave these up here?

21 THE COURT: You can just hand them to me.

22 THE WITNESS: Okay.

23 THE COURT: All right. I believe that's the last
24 witness for today; is that correct?

25 MS. WECKERLY: That's correct.

1 THE COURT: May I see counsel at the bench, please?

2 (Off-record bench conference.)

3 THE COURT: Ladies and gentlemen, we're going to
4 take our evening recess. We will reconvene tomorrow morning
5 at 9:15.

6 During the evening recess you're reminded that
7 you're not to discuss this case or anything relating to the
8 case with each other or with anyone else. You're not to read,
9 watch, or listen to any reports of or commentaries regarding
10 this case, any person or subject matter relating to the case.
11 Don't do any independent research by way of the Internet or
12 any other medium, and please do not form or express an opinion
13 on the trial.

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

16 (Jury recessed at 5:08 p.m.)

17 THE COURT: We got -- while I think of it, we got --
18 I got from Ms. Killebrew the disclosure on the Meana, and the
19 global net settlement amount was two million -- anybody
20 writing this down?

21 MR. WRIGHT: Yep.

22 MS. WECKERLY: No.

23 THE COURT: Okay. Well, Ms. Stanish has such a head
24 for numbers. It's \$2,349,268.18.

25 MS. STANISH: I would never remember that.

1 THE COURT: I know you wouldn't, but I'm telling you
2 so in case I forget to tell you tomorrow you now know that I
3 have this amount.

4 MR. WRIGHT: Say it again.

5 THE COURT: Well, you can ask me tomorrow. I just
6 didn't want to forget that I had this envelope sitting up here
7 and not say anything. It's \$2,349,268.18.

8 MR. WRIGHT: Thank you.

9 (Court recessed for the evening at 5:09 p.m.)
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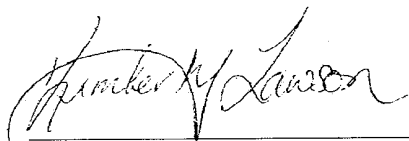
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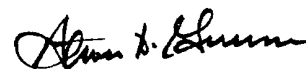
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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 43

TUESDAY, JUNE 25, 2013

APPEARANCES:

| | |
|------------------------|----------------------------------------------------------------------------------------|
| FOR THE STATE: | MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys |
| FOR DEFENDANT DESAI: | RICHARD A. WRIGHT, ESQ. |
| FOR DEFENDANT LAKEMAN: | MARGARET M. STANISH, ESQ. FREDERICK A. SANTACROCE, ESQ. |

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1 LAS VEGAS, NEVADA, TUESDAY, JUNE 25, 2013, 9:30 A.M.

2 * * * * *

3 (Outside the presence of the jury.)

4 THE COURT: Did anyone need me for anything before
5 we start?

6 MR. WRIGHT: I was going to mark that as an exhibit.
7 It's simply the Meana family proceeds received from the civil
8 litigation.

9 THE COURT: Oh. Okay.

10 MR. WRIGHT: That's the number we got from you.

11 THE COURT: Right. Which --

12 THE CLERK: It's a Court's exhibit.

13 THE COURT: All right. So are we just going to read
14 that as a stipulation, or do you want it to be an exhibit
15 exhibit or what?

16 MR. WRIGHT: I'll just make it a defense exhibit.

17 THE COURT: Okay. So make it BB-1 or whatever is
18 next.

19 MR. WRIGHT: And then I was going to read in a
20 portion of Meana deposition.

21 THE COURT: Okay.

22 MR. STAUDAHER: Which we don't necessarily have an
23 issue with, but the issue that's concerning that area that
24 counsel gave us a head's up on was related to interferon. And
25 if he wants to read it in, I want the entirety of that section

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1 dealing with interferon read, which is pages 31 through 45.

2 MR. WRIGHT: Well, I -- I object to it.

3 THE COURT: Basis?

4 MR. WRIGHT: I never got the right to cross-examine
5 him. I am -- at all. This was already offered by the State,
6 denied confrontation, then over our objections you introduced
7 the -- his deposition.

8 THE COURT: Yeah, I mean, that would be the point of
9 them introducing the deposition testimony that they didn't get
10 to complete their cross-examination. I mean, it's not fair to
11 say you didn't get to cross-examine him. You didn't complete
12 your cross-examination.

13 MR. STAUDAHER: I don't have a problem with him
14 introducing it. I just don't want it to be piecemeal. I
15 think that that whole section should --

16 THE COURT: Well, what's the whole section say?

17 MR. STAUDAHER: It's all about -- it's the exchange
18 back and forth about his understanding about his interferon
19 therapy, why he didn't do it, what his symptoms were, things
20 like that. I think it's fair if --

21 THE RECORDER: I'm not picking you up, Mr.
22 Staudaher.

23 MR. STAUDAHER: Oh. I think it's fair that if we
24 bring that in, which I don't have an objection to, that we do
25 the complete section of that to get context so it's not just

1 parsed out. That's what would have happened at a deposition.

2 MR. WRIGHT: Well, let's -- let's read the entire
3 thing because it is the entire thing. I selected the portions
4 that were relevant because he was confused between Dr. Lipman
5 and Dr. Sood and who gave him the -- or the questioners were,
6 or the lawyers or he were confused and mixing up Lipman and
7 Sood.

8 Lipman was only in the case from like April -- no,
9 February, March, April 2008. And Sood and the interferon
10 treatments were in the spring of 2009. And so if you read
11 that part, Lipman's name hasn't even been introduced here in
12 evidence as to who Dr. Lipman is.

13 MR. STAUDAHER: But that's what he's saying. He got
14 advice, at least, from Dr. Lipman in this part of the
15 deposition. So, I mean, that's what I mean. It's a
16 collective whether it was --

17 THE COURT: Well, my other concern is now you're
18 introducing this purported hearsay from Dr. Lipman that Dr.
19 Lipman gave him advice that he wasn't supposed to do or could
20 -- what's the advice? I don't even know.

21 MR. STAUDAHER: That he didn't need to continue it
22 if he had -- if he had problems.

23 THE COURT: That's kind of big stuff, that he didn't
24 need to continue it. So to me, now to introduce something
25 with this Dr. Lipman, do you see what I'm saying? I mean,

1 then that's putting that out there that it's true that Dr.
2 Lipman told him he didn't need to continue it. Is that
3 basically --

4 MR. STAUDAHER: But it's in the context of the exact
5 -- I mean, it's not -- I mean, you just can't take a little
6 piece out and out of context. That's the whole discourse back
7 and forth about interferon therapy, what he was -- that it was
8 offered to him, who offered to him, when did they offer it,
9 what were the -- what -- what did he know about side effects
10 or lack thereof, why he stopped it, why he didn't start it.
11 That's the questioning that goes on.

12 So to take an individual question out of it and put
13 that out there I don't think is fair. I think if that's the
14 case, read it in context, and then he can argue to his heart's
15 content.

16 MR. WRIGHT: You know it's misleading deposition
17 testimony when they say it was Lipman who told him to
18 discontinue it when he is wrong by a year as to what doctor he
19 is talking about. And you're trying to interject information
20 you know is not accurate. That's why I edited it to make it
21 comport with the truth, which is what we're supposed to be
22 looking here --

23 MR. STAUDAHER: Again --

24 MR. WRIGHT: -- for here.

25 MR. STAUDAHER: -- I would ask him --

1 MR. WRIGHT: There is no --
2 MR. STAUDAHER: -- to address the Court --
3 MR. WRIGHT: -- question --
4 MR. STAUDAHER: -- instead of counsel.
5 THE COURT: Okay. First of all, address the Court.
6 MR. WRIGHT: Yes.
7 THE COURT: Second of all, don't interrupt each
8 other. And third of all, and most significantly, don't
9 interrupt me. You may speak.
10 MR. WRIGHT: There -- there is no question in the
11 evidence if you go through all of the medical records of Mr.
12 Meana that starting in February -- January and February of
13 2007 Dr. Carrera and Dr. Clifford Carrol told him to start
14 interferon treatment. That's in evidence by the documents
15 AA-1.
16 And then it's -- there is no question that he
17 learned of the outbreak and obviously I'm not going back to
18 Gastro Center, terminated his relationship. Then there's no
19 question Dr. Jurani told him you need to start interferon, go
20 see another gastroenterologist. Instead, there's no question
21 Mr. Meana hired a lawyer and the lawyer said I want you to go
22 to Infectious Diseases Specialist Lipman.
23 And so he went from March, April, into May to
24 Infectious Control Dr. Lipman. And finally Lipman said I'm
25 not going to treat you for hepatitis C. You need to go to a

1 gastroenterologist. Dr. Jurani then referred him to Dr. Sood
2 like in May or June of 2008. From May or June of 2008, Dr.
3 Sood raised various questions. You need a cardiologist
4 clearance, you need an ophthalmologist clearance because of
5 your blood pressure. Those took -- took from -- took six
6 months because of foot dragging or problems with medical --
7 with --

8 THE COURT: Getting --

9 MR. WRIGHT: -- insurance.

10 THE COURT: -- appointments, whatever.

11 MR. WRIGHT: Right. Then into 2009, spring, Dr.
12 Sood, records are in evidence in AA-1, told him you need to
13 start this. No more foot dragging. No more excuses. And he
14 then started it and next treatment by Dr. Sood in evidence, he
15 said I'm not taking it anymore. I took it once and I can't
16 tolerate the side effects.

17 And so the testimony I am offering is solely about
18 Dr. -- Mr. Meana's testimony about his relationship with Dr.
19 Sood and why he stopped doing it. And significantly did Dr.
20 Sood tell you the consequences it could flow? Yes, he told me
21 I could get cirrhosis, but he said I could beat it on my own
22 if I have a strong immune system, and I do have a strong
23 immune system, so I elected not to take it.

24 THE COURT: All right. Two questions. Number one,
25 you, I'm assuming, have the Lipman records that you're

1 referring to and you reviewed them and that's what the Lipman
2 records indicate, that Lipman said to him, said I can't treat
3 you, you need to go to a gastroenterologist?

4 MR. WRIGHT: I have Lipman's records that Dr. Jurani
5 -- I'm unclear where I acquired them, but I have Lipman's
6 records, Sood's records, and Jurani's records.

7 THE COURT: Okay. So do you have -- the question is
8 do you have records from Dr. Lipman showing from Dr. Lipman,
9 yes, I can't treat him here anymore, he needs to see a gastro
10 specialist? Are those in the records that you have?

11 MR. WRIGHT: I -- I --

12 MR. STAUDAHER: Because I don't have Dr. Lipman's
13 records, so --

14 THE COURT: Yeah, I'm just wondering where that's
15 coming from. Is that coming from Jurani's records, is that --

16 MR. WRIGHT: Jurani's records.

17 THE COURT: Okay.

18 MR. STAUDAHER: Those aren't Lipman's records, then.

19 MR. WRIGHT: Well, it's -- it's -- I don't know.

20 THE COURT: Okay. Then the second question I've now
21 forgotten. What does he say, then, in the deposition about
22 Dr. Lipman that you think is not true that Mr. Staudaher wants
23 to read?

24 MR. STAUDAHER: No, I just want it to be complete.

25 THE COURT: Well, and it's the part you want to read

1 or have read or present to the jury.

2 MR. WRIGHT: Well, where I stop is, question -- I
3 mean, this is part of what I left out.

4 Do you remember seeing Dr. Lipman in November 2008?

5 Answer, I cannot remember.

6 Do you remember Dr. Lipman offering to set up the
7 interferon treatment plan for you?

8 I mean, I just know these questions are wrong.

9 THE COURT: Who is asking the questions in the
10 deposition? Is it the --

11 MR. WRIGHT: Civil attorney.

12 THE COURT: I know. Is it the defendants that are
13 asking those questions or his own lawyer?

14 MR. WRIGHT: Stoberski.

15 THE COURT: Oh, yeah, Mr. Stoberski. Okay. He was
16 on the defense side. I don't remember who he represented,
17 but --

18 MR. STAUDAHNER: It says right in the deposition, and
19 I'm referring to page 34.

20 It says, question, You first saw Dr. Lipman in March
21 of 2008?

22 His answer, I don't remember.

23 Do you recall discussing with Dr. Lipman whether you
24 should go on interferon treatment? Yes. Dr. Lipman
25 told me I don't have to take the treatment because I'm too old

1 for the supposed treatment and I may not be able to -- to be
2 the side effects.

3 Did you start treatment despite his warning?

4 Yes, only once.

5 Then there's an objection.

6 Did Dr. Lipman advise you start interferon
7 treatment?

8 No.

9 Did he want you to start interferon treatment?

10 The what?

11 He didn't want you to do interferon treatment?

12 Yes.

13 And you tried interferon treatment once?

14 Yeah. Not Dr. Lipman, but another gastro
15 specialist.

16 So he's telling -- he's saying that's not who he did
17 it with. He's saying it was with another one.

18 Later on after Dr. Lipman?

19 Yes.

20 Do you remember the other specialist that you went
21 to, what his name was?

22 Dr. Rajat Sood. I'm not sure about the first name.

23 I think you're correct, it's Dr. Sood. What is your
24 understanding of what kind of specialist Dr. Sood is?

25 And then he goes on. But that's clearly a conversation he had

1 with Dr. Lipman beforehand. He knows that there's a
2 difference, that he actually treated with interferon with --
3 with Dr. Sood. So I don't necessarily think based on that
4 that it appears as though it's false or inaccurate. He went
5 to Dr. Lipman in the time frame in question, he got advice
6 from him, and then he went to Dr. Sood for the actual
7 treatment.

8 THE COURT: Here's the deal. Because the
9 limitations with cross-examination and the fact -- I mean,
10 we've heard abundant evidence of Mr. Meana's sort of weakened
11 mental state and everything like that, I'm not going to allow
12 either side to introduce something that's inconsistent with
13 the medical records. Because I think we can assume that that
14 would be the truth. So do we -- that's why I ask. Do we have
15 anything from either Dr. Jurani or from Dr. Lipman showing
16 that he was told he wasn't a good candidate for interferon
17 or --

18 MR. STAUDAHER: I don't have --

19 THE COURT: -- that that was --

20 MR. STAUDAHER: -- Dr. Lipman's records.

21 THE COURT: Okay.

22 -- or that was discussed or if they're in Dr.
23 Jurani's records? Because at some point he came back from Dr.
24 Lipman to Dr. Jurani; is that correct?

25 MR. STAUDAHER: I don't know the answer to that.

1 THE COURT: You see what I'm saying? So if the
2 medical records don't comport with that, then I'm reluctant to
3 let you get into it because I would defer to the medical
4 records. If the medical records are consistent with that or
5 -- then I would say certainly I think you're -- you can
6 introduce the whole thing or that portion.

7 MR. STAUDAHER: Right. I mean, then that's just
8 what we're talking about. The State's position is that if you
9 piecemeal put in between those two pages, which is 31 to 45,
10 it's incomplete and misrepresents what the questions and
11 answers were about that very issue. So that's why I'm just
12 asking for completeness --

13 THE COURT: Okay.

14 MR. STAUDAHER: -- if he's going to put it in.

15 THE COURT: Does someone have Dr. Jurani's medical
16 records --

17 MR. WRIGHT: Yes.

18 THE COURT: -- that show when he came back and was
19 referred to Dr. Sood?

20 MR. WRIGHT: Yes.

21 THE COURT: Can I see that, please?

22 Are the jurors all here, Kenny?

23 THE MARSHAL: Yes, Judge.

24 (Pause in the proceedings.)

25 THE COURT: So am I correct that neither side

1 requested the medical records from Dr. Lipman?

2 MR. STAUDAHER: The State did not, Your Honor.

3 MR. WRIGHT: Yeah, I --

4 THE COURT: Okay. No, I'm just -- just trying to
5 get to the bottom of things. I'm not --

6 MS. STANISH: I can tell you when we arranged for
7 the deposition we requested complete records so we could be
8 prepared for the deposition and the State provided us with
9 what it had and it did not include that.

10 THE COURT: Okay.

11 MR. STAUDAHER: Your Honor, while --

12 THE COURT: Like I said, with all of the limitations
13 that have been imposed with the -- on the defense, I'm going
14 to go with whatever the medical records say.

15 MR. STAUDAHER: Your Honor, while Mr. Wright is
16 looking that up, I just wanted to -- I went through the -- I
17 went up and went through the exhibits today. There are a
18 couple of issues with some things related to the -- I know
19 there was all this stuff that was going on with the billing
20 records. There were some things related to that that appear
21 as though they're not marked as being admitted. It's my
22 understanding that they were. I'm willing to go through it
23 with counsel to go through that, but as far as our resting, I
24 would rest with the caveat that we have to get that
25 straightened out.

1 THE COURT: Okay. That's fine.

2 MR. STAUDAHER: And I believe that there is -- those
3 are the only -- I've marked the areas and I'll go over that
4 with counsel if we -- if we have some time to do that. But I
5 just wanted to make sure that that was on the record that
6 we're resting kind of --

7 THE COURT: Okay.

8 MR. STAUDAHER: -- with that.

9 THE COURT: And then, defense, you have your witness
10 here?

11 MS. STANISH: Yes, she's here, Your Honor. And then
12 we, basically just for scheduling purposes, should be done
13 today.

14 THE COURT: Okay. So we're going to do her -- is
15 she a full day witness?

16 MS. STANISH: She's a half day witness, and then we
17 have our expert, and he'll be -- we figured he probably
18 wouldn't get on until the afternoon.

19 THE COURT: Okay.

20 MS. STANISH: I don't imagine he'll be very long.

21 MR. STAUDAHER: And we do need to talk about him
22 before he gets on the stand.

23 THE COURT: Okay. And then I'll do the -- probably
24 then at the lunch break or so I'll do the Fifth Amendment
25 admonishment with the defendants.

1 MS. STANISH: Correct.

2 THE COURT: I still have to do that.

3 MS. STANISH: And, Your Honor, just kind of long
4 term if you could bear with us, we -- both sides, I believe,
5 would like to have tomorrow off to address with you the jury
6 instructions, as well as prepare for closing arguments.

7 THE COURT: That's fine. I think -- I don't know.
8 I mean, my guess would be jury -- there might be a lot of
9 argument on the instructions. That would be my guess, but I
10 -- I don't know.

11 MS. WECKERLY: We haven't received any yet, so I
12 think we're going to get those tonight. And so that -- you
13 know, I mean, we can maybe --

14 THE COURT: Right.

15 MS. WECKERLY: -- shorten some of it.

16 THE COURT: What I like to make the lawyers do, I
17 mean, if it's clear that there's just, you know, you're not
18 going to agree on some of them, I like the lawyers to meet
19 themselves. Sometimes it's just rewriting one. For example,
20 you may find the defendant guilty or innocent. You know, if
21 they want it changed to not guilty, I normally make that
22 change.

23 Little things like that you may be able to just
24 agree on and make those changes together. Or let's say you
25 want to add a paragraph to one of theirs and if you agree to

1 that or -- you know, things like that if you can agree. On
2 the ones you can't agree on, then, obviously, we just -- we'll
3 settle them in here in front of me. And then I just ask that
4 you just do the special ones that you want either
5 alternatively or in addition to whatever specials they have.

6 And then is this a concerted effort between Mr.
7 Santacroce and Ms. Stanish on the jury instructions?

8 MS. STANISH: It will be. I have --

9 THE COURT: Okay.

10 MS. STANISH: I have my --

11 THE COURT: So there's just --

12 MS. STANISH: -- first draft done.

13 THE COURT: -- going to be, in other words, one
14 defense packet for both defendants; is that correct?

15 MR. SANTACROCE: Yes.

16 THE COURT: Okay. And then I want you to then, of
17 the ones that can't be agreed on that you are submitting, I
18 want those to come to the Court to be made a Court's exhibit
19 in their original form as well. I don't really care about
20 annotations if you want to also submit an annotated form.
21 That's fine. So a copy, two copies, one for me to work off of
22 and one that's a clean copy that won't have my notes on it to
23 be the original Court's exhibit.

24 MS. WECKERLY: Right.

25 THE COURT: Okay.

1 MS. STANISH: Well, we're giving you an annotated
2 one because that fan man statute is -- you know, there's
3 nothing published on it.

4 THE COURT: Okay. That's fine. I'm just saying,
5 you know, I definitely want a clean copy and an annotated
6 copy --

7 MS. STANISH: Absolutely.

8 THE COURT: -- if you're going to do the annotated.
9 And then, like I said, clean to go to the clerk so that
10 anything that we don't use then is definitely part of the
11 record for potential appellate purposes.

12 MS. STANISH: Okey-dokey.

13 MR. WRIGHT: May I -- I'm going to read six pages of
14 deposition of Dr. Jurani, and the reason I'm doing it is
15 that's his records.

16 THE COURT: Okay. May I see that, please?

17 MR. WRIGHT: Okay. And so you can't tell anything
18 from his records, but he testifies to those records.

19 THE COURT: Okay. Would you just show this to the
20 State so they can see what page you're talking about?

21 MR. WRIGHT: Right. I'll just --

22 THE COURT: His writing is pretty impossible to
23 read, I will say.

24 MR. WRIGHT: Right. The -- the portion I'm going to
25 read, 67 to 73, is his reading of the documents --

1 THE COURT: Okay.

2 MR. WRIGHT: -- for March and April regarding Lipman
3 and why it's being switched to Dr. Sood. Page 67 of his May
4 14, 2009, deposition of Dr. Jurani.

5 March 6, 2008, can you go over the clinical history
6 with me, please?

7 Okay. It states he's hired an attorney to sue
8 Endoscopy Center. GI Center was closed. He needs a new
9 referral. He is referring to a gastroenterologist.

10 What does it say under that?

11 It says he knows that it's out of plan, his
12 insurance will not pay if you refer him to a
13 gastroenterologist that's not -- that's out of plan.

14 Okay.

15 Answer, The insurance will not pay. It states Dr.
16 Lipman-- he's referring to his notes. It states Dr. Lipman
17 and attorney will manage the payment. He was very specific
18 about getting referred to a specific person.

19 And that specific person was Dr. Brian Lipman?

20 Answer, Well, that's -- initially that was, you
21 know, Dr. Lipman, infectious disease specialist.

22 Did you refer him to another GI?

23 Well, at that particular time he was insisting on
24 going to -- we have like a healthy discussion of -- because I
25 don't really feel like he should go there, but he insisted on

1 going there.

2 Going where?

3 To see Dr. Lipman. I said patient will go on his
4 own to Dr. Lipman.

5 Why? Did you want him not to go to Dr. Lipman?

6 No, because the appropriate consult would be a
7 gastroenterologist, the one who deals with hepatitis more than
8 infectious diseases.

9 Is that why you wrote in the clinical history needs
10 referral?

11 When he insisted on seeing Dr. Lipman, I crossed it.

12 Do you know if he's still seeing Dr. Lipman?

13 No.

14 Under this note under the test results and
15 medication notes, are you saying that Dr. Lipman -- the note
16 here says -- does that say Dr. Lipman will take care of
17 payments? Can you read that? Can you read it again, please?

18 Okay. GI referral is crossed out, and it says Dr.
19 Brian Lipman, infectious disease, and then the note, it says
20 patient will go on his own.

21 THE COURT: Okay. I'm assuming -- I'm just -- my
22 comment would be, my assumption would be Dr. Lipman would have
23 been treating him on a lien if he was referred by the
24 plaintiff's attorney. That's what that sounds like to me.

25 MR. WRIGHT: Right.

1 Under test results, medication notes, his insurance
2 will not pay. That's under clinical history. Then it
3 continues into test results. He states Dr. Lipman and
4 attorney will manage payment. And is the payment for you or
5 for Dr. --

6 Objections.

7 Okay. I was not involved because he knows insurance
8 will not pay, so they will take care of payment.

9 When did you next see Mr. Meana?

10 April 3, 2008.

11 Can you read the clinical history for me?

12 Saw Dr. Lipman, has more blood tests, no fever, no
13 further treatment. No further treatment was given. He was
14 given a hepatitis B shot, and then below that is the hepatitis
15 RNA report, 12/27/07, \$5,980,000.

16 Going back on something. Brian Lipman.

17 Yes?

18 Have you ever referred to an infectious disease
19 specialist? Why did you have a problem with Dr. Lipman?

20 Well, my concern is treating hepatitis C, an
21 infectious disease, while they deal with that, apparently
22 that's not the normal course that we take when we are dealing
23 with hepatitis C. It has to be either a gastroenterologist,
24 or even a hepatologist. So you're granting, as primary care
25 physician, you're told hep C to refer to a gastroenterologist

1 or a hepatologist.

2 THE COURT: All right. I've heard enough.
3 Balancing everything, you know, like I said the constraints
4 placed upon the defense, the fact that we don't have the
5 Lipman records, the fact that he went to this doctor against
6 the advice of his primary care physician, apparently on an
7 attorney's lien or a personal injury lien it sounds like, it
8 was a separate arrangement, that he ultimately comes back to
9 Dr. Jurani, his primary care physician who has been sort of
10 managing his care this entire time, who then sends him to --
11 I'm sorry --

12 MR. WRIGHT: Dr. Sood.

13 THE COURT: -- Dr. Sood. The fact that the defense
14 is limited in their ability to cross-examine, clearly, Mr.
15 Meana on all of these things, including the incredibly
16 important question of, well, why would you go against the
17 advice of your primary care physician, Dr. Jurani, who you
18 presumably trusted, to go to this other specialist who is not
19 the recommended kind of specialist at the advice of your
20 lawyer I think is opening up a huge Pandora's box of
21 questions.

22 So balancing everything out, the constraints that
23 have been placed due to the, you know, death of Mr. Meana, the
24 fact that he left the country, you know, to die in his
25 homeland, you know, that -- obviously, he had the right to do

1 that, but that placed further constraints on the ability to
2 depose him.

3 The unfortunate timing in the matter and everything
4 else, I'm going to have Mr. Wright just read the portion of
5 the deposition that he selected because, as I just said,
6 looking at the records of Dr. Jurani, which really we can't
7 make out, but Dr. Jurani's testimony, what we understand from
8 that, I think that that creates more questions that then would
9 open more doors for cross-examination that would need to be
10 pursued.

11 Because, like I said, you know, the question is,
12 well, why on earth would he disregard the advice of his
13 primary care physician, Dr. Jurani, and go to a lawyer who was
14 suggested apparently by his attorney when he had insurance in
15 place which would have covered initially a gastroenterologist,
16 presumably. So reading the rest of it along -- and then, you
17 know, if you're going to read that, then we have to read the
18 testimony of Dr. Jurani. I mean, it just opens up a whole new
19 kettle of worms, if you will.

20 So I'm going to have Mr. Wright just read the -- you
21 know, balancing everything, the limitations that were place,
22 the fact that the deposition was played, I'm going to let Mr.
23 Wright just read that portion. Because, again, I think that
24 the testimony, the independent testimony of the primary care
25 physician, who I'm assuming testified as not an expert, but as

1 a treating -- he may have also been an expert, but certainly
2 he was testifying as a treating physician in the civil cases
3 -- I think suggests that the recommended course of treatment
4 was a GI specialist, was Dr. Sood, and there was this sort of
5 deviation that ultimately resulted in him going back to Dr.
6 Jurani and pursuing the course of action that Dr. Jurani had
7 recommended in the first place. So for those reasons I'm
8 going to deny the State's request.

9 Are they ready?

10 MR. STAUDAHER: Your Honor?

11 THE COURT: Yes.

12 MR. STAUDAHER: I understand the Court's ruling, I
13 just want to make a record on it --

14 THE COURT: That's fine.

15 MR. STAUDAHER: -- because of the accusation that
16 was proffered. I did not hear in any of the discourse that
17 counsel read regarding the deposition or any reference to any
18 medical record that what was contained at least in the
19 deposition transcript of Mr. Meana was false, as was implied.
20 We're talking about a date of March of 2008. The dates that
21 counsel referenced were March of 2008, and then in April 2008
22 also when he followed back up after seeing Dr. Lipman. So I
23 think that that was consistent.

24 THE COURT: I think it is consistent with what Mr.
25 Meana said. All I'm saying is I think it opens up --

1 MR. STAUDAHER: I have no problem with that.

2 THE COURT: -- a whole array of other questions and
3 more cross-examination, which obviously he would want to know,
4 well, why are you disregarding Dr. Jurani's suggestion? Why
5 is your lawyer telling you who to treat with that ultimately
6 could have contributed to, you know, a misunder -- I don't
7 want to say contributed to his death, but certainly could have
8 contributed to a misunderstanding in his own mind that led him
9 to refuse treatment?

10 Now, we -- we don't know the answer to that
11 question, but that's certainly a question that pops into my
12 mind hearing the deposition of Dr. Jurani. The reason I said
13 he's certainly a treating physician is because if he testified
14 solely as a treating physician, then he has no dog in the
15 fight. He's not a retained expert. He's just there to say
16 these are my notes, this is what happened as opposed to, as
17 you know, a retained expert that's been paid by either side.

18 So certainly he's testifying as a treating, possibly
19 as an expert, but I don't -- I don't know. But I think, you
20 know, his records as -- my point being I think the records of
21 a treating are more inherently reliable than something that's
22 done by an expert who has been retained by one side or the
23 other and is being paid to form, essentially, a particular
24 opinion.

25 You know, Dr. Jurani's records, he was strictly

1 treating at that point in time, had been his primary care
2 physician. So I think there is a great deal of reliability in
3 those records and the testimony that was based on the records.
4 So if anyone needs to take a quick restroom break, let's --
5 oh, we're not done.

6 MR. WRIGHT: He was a treating physician.

7 THE COURT: No, he was a treating, but I'm saying he
8 could have also then been brought in as an expert. I suspect
9 he wasn't, but that's what I meant.

10 MR. WRIGHT: He was not.

11 THE COURT: Clearly he was a treating. And like I
12 said, all of his records and the testimony was based on his
13 role as a treating physician, which I think is more accurate
14 or is more likely to be accurate because there is no dog in
15 the fight at that point. And he wasn't -- it doesn't sound
16 like he's working on a medical lien, either. He was paid by
17 insurance.

18 MR. WRIGHT: Correct.

19 THE COURT: So in any event --

20 (Court recessed at 10:00 a.m., until 10:03 a.m.)

21 (Outside the presence of the jury.)

22 MR. STAUDAHER: Your Honor, we're going to -- we
23 will be resting with the reservation about the exhibits.

24 THE COURT: Okay.

25 MR. STAUDAHER: And also with the reservation that

1 there's just a couple of cleanup things we want to put on the
2 record in our case in chief, outside the presence, obviously,
3 later on. It doesn't have to be done now, but we just want to
4 make sure that that's reserved, as well.

5 THE COURT: Okay. Like what?

6 MR. STAUDAHER: Well, things that were brought up
7 initially about records with Tom Pitaro involved with
8 attorney-client privilege stuff, things like that.

9 THE COURT: Oh.

10 MR. STAUDAHER: We ferreted out some of that and
11 want to make sure --

12 THE COURT: Okay. So you just --

13 MR. STAUDAHER: -- we put it on the record.

14 THE COURT: -- want to correct some
15 representations --

16 MR. STAUDAHER: I just want to put --

17 THE COURT: -- that were made --

18 MR. STAUDAHER: -- it on the record, yes.

19 THE COURT: -- that maybe weren't correct? That's
20 fine.

21 MR. STAUDAHER: And also that we made a disclosure
22 to the defense as to who the CI was listed in the search
23 warrant so that that's on the record, too.

24 MR. WRIGHT: And -- and at the same time I -- I want
25 to reserve arguing about Exhibit 87. That's the affidavit

1 prepared for CRNAs that I had stipulated to, then withdrew my
2 stipulation because I didn't know where it came from.

3 THE COURT: Oh, this was from the search warrant
4 that they found?

5 MR. WRIGHT: Right. I want to -- and we reserved on
6 that, and so I want to -- and we don't have to do it now.

7 THE COURT: Okay.

8 MR. WRIGHT: I mean, but at the same time I want to
9 argue about --

10 THE COURT: Yeah, we never had any testimony on that
11 anyway about where that came from --

12 MR. WRIGHT: Right.

13 THE COURT: -- as a result of the search warrant, if
14 it was in a box, if it was --

15 MR. STAUDAHER: Well, it's because it was a
16 stipulated --

17 THE COURT: -- on a computer. Right. It was
18 stipulated.

19 MR. STAUDAHER: He can get back up on the stand if
20 we need to deal with that.

21 THE COURT: I don't know if -- I mean --

22 MR. WRIGHT: Well, I -- I stipulated to it not
23 knowing that it was -- what I stipulated to was when I went
24 over there on that Friday afternoon and looked at everything
25 and I understood it had all come from, and then this appeared

1 and I didn't stipulate to that. I agree I --

2 THE COURT: What do you mean this appeared? Was it
3 there when you looked at the exhibits in their office --

4 MR. WRIGHT: No.

5 THE COURT: -- or wasn't it?

6 MR. STAUDAHER: I don't believe that -- at least at
7 court beforehand, the two weeks before or whatever, or the
8 week before we started trial, it was not part of that. It was
9 part of the exhibits that I brought over to show --

10 THE COURT: That particular day.

11 MR. STAUDAHER: -- before we started, then they
12 stipulated in court that day as to them, but I don't believe
13 that he realized, afterward, at least that was what he said,
14 that he didn't realize what it was until later. So --

15 MR. WRIGHT: Right.

16 MR. STAUDAHER: But -- but we did, then, disclose
17 where that information came from one of the computers, and I
18 think that --

19 THE COURT: Right. Well, here's the deal. Where
20 did that -- does --

21 Detective Whitely, do you know where that particular
22 exhibit even came from?

23 MR. STAUDAHER: He does.

24 MR. WHITELEY: I'll find it.

25 THE COURT: Okay.

1 MS. STANISH: Well, he didn't know where the other
2 exhibits came from yesterday.

3 MR. STAUDAHER: He knows. He said that he needed a
4 cover sheet. And he can actually do that, it's just that you
5 didn't provide the cover sheet for him.

6 MR. WHITELEY: Where's the cover sheet?

7 MS. STANISH: I didn't provide the cover sheet?

8 MR. WRIGHT: We can do this --

9 THE COURT: All right. We can do it later. I'm
10 just -- just making sure that we have a witness who even knows
11 where it comes from as opposed to --

12 MR. STAUDAHER: He does.

13 THE COURT: -- oh, here's just this exhibit that
14 came out of the search warrant, but we don't know if it's from
15 a computer or if it was in a file or, you know, who downloaded
16 it or where it was, if it was an email. Because that was the
17 attorney-client issue --

18 MR. WRIGHT: Right.

19 THE COURT: -- that I had raised that I was
20 concerned about that this better not have been an attachment
21 to an email or in a file or something like that because it
22 could also be -- I mean, it's clearly written by a lawyer or
23 appears to be. Clearly, I'm pretty sure it wasn't written by
24 Dr. Desai based on the other things he's written. There is no
25 way he wrote that. Nothing against --

1 MR. STAUDAHER: Just so the Court would be aware
2 that if we -- if there was an issue on that and we had to then
3 bring it in through the detective --

4 THE COURT: Okay.

5 MR. STAUDAHER: -- we would have to reopen --

6 THE COURT: That's fine.

7 MR. STAUDAHER: -- our case.

8 THE COURT: That's fine. All right. Bring them in.

9 (Inside the presence of the jury.)

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

15 Mr. Staudaher.

16 MR. STAUDAHER: Your Honor, at this time with the
17 reservations that we have discussed previously related to
18 exhibits and other things, the State would rest at this time.

19 THE COURT: All right. Mr. Wright.

20 MR. WRIGHT: Yes, before calling a witness I'm going
21 to offer two items.

22 THE COURT: All right.

23 MR. WRIGHT: One is Exhibit BB-1.

24 THE COURT: All right. And that's stipulated to; is
25 that correct?

1 MS. WECKERLY: Is that this one?
2 THE COURT: Yes.
3 MS. WECKERLY: Yes.
4 MR. STAUDAHER: Yes.
5 THE COURT: Thank you.
6 MR. STAUDAHER: Oh, yes. I'm sorry.
7 THE COURT: All right. And would you just present
8 that? You can publish that to the jury, if you'd like.
9 MR. WRIGHT: Thank you. Exhibit BB-1 deals with
10 resolution of the civil cases with the Meana family by the
11 Meana family's civil litigation against various individuals.
12 And the Meana family total proceeds received from civil
13 litigation, \$2,349,268.18.
14 THE COURT: All right. Thank you.
15 MR. WRIGHT: And I'm going to read, Your Honor, a
16 portion of a deposition of Mr. Meana taken on November 22,
17 2011, in civil litigation.
18 THE COURT: All right. Thank you.
19 And, ladies and gentlemen, this deposition, as Mr.
20 Wright just told you, was taken in connection with one of the
21 civil lawsuits that Mr. Meana was involved with.
22 MR. WRIGHT: And I will read the questions and
23 answers, Your Honor.
24 THE COURT: All right.
25 MR. WRIGHT: Question, Did Dr. Sood recommend that

1 you start the interferon treatment?

2 Answer, Dr. Sood actually was the one who told me to
3 undergo the tests, the treatment of the interferon.

4 Question, Did you start the interferon based on Dr.
5 Sood?

6 Answer, And Dr. Sood.

7 Question, And how many times did you take
8 interferon?

9 Answer, Only once.

10 Question, Did you give yourself a shot?

11 Answer, Yes.

12 Where did you take the shot?

13 Answer, On my thigh.

14 Question, And what type of side effects did you have
15 from the shot?

16 Answer, I have a flu-like symptom. I have diarrhea,
17 jaundice, and some sort of slight depression.

18 Question, Did Dr. Sood explain to you what might
19 happen if you didn't continue with the treatment?

20 Answer, Yes.

21 What do you remember him telling you?

22 Answer, Telling me that I might not -- telling me
23 that I might have some scar -- scar in my -- and that I might
24 also possibly will have later on cirrhosis and it will
25 actually try to destroy some cells in my liver.

1 Question, Did Dr. Sood tell you how long the
2 cirrhosis might take to develop?

3 Answer, No.

4 Question, Was it your decision to not stay with the
5 interferon, to not keep going with the interferon?

6 Answer, Yes, I have decided not to take it.

7 Question, And was that because of the side effects
8 only?

9 Answer, Yes.

10 Did Dr. Sood tell you that the interferon treatment
11 could cure you?

12 Answer, Yes.

13 But the side effects were too much, so you decided
14 not to stay on the interferon?

15 Answer, Yes.

16 Did you understand that there was a risk that you
17 would develop cirrhosis of the liver if you did not continue
18 with interferon treatment?

19 Answer, Yes, I understand that, but I was told that
20 it depends on how strong is your immune system. Sometimes the
21 immune system might be able to cure you.

22 Question, Did you feel that you had a strong immune
23 system that would be cured without the interferon?

24 Answer, Yes.

25 THE COURT: All right.

1 MR. WRIGHT: Thank you, Your Honor.

2 THE COURT: Thank you, Mr. Wright. And the defense
3 may call its first witness.

4 MR. WRIGHT: We call Dorothy Sims.

5 THE COURT: Ma'am, just right up here, please, up
6 those couple of stairs. And then just remain standing facing
7 that lady right there who will administer the oath to you.

8 DOROTHY SIMS, DEFENDANT'S WITNESS, SWORN

9 THE CLERK: Thank you. Please be seated. And
10 please state and spell your first and last name for the
11 record.

12 THE WITNESS: Dorothy, D-O-R-O-T-H-Y, Sims, S-I-M-S.

13 THE COURT: All right. Thank you.

14 Mr. Wright, you may proceed.

15 DIRECT EXAMINATION

16 BY MR. WRIGHT:

17 Q Dorothy Sims, is it Nurse Sims or what's your
18 title?

19 A I am a registered nurse, yes.

20 Q Okay. And tell the jury a little bit about
21 your education.

22 A I attended the University of Nevada at Las
23 Vegas. I have a bachelor's degree in nursing. I have five
24 years experience in neonatal intensive care nursing, I did two
25 years of case management, and for the last eight years I've

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1 been with the Bureau of Healthcare Quality and Compliance.

2 Q Okay. The Bureau of Healthcare Quality and
3 Compliance was previously known as what?

4 A The Bureau of Licensure and Certification.

5 Q Okay. In the courtroom here for the period in
6 2007 and 2008 we've been referring to a state agency as the
7 BLC. Is that where you work?

8 A Yes.

9 Q Okay. And it's now changed its name?

10 A Yes.

11 Q Okay. Just for continuity and what we've been
12 doing here in the courtroom I'm going to call it the BLC,
13 okay?

14 A Okay.

15 Q And so you were employed by the BLC in January
16 2008, five and a half years ago?

17 A Yes.

18 Q And you're still so employed?

19 A Yes.

20 Q And what is your current position?

21 A I'm a Health Facilities Inspector III,
22 supervisor position.

23 Q Okay. And in January 2008 what was your
24 position?

25 A I was a Health Facilities Inspector II as a

1 surveyor, and then I got promoted to a Health Facilities -- or
2 at the time it was a Health Facilities Surveyor III,
3 supervisor position.

4 Q Okay. And so did you participate in January
5 2008 for the BLC with an inspection at the endoscopy clinic on
6 Shadow Lane here in Las Vegas?

7 A Yes.

8 Q Now --

9 THE COURT: Keep your voice up.

10 MR. WRIGHT: Okay.

11 BY MR. WRIGHT:

12 Q Do -- do you recall your first involvement?
13 When did you first go to the clinic?

14 A That I can't recall.

15 Q Okay.

16 A Can --

17 Q I'm going to show you some documents. It's
18 been five and a half years; correct?

19 A Yes, it has.

20 Q Okay. And we have not met until I just saw
21 you in the anteroom; correct?

22 A Yes.

23 Q So I have not interviewed you or had meetings
24 to prepare your testimony; correct?

25 A Yes.

1 MR. WRIGHT: May I approach, Your Honor?

2 THE COURT: You may.

3 BY MR. WRIGHT:

4 Q I'm going to show you something called a ACPS
5 complaint incident investigation report.

6 A Okay.

7 Q Look at that to yourself and tell me if you
8 recognize what that is.

9 A Yes, I do recognize it.

10 Q Okay. Is that the incident investigation
11 report pertaining to the Shadow Lane clinic for January 2008?

12 A Yes, it is.

13 Q Okay. And was this report produced based upon
14 BLC's investigation at the Shadow Lane clinic?

15 A Yes, it is.

16 Q Okay. You -- you may utilize that to refresh
17 your recollection as to dates, times, meetings.

18 A Okay.

19 Q And the -- what I'm -- what I'm initially
20 looking for is do you recall a first entry meeting when it was
21 the first time you went to the clinic?

22 A Yes.

23 Q Okay. And can you tell when that was by
24 refreshing your recollection?

25 A January 9, 2008.

1 Q Okay. And do you -- using that date, do you
2 recall the meeting and who you went with?

3 A Yes.

4 Q Okay. And who was that?

5 A There was another member of the Bureau of
6 Licensure and Certification, there were two members from the
7 CDC or Center for Disease Control, and one member from the
8 Southern Nevada Health District.

9 Q Okay. And would that have been Brian Labus?

10 A Yes.

11 Q Okay. And do you -- you -- you went to the
12 clinic to participate in an investigation because there had
13 been a hepatitis C outbreak; is that correct?

14 A Yes.

15 Q Okay. Do you recall that independently?

16 A No, I read it from the --

17 Q Okay.

18 A -- report.

19 Q The -- okay. Well, I'm just trying to figure
20 -- do you recall going to the clinic and participating in the
21 investigation? Forget in the time frame and day of the week.
22 Just tell me if you remember that.

23 A I do remember going to the clinic to
24 participate in an investigation.

25 Q Okay. And do you remember that it was a

1 hepatitis C -- outbreak was my word, but there had been
2 several cases of hepatitis C identified for patients from the
3 clinic?

4 A That's correct.

5 Q Okay. And do you recall that they had been
6 patients, the victims had been patients at the clinic on a
7 couple of specific days?

8 A I'm not -- I'm not understanding the question.

9 Q Okay. Do you recall that they -- the -- the
10 patients who contracted hepatitis C had been patients at the
11 clinic on Shadow Lane on a couple, two specific dates in 2007?

12 A Yes.

13 Q Okay. Now, your -- your purpose in going --
14 you -- you went with -- who did you go with from BLC?

15 A On the first day of the survey, so on Sep --
16 no, on January 9th it was Nadine Howard.

17 Q Okay. And the first meeting you had at the
18 clinic, do you recall who was present on behalf of the clinic?

19 A Can I refer to my --

20 Q Yeah. Do you --

21 A -- notes?

22 Q Do you recall was a -- well, you can go ahead.
23 I don't want to lead you.

24 A According to the report we met with the chief
25 operating officer, a physician, the charge nurse, and the

1 director of nursing.

2 Q Okay. And would the -- would the -- do you
3 recall the name Tonya Rushing?

4 A Yes.

5 Q Okay. Would she be like the chief operating
6 officer?

7 A Yes.

8 Q Okay. And Dr. Clifford Carrol?

9 A Was the physician.

10 Q Okay. And Jeffery Krueger?

11 A Was the charge nurse.

12 Q Okay. And the director of nursing, Katie
13 Maley?

14 A Yes.

15 Q Okay. And at -- at this initial meeting, tell
16 the jury what the purpose of the initial meeting was.

17 A The initial meeting was to inform the -- the
18 facility that we were there to investigate a complaint
19 allegation regarding infection control.

20 Q Okay. And did you tell them what the issue
21 was?

22 A The Southern Nevada Health District informed
23 them of the issue.

24 Q Okay. And was the issue the outbreak of
25 hepatitis C connected to that clinic?

1 A Yes.

2 Q Okay. And did -- at that meeting did the
3 clinic representatives cooperate?

4 A Yes.

5 Q Okay. And did the clinic representatives
6 explain their procedures and what they do there?

7 A Can you clarify the procedures?

8 Q Okay.

9 A Like as to what you're asking.

10 Q Okay. Like what type of anesthesia they use
11 for the procedure.

12 A Yes.

13 Q Okay. And do -- do you recall what -- what
14 they -- what you learned?

15 A And I can go by my notes here?

16 Q Sure, if you need to refresh your
17 recollection.

18 A Okay. Okay.

19 Q Do you recall what they said about the
20 anesthesia used at the clinic?

21 A Yes.

22 Q And what did they say?

23 A They use propofol and lidocaine to sedate the
24 patient.

25 Q Okay. And did they use multi-dose vials?

1 A Yes.

2 Q Okay. And you were -- you were -- you and
3 everyone at the meeting were told that at the initial entry
4 meeting; correct?

5 A Yes.

6 Q Did you have familiarity with propofol?

7 A No.

8 Q Okay. Did -- did you know if propofol is
9 single-dose or multi-dose vials on Wednesday, January 9th at
10 the first meeting?

11 A No, I did not.

12 Q Okay. Did -- is -- is it fair to say that at
13 that meeting the -- do you recall specifically who of the
14 individuals, who explained that they use multi-dose propofol
15 and multi-dose lidocaine to sedate?

16 A No, I don't.

17 Q Okay. The -- did anyone at that meeting, the
18 CDC or the -- you're the BLC, but your other BLC member there
19 with you, or the Southern Nevada Health District, did anyone
20 at that meeting say stop, you can't multi-dose propofol at
21 that initial meeting?

22 A No.

23 Q Okay. At that initial meeting it -- it was
24 not known by the -- by yourself that propofol could not be
25 used multi-dose, is that fair?

1 A Yes.

2 Q Okay. You learned differently, correct, after
3 the initial meeting?

4 A Yes.

5 Q Okay. I mean, I saw some hesitancy on your
6 face. I want to be clear. That initial meeting Wednesday the
7 9th we multi-dose propofol and no one -- no representative of
8 the government said anything about stopping that practice;
9 correct?

10 A That's correct.

11 Q Okay. And did you -- did you all return the
12 next day?

13 A Yes.

14 MS. WECKERLY: I just want to -- if we could just
15 clarify who it is that's returning.

16 BY MR. WRIGHT:

17 Q Okay. Who -- who is returning on January
18 10th?

19 A The BLC returned with -- Nadine returned, I
20 returned, and we had another surveyor from the BLC, Leslee
21 Kosloy joined us. There were representatives from the CDC and
22 representatives from the Southern Nevada Health District.

23 Q Okay. And on that next day, Thursday, January
24 10th, did -- did you -- were you there all day, the three of
25 you, from BLC?

1 A Yes, we were.

2 Q Okay. And did you participate in chart
3 reviews and observations in the clinic?

4 A Yes.

5 Q Okay. And were you observing procedures and
6 cleaning of scopes and everything that goes on in the clinic?

7 A Yes.

8 Q And you were looking to see if, in layman's
9 terms, they were doing everything right?

10 A Yes.

11 Q Is that -- is that fair?

12 A Yes.

13 Q Okay. Because there -- there had been an
14 outbreak of hepatitis C tied to the clinic, and you all were
15 investigating to determine if you could figure out how the
16 hepatitis C spread and any wrongdoing in any of the procedures
17 or processes in the clinic; correct?

18 MS. WECKERLY: I'm going to object to leading.

19 THE COURT: Overruled.

20 You can answer.

21 THE WITNESS: We were looking at whether they were
22 following infection control practices. Whether they were --
23 the cleaning of the scopes was done properly, so that's what
24 we were looking -- looking at.

25 BY MR. WRIGHT:

1 Q Okay.

2 A So we were looking at infection control
3 practices in the facility.

4 Q Okay. And so in doing that you would observe
5 procedures?

6 A Yes.

7 Q Okay. And follow a patient through -- a
8 patient is done and following to the cleaning of the scopes
9 and all that takes place?

10 A Yes.

11 Q Okay.

12 THE COURT: You are leading.

13 MR. WRIGHT: Okay. Correct.

14 BY MR. WRIGHT:

15 Q Tell me, who did -- do you recall who you
16 observed on Thursday, January 10th? And I'm going to give you
17 some more notes.

18 A Okay.

19 Q Okay?

20 A Okay.

21 Q Because it's been five and a half years.

22 MR. WRIGHT: I'm going to ask her to identify --

23 MS. WECKERLY: Okay.

24 MR. WRIGHT: -- what they are.

25 MS. WECKERLY: Yeah, would you, please.

1 BY MR. WRIGHT:

2 Q I have one stack here. Can you -- do you --
3 can you tell me what those represent?

4 A These are my handwritten notes.

5 Q Okay. And so the -- your handwritten notes,
6 you write well, I can read it. And the -- to your right, you
7 were actually looking at the typed report; correct?

8 A That's correct.

9 Q And so this -- your handwritten notes were
10 made simultaneously while you were at the clinic?

11 A Yes.

12 Q Okay. And I have another package of notes.
13 Can you tell me what those represent?

14 A These are notes that were taken during
15 telephone calls after the investigation was completed.

16 Q Okay. And are those your notes?

17 A Yes, they are.

18 Q Okay. You can just hang on to those three
19 things as I go through because the first question I have is on
20 January 10th did you observe an endoscopic procedure in which
21 a CRNA participated? Looking at your handwritten notes, look
22 at the second to the last page.

23 A Okay. Okay.

24 Q Is that a 1/10/08 observation?

25 A Yes.

1 Q Okay. And is -- and these are your notes, and
2 is this your observation?
3 A Yes.
4 Q Okay. And do you recall who is the CRNA you
5 were observing?
6 A Linda Hubbard.
7 Q Okay. And it's -- the date is January 10,
8 2008. That's a Thursday. I'll tell you that. We know it
9 because we've been dealing with it here. Okay?
10 A Okay.
11 Q And what time?
12 A 3:35 p.m.
13 Q And the -- the administration of anesthesia,
14 did the CRNA administer propofol?
15 A Yes.
16 Q Okay. And is it -- is she using the propofol
17 -- Linda Hubbard using the propofol vial as a multi-dose vial
18 on Thursday afternoon?
19 A Yes.
20 Q And if -- do you recall watching her like
21 administer propofol?
22 A I watched her administer the propofol to the
23 patient.
24 Q Okay. And if the patient needed additional
25 propofol, another dose, she was utilizing the same vial of

1 propofol; is that correct?

2 A Yes.

3 Q And when -- when she would redose, did she use

4 same needle and syringe or new needle and syringe?

5 A New syringe.

6 Q Okay. So the -- she -- she -- she would --

7 and we're talking about giving a second injection to the

8 patient; correct?

9 A Yes.

10 Q Okay. And she would utilize a new needle and

11 syringe to give an additional dose to the patient?

12 A I have written down just that new syringe.

13 Q Okay. I see written there separate syringes

14 for additional doses propofol.

15 A Yes.

16 Q Okay. Is that what you're referring to?

17 A Yes.

18 Q And at the time they were still utilizing

19 propofol as multi-dose vial; correct?

20 A Yes.

21 Q Meaning if -- if a new patient, if there's

22 still propofol available and a new patient comes in, they

23 would use the same vial on the new patient, but with a new

24 needle and syringe --

25 MS. WECKERLY: Objection.

1 BY MR. WRIGHT:

2 Q -- is that correct?

3 THE COURT: Basis?

4 MS. WECKERLY: Well, he said they, and I think she's
5 only observing Ms. Hubbard.

6 THE COURT: All right. So be more specific in your
7 question.

8 BY MR. WRIGHT:

9 Q Ms. Hubbard.

10 A I'm sorry. Can you ask that again?

11 Q Yes. Now, tell me the propofol was being used
12 multi-dose; correct?

13 A Yes.

14 Q Okay. And so one vial could be used on more
15 than one patient; correct?

16 A Yes.

17 Q Okay. And so if one patient is done and a new
18 patient comes in and the remainder of the propofol is to be
19 used, what would Linda Hubbard do?

20 A She indicated she would get a new syringe.

21 Q Okay. And is -- is all of that safe and
22 aseptic as you understand it?

23 A Yes.

24 Q Okay. Because she is utilizing a new -- is it
25 because she is utilizing a new needle and syringe each time

1 she goes into the vial?

2 A Yes.

3 Q Now, did anyone at that time, Thursday, okay,
4 you three representatives from BLC are there, CDC is there,
5 Southern Nevada Health District is there; correct?

6 A Yes.

7 Q Okay. Did anyone on Thursday step in and stop
8 the clinic and say propofol is single-use, you shouldn't be
9 multi-dosing?

10 A No.

11 Q Okay. I want to go -- you -- you made
12 additional visits to the clinic; correct?

13 A Yes.

14 Q Okay. And did you make additional
15 observations at the clinic?

16 A Yes.

17 Q Okay. And do you recall observations on
18 January 16, 2008?

19 MR. WRIGHT: If I can approach?

20 THE COURT: That's fine.

21 BY MR. WRIGHT:

22 Q I'll direct you to the way I read your notes.
23 Did you again see -- observe Linda Hubbard on the 16th?

24 A This was just an interview.

25 Q Okay. An interview with Linda Hubbard on

1 January 16, 2008?

2 A Yes.

3 Q Okay. And that's you interviewing her?

4 A Yes.

5 Q Okay. And she is the CRNA you had previously
6 observed?

7 A Yes.

8 Q Okay. And why don't -- why don't you run
9 through your interview with her?

10 MS. WECKERLY: Objection. Hearsay.

11 THE COURT: I'll see counsel up here.

12 (Off-record bench conference.)

13 THE COURT: All right. That's overruled.

14 Ladies and gentlemen, the statements made by Ms.
15 Hubbard that are testified to may only be considered by you as
16 to their effect on the listener, the person hearing the
17 statements and what knowledge and what information they had in
18 the course of their investigation.

19 So go on, Mr. Wright.

20 BY MR. WRIGHT:

21 Q Go ahead and explain what Linda Hubbard told
22 you on January 16th.

23 A The registered nurse would give the propofol
24 vials to the CRNA. The propofol vials were to remain in the
25 room. A syringe and needle, both new, and 20 milligrams of

1 lidocaine and 110 milligrams of propofol would be drawn up.
2 They would refill same syringe, same vial, and toss the
3 propofol after each patient.

4 Q Okay. And -- and what did she tell you had
5 been the practice in the past?

6 A In the past did not use the propofol as a
7 single-use vial. Used a clean syringe for each patient, may
8 use the propofol for two patients, clean draw.

9 Q Okay. Now, it -- interpret what her practice
10 on January 16th was as you understood it. At that time were
11 they using propofol as a single patient -- a single-use vial
12 as opposed to multi-use?

13 A Yes. On January 16th Linda Hubbard indicated
14 that the propofol was used for one patient only.

15 Q Okay. And so no more multi-use, single-use
16 propofol; correct?

17 A Yes.

18 Q Okay. And if the patient needed additional
19 dose of propofol, Linda Hubbard was refilling same syringe,
20 same vial; is that correct?

21 A Yes.

22 Q Okay. And does that -- rather than using a
23 new needle and syringe, she was reusing same needle and
24 syringe, go back into the vial, redose the patient, and at the
25 conclusion toss needle, syringe, and remnants of propofol; is

1 that correct?

2 A Yes.

3 Q Okay. And is all of that safe injection
4 practices and aseptic technique?

5 A It would not be the best practice, but if she
6 tossed the propofol vial after each patient, my opinion it
7 would be safe, but not best practice.

8 Q Okay. What -- what would you view as best
9 practice?

10 A New syringe, new needle to reenter the vial.

11 Q Okay. At -- at the time did you or BLC tell
12 Linda Hubbard on the 16th you can't do that?

13 A No, we did not. I did not.

14 Q Okay. At -- at that time -- I'm taking this
15 chronologically.

16 A Okay.

17 Q At that time you were aware of the fact that
18 the clinic historically had been using propofol as multi-use
19 vials; correct?

20 A Yes.

21 Q Okay. You were aware of reuse of syringes on
22 same patient; correct?

23 A Yes.

24 Q Okay. And at that time you and the BLC did
25 not recognize those two components as creating a health

1 hazard; correct?

2 A From what they told us, that's correct.

3 Q Okay. And ultimately BLC issued a -- what do
4 you call that document where -- where the clinic then gives
5 you a plan of correction?

6 A A statement of deficiencies.

7 Q Okay. Statement of deficiencies. That's what
8 I was looking for. The BLC, your agency, issued a statement
9 of deficiencies to the clinic on Shadow Lane; correct?

10 A Yes.

11 Q And that statement of deficiencies identified
12 what deficiencies, do you recall?

13 A No, I would -- I would need to see the
14 statement of deficiencies.

15 Q Okay. Does that look like it?

16 A Yes.

17 Q Okay. And what -- what were the deficiencies
18 -- when did your investigation end?

19 A January 17, 2008.

20 Q Okay. So it went from January 9th through
21 January 17th; correct?

22 A Yes.

23 Q Okay. And then a -- a report or a statement
24 of deficiencies is issued to the clinic; correct?

25 A Yes.

1 Q And it's pointing out any deficiencies that
2 have been identified by inspection, observation, or
3 interviews?

4 A Yes.

5 Q Okay. And then once the clinic receives that,
6 just like any other clinic here in Nevada or hospital or
7 doctor's office now, they -- they get to respond; correct?

8 A Yes.

9 Q And that response is called what?

10 A A plan of correction.

11 Q Okay. And is that -- that document there,
12 does that have the statement of deficiencies and the plan of
13 correction?

14 A Yes, it does.

15 Q Okay. And so the statement of deficiencies
16 was authored -- was authored or delivered to them, the clinic,
17 about when?

18 A It was provided to the clinic on -- around
19 February 4, 2008.

20 Q Okay. And -- and did they -- and you
21 indicated that there is a plan of correction. Is that where
22 they essentially -- the clinic answers and states what they
23 will do to correct each deficiency right in on the same
24 report?

25 A Yes.

1 Q Okay. And did the clinic provide a plan of
2 correction?

3 A Yes, they did.

4 Q Okay. Now, explain what the deficiencies were
5 that were that were identified for the clinic.

6 A The first deficiency was the facility failed
7 to ensure the center adopted and reviewed written policies and
8 procedures for the use of single dose of propofol vials, and
9 for the first step of the cleaning process for the upper
10 gastrointestinal endoscopy and colonoscopy scopes, and the use
11 of disposable biopsy instruments.

12 Q Okay. So three different deficiencies?

13 A For the first tag, yes.

14 Q First tag?

15 A Yes.

16 Q What's that mean?

17 A In our regulations we have tag numbers to
18 identify specific regulation sets. So when we find a
19 deficient practice we would cite it at the most appropriate
20 tag.

21 Q Okay. So you -- to a layman it sounds like
22 you found three things wrong.

23 A Under the administration tag, so it's the
24 governing body, the regulation is the governing body shall
25 ensure that that the center adopts and enforces and annually

1 reviews written policies and procedures required by the NAC,
2 inclusive and including an organizational chart, and these
3 policies and procedures must be approved by the governing body
4 annually. So that --

5 Q Okay.

6 A -- was the regulation, and we found three
7 areas of deficient practice under that regulation.

8 Q Okay. And what were the three deficient
9 practices? Number one was propofol?

10 A Failure to adopt and review written policies
11 and procedures. The first one was the use of single-dose
12 propofol vials.

13 Q Okay. And -- and the deficiency was what?
14 Using single-dose as multi-dose?

15 A That's correct.

16 Q Okay. And it had -- when we went through it
17 chronologically you all had been there on Wednesday and they
18 explained that they used propofol multi-dose.

19 A Uh-huh.

20 Q It was observed on Thursday, multi-dosing
21 propofol. And then by the 16th of January, the practice had
22 changed; correct?

23 A Yes.

24 Q Okay. And during the interim was it brought
25 to the clinic's attention? Between January 10th and 16th when

1 they changed their practices, was that because they were told
2 use this single-dose, not multi-dose?

3 A Yes.

4 Q Okay. And that was why?

5 A We did not -- the BLC did not inform them to
6 use it as a single-dose. That was done by either the CDC or
7 Southern Nevada --

8 Q Okay.

9 A -- Health District.

10 Q All right. So you -- you were aware -- this
11 investigation you were participating in, there were other
12 agencies there at the same time?

13 A Yes, during the investigation.

14 Q Okay. And so you were aware that that was
15 brought to the clinic's attention that propofol should be used
16 single-dose rather than multi-dose?

17 A Yes.

18 Q Okay. And did -- did you independently learn
19 that yourself, like by researching?

20 A That I have to review to my notes.

21 Q Okay. You don't recall?

22 A The -- the question -- can you repeat the
23 question?

24 Q Did you like go online to AstraZeneca and look
25 up propofol and determine whether it should be used single-use

1 or multi-use?

2 A Yes, we did do that.

3 Q Okay. I mean, does that refresh your
4 recollection --

5 A Yes, that does.

6 Q -- when I told you?

7 A Yes.

8 Q Okay. And the -- do you -- do you recall from
9 your investigation that it -- it should be single-use rather
10 than multi-patient use because of the lack of preservatives in
11 the propofol?

12 A Yes.

13 Q Okay. Now, what was the -- the deficiency
14 pointed out to the clinic -- I'm just taking them one at a
15 time.

16 A Okay.

17 Q But regarding propofol, what was the plan of
18 correction?

19 A The facility implemented a policy which was
20 approved by the governing body outlining the strict adherence
21 to the administration of propofol. The policy states that all
22 propofol vials are to be utilized as single-dose only, one
23 vial per patient. The policy also states that needles and
24 syringes are to be utilized as single-use only and are to be
25 discarded intact in an appropriate Sharps container

1 immediately after use.

2 The nurse anesthetists and staff nurses have been
3 informed and reeducated regarding the newly implemented policy
4 and proper protocols for single-dose vial medications, and
5 needle and syringe utilizations. The facility no longer uses
6 any multi-dose medication vials.

7 The 50 milliliter 2 percent lidocaine and the .9
8 percent normal saline vials have been discontinued and removed
9 from the facility. The 0.9 percent vial, normal saline, now
10 comes in a prefilled single-use 3 cc syringe, 2.5 percent
11 lidocaine injectable for use with propofol has been stopped
12 until further notice. If the 2 percent lidocaine is
13 reimplemented for use with propofol at a later date, 5
14 milliliter single-dose vials will be utilized

15 Q Okay. And when a clinic responds like -- you
16 -- the deficiencies are served on them, and then a plan of
17 correction is returned to the agency, BLC. What -- what then
18 happens? Is it -- is it approved? Is it disapproved? What's
19 the agency do? Like okay, or not good enough? How does this
20 work?

21 A We would review the plan of correction to see
22 if they have addressed the deficient processes that were
23 identified. If they have, we can accept the plan of
24 correction. If they have not addressed the deficiencies
25 practice, then we cannot accept it and we would inform the

1 facility that the plan of correction was unacceptable and
2 identify why it was unacceptable.

3 Q Okay. And what happened here?

4 A I don't know because when we accept a plan of
5 correction we usually identify at the top of the statement of
6 deficiencies that the plan of correction was acceptable. It's
7 not identified on this here, so I'm not sure if this was
8 accepted or not.

9 Q Okay. Do you have any recollection at all?
10 That's the only copy I've got.

11 A No, I don't. We would usually, like I said,
12 whoever reviews it will identify if it was acceptable or not.

13 Q Okay. Who would have reviewed that?

14 A It would have been either the Health Facility
15 Surveyor III, the supervisor, myself, or any other surveyor
16 who was available to review it.

17 Q Okay. And to jump back -- what were -- what
18 were the other two deficiencies?

19 A In regards to this tag, the first step of the
20 cleaning process for the upper GI endoscopy and colonoscopy
21 scopes, the facility failed to ensure the center adopted and
22 reviewed written policies and procedures. Again, for the
23 first step of the cleaning process and for the upper GI
24 endoscopy and colonoscopy scopes and the use of disposable
25 biopsy instruments.

1 Q Okay. Sounds like two different things there.
2 One is biopsy instruments, one is scope cleaning.

3 A That's correct.

4 Q Okay. There was a scope cleaning deficiency.

5 A Yes.

6 Q Okay. When you keep talking tags, you throw
7 me for a loop. Were there additional tags in there,
8 additional things found wrong?

9 A Let's see. There was another tag, again,
10 related to the center failed to ensure the administrator
11 evaluated and revised the policy and procedure for the use of
12 propofol, for the cleaning of the scopes.

13 Q Okay. The way I read that, tell me if I'm
14 wrong. I'm just a layman. Without tags and everything, just
15 tell me how many things were found wrong.

16 A Okay. Let me see.

17 Q The way I read it there's three things.

18 A That's correct.

19 Q Okay.

20 A There are three areas of deficient practice.

21 Q Okay. And it impacts various ways because
22 they didn't have written policies or else they were not
23 following them or something, and that accounts for the
24 different tags under the regulations; right?

25 A That's correct.

1 Q But -- but basically three things wrong.
2 A That's correct.
3 Q Okay. And one of them was the propofol. They
4 were using multi-use; correct?
5 A Yes.
6 Q Secondly, scope cleaning problems?
7 A Yes.
8 Q And was there a plan of correction for that?
9 A Yes.
10 Q Okay. And basically did they say we will --
11 we'll clean them properly?
12 A Yes.
13 Q Okay. So the plan of correction was the
14 deficiencies found in scope cleaning, they will correct and
15 clean them properly, is that fair?
16 A Yes.
17 Q Okay. And the third deficiency you said had
18 to do with biopsy forceps?
19 A Disposable biopsy instruments, yes.
20 Q Okay. And what was -- what was the
21 deficiency?
22 A The administrator failed to ensure the
23 policies and procedures were evaluated and revised to reflect
24 the current practice at the center.
25 Q What's that mean in layman's terms?

1 A In layman's terms, let me see. The
2 administrative staff indicated that the facility used
3 disposable biopsy instruments, and the policies and procedure
4 had not been updated to reflect the current practice. So the
5 facility had switched from --

6 Q Reusable.

7 A -- reusable to disposable, and the policy and
8 procedure was not updated to reflect that current practice.

9 Q Okay. The policy and procedure still said
10 using reusables and cleaning them, and, in fact, they had gone
11 to disposable biopsy forceps and the policy was outdated?

12 A Yes.

13 Q And I guess the plan of correction would be we
14 updated the policy?

15 A Yes.

16 Q Okay. Now, I want to go back to your notes.
17 Aside from January 16th interviews at the clinic, did you also
18 interview Vincent Mione, another CRNA? And if you'll go to
19 the third page -- you found it?

20 A Yes.

21 Q Is that January 16, 2008?

22 A Yes.

23 Q And Vincent Mione, a CRNA?

24 A Yes.

25 Q And what did -- in this interview, what did he

1 explain?

2 A He indicated that the RN distributes the
3 propofol vials to the CRNA, the vials were to remain in the
4 procedure room, propofol single-use vials, they were 20
5 milliliter vials. He would open the vial, draw up 20 ccs,
6 same vial, same patient, same syringe. Throw out remaining
7 propofol and open bottle after each patient. The usual
8 propofol dose was 120 to 180 milligrams, and lidocaine 2
9 percent, they would draw up -- or he would draw up .5 ccs
10 first, and then 10 ccs of propofol.

11 Q Okay. Now, on January 16th when you
12 interviewed Mr. Mione, his practice on single-use -- because
13 it's January 16th now. So propofol being used single-use
14 vial, and his practice for a patient was the same as Linda
15 Hubbard's; is that correct?

16 A Yes.

17 Q Okay. Meaning one needle and syringe, dose
18 patient, if patient needs more, use the same needle and
19 syringe back into the same propofol vial, same needle and
20 syringe back into the patient, and then at the conclusion,
21 discard propofol vial, needle, and syringe; correct?

22 A Yes.

23 Q And once again, at that time on January 16th,
24 you didn't say anything to Mr. Mione about this being an
25 improper procedure; correct?

1 A That's correct.

2 Q Because at -- at that time it was viewed as a
3 safe aseptic procedure, meaning on January 16th.

4 A It was a safe procedure. Now, again, not best
5 practice, but, yes.

6 Q Okay. But the -- I mean, Linda Hubbard and
7 Vincent Mione are telling you in interviews, BLC, this is the
8 way we are doing it under our new policy of single-use
9 propofol; right?

10 A Yes.

11 Q And no one said to them, well, this is okay,
12 but it's not best practices; correct?

13 A That's correct.

14 Q Okay. That -- that determination came at a
15 later time?

16 A I'm not sure what you mean.

17 Q Did -- did you have discussions with Brian
18 Labus like in February about the dangers of such a practice?

19 A That I don't recall.

20 Q Okay. Well, at -- at what point was the
21 determination made, as you understand it, to put them on
22 notice that, hey, you need to use a brand new needle, brand
23 new syringe every single time you enter the propofol vial or
24 the patient?

25 A So a brand new syringe, brand new needle for

1 each patient?

2 Q Well, you tell me. You're a nurse and you're
3 an inspector for the BLC; correct?

4 A I didn't -- I did not tell them that, no. Not
5 during my -- not during the investigation --

6 Q Okay.

7 A -- that I participated in.

8 Q And had you -- had you been there on January
9 16th and seen a practice that was putting patients in danger
10 because they were operating and doing it exactly the way they
11 were telling you; correct?

12 MS. WECKERLY: I'm going to object, unless she --

13 THE COURT: That wasn't really --

14 MS. WECKERLY: -- observed procedures.

15 THE COURT: -- a question, either.

16 MR. WRIGHT: I threw a correct on the end.

17 THE COURT: Well, I know, but the first part didn't
18 match up with the second part. Is your question -- I mean,
19 state your question again.

20 MR. WRIGHT: Okay.

21 BY MR. WRIGHT:

22 Q I presume other inspectors were there other
23 than yourself; correct?

24 A Yes.

25 Q And if -- if a clinic is telling you they are

1 engaging in certain practices and you have any inkling that
2 those are unsafe practices putting patients at risk, you would
3 stop those practices and advise them; correct?

4 A That's correct.

5 THE COURT: Maybe this would be a good time for a
6 morning recess.

7 MR. WRIGHT: Thank you.

8 THE COURT: Ladies and gentlemen, we're going to go
9 ahead and take until about 11:30 our morning recess.

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

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

18 And, ma'am, during the break, don't discuss your
19 testimony with anyone else.

20 THE WITNESS: Okay.

21 THE COURT: Okay. And if you want to take a break,
22 it's just through the double doors there.

23 THE WITNESS: Okay. Thank you.

24 (Court recessed at 11:15 a.m., until 11:28 a.m.)

25 (Inside the presence of the jury.)

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

3 Mr. Wright, you may resume your questioning.

4 MR. WRIGHT: Thank you.

5 BY MR. WRIGHT:

6 Q Did you also observe or interview another CRNA
7 on January 16th, Mr. Vincent Sagendorf? And the -- like on
8 page 5.

9 A Yes.

10 Q Do you have that? Yes.

11 A Yeah.

12 Q January 16, 2008, interview of Vinnie
13 Sagendorf, CRNA; correct?

14 A Yes.

15 Q And what did Mr. Sagendorf explain regarding
16 his procedure?

17 A The RN distributes the propofol in the
18 morning. He draws up 1 cc of Xylocaine first, then 10 ccs of
19 propofol. It's a 20 cc standard vial. When -- when a patient
20 -- when with the patient and ready to start the procedure,
21 that's when he would draw up the propofol. Start with 100
22 milligrams of propofol, augment as needed, use a new syringe,
23 discard the propofol after each patient, standard practice for
24 CRNA.

25 Q Okay. So as -- tell me if I'm incorrect, but

1 as far as Mr. Vinnie Sagendorf, he indicates that he would be
2 doing what you refer to as best practices.

3 A Yes.

4 Q Is that right?

5 A Yes.

6 Q Whereas Linda Hubbard and Mr. Mione were
7 reusing needle and syringe for same patient, Vincent Sagendorf
8 is saying every time I draw up again I use a new needle and
9 syringe.

10 A Yes.

11 Q And at the end, toss the propofol because it's
12 single-patient use as of now; correct?

13 A Yes.

14 Q Okay. And do you recall you and Nadine Howard
15 and Leslee Kosloy, the three BLC investigators, were
16 interviewed by the Metropolitan Police Department in March
17 2008? Do you recall that?

18 A Yes.

19 Q Okay. Have you seen your transcript of
20 interview?

21 A Briefly.

22 Q Okay. And do you recall that at that
23 interview in March -- on March 5, 2008, it was all three of
24 you; correct?

25 A Yes.

1 Q Okay. And you are all three nurses?
2 A Yes.
3 Q And inspectors?
4 A Yes.
5 Q Okay. And you explained to the detectives
6 that the procedures described on January 16th by Mr. Mione,
7 Mr. Sagendorf, and Linda Hubbard were proper and correct
8 procedures; right?
9 A That I don't recall. I'll need to see the --
10 Q Okay. 23 to 27 -- 23 to 26, read that to
11 yourself, all four pages.
12 A Okay.
13 Q Starting like about there on line -- page 23.
14 A [Witness complied]. Okay.
15 Q Does that refresh your recollection?
16 A Yes.
17 Q And that's on March 5, 2008. I'll tell you
18 because I didn't hand you the cover page.
19 A Okay.
20 Q And that's interview of Leslee Kosloy, Dorothy
21 Sims, Nadine Howard at the BLC; correct?
22 A Yes.
23 Q And it's by Detective Gray and Detective Hahn
24 of the Metropolitan Police Department.
25 A Okay.

1 Q And at that time you were interviewed, you
2 all, let me put it that way, and the practices described of
3 Mr. Mione, Linda Hubbard, Sagendorf were stated by you all to
4 be perfectly acceptable.

5 A That's correct.

6 Q Is that correct?

7 A Yes.

8 Q And there was nothing in there to the
9 detectives about not best practices or anything else. It was
10 they are using acceptable safe practices --

11 A Yes.

12 Q -- correct?

13 A Uh-huh.

14 Q And it was talking specifically about reusing
15 needle and syringe; correct?

16 A Yes.

17 Q And apparently at some later time after March
18 5, 2008, there was a determination that that may not be safe
19 practices or best practices; right?

20 A My opinion, yes, not best practice.

21 Q Okay. After March 5, 2008?

22 A Yes.

23 Q Okay. And -- because on March 5, 2008, you
24 and the other two inspectors are agreeing that those are safe
25 practices; correct?

1 A Yes.

2 Q Okay. And you're now saying today it's not
3 best practices; right?

4 A That's correct.

5 Q Okay. So that change occurred after March 5,
6 2008?

7 A Yes.

8 Q Okay. And investigation of Shadow Lane had
9 ended by BLC on January 17th when the statement of
10 deficiencies was issued; correct?

11 A That's correct.

12 Q Additional -- did additional investigation by
13 BLC occur at the sister clinic on Burnham Lane?

14 A Did we do an inspection over there?

15 Q Yes.

16 A Yes, we did.

17 Q Okay. And that was after Shadow Lane?

18 A Yes.

19 Q Okay. And so -- and you knew Burnham was
20 simply another clinic of the same practice; correct?

21 A That's correct.

22 Q Okay. And so BLC went and inspected there --

23 A Yes.

24 Q -- correct? And did another statement of
25 deficiencies; correct?

1 A Yes.

2 MS. WECKERLY: I'm going to object as to foundation
3 unless she was at Burnham and observed it.

4 MR. WRIGHT: Okay. Well, the -- I'm not going to go
5 any further with going into Burnham.

6 THE COURT: Okay. Move on.

7 BY MR. WRIGHT:

8 Q There -- thereafter did your agency conduct
9 further investigations of other ambulatory surgical centers,
10 starting in February 2008?

11 A We did do inspections of other ambulatory
12 surgery centers. I don't know the exact date as when they
13 were started, but we did do other investigations, yes.

14 Q Okay. And was that precipitated, started
15 because of what was found at Shadow Lane?

16 MS. WECKERLY: Objection. Calls for speculation.

17 THE COURT: If she knows.

18 You can answer. Don't guess if you don't know.

19 THE WITNESS: That I don't know.

20 BY MR. WRIGHT:

21 Q Okay. You don't know why the governor asked
22 all of the ambulatory surgical centers in the state to be
23 inspected starting right after the Shadow Lane clinic?

24 THE COURT: Well, that would --

25 MS. WECKERLY: Objection.

1 THE COURT: -- be speculation.

2 MS. WECKERLY: That's not in evidence.

3 THE COURT: Yeah, so --

4 BY MR. WRIGHT:

5 Q Okay. Do you know?

6 THE COURT: Mr. Wright, I already sustained the
7 objection --

8 MR. WRIGHT: Okay.

9 THE COURT: -- so you need to move on.

10 BY MR. WRIGHT:

11 Q Did you -- in February did BLC inspect another
12 clinic on Maryland Parkway, an endoscopic clinic?

13 MS. WECKERLY: I'm going to object unless she
14 personally did the inspection. I mean, she could, I guess,
15 say that --

16 THE COURT: Well, she could --

17 MS. WECKERLY: -- she heard

18 THE COURT: -- be aware of it in her role as part of
19 the team.

20 So do you know whether or not there was another
21 inspection?

22 THE WITNESS: We did do an inspection on an
23 ambulatory surgery center on Maryland Parkway. I don't know
24 the exact date, though.

25 THE COURT: Okay. Were you involved in that

1 inspection?

2 THE WITNESS: No, I was not.

3 BY MR. WRIGHT:

4 Q Would you look at that document and tell me --
5 tell me what that is?

6 A Going back to your -- the Judge's question on
7 was I involved with it, is that directly involved with it, or
8 as a supervisor?

9 Q As a supervisor.

10 A As supervisor, I may have been involved with
11 it, but I wasn't directly onsite.

12 Q Okay.

13 A This is a state --

14 MS. WECKERLY: My objection, then, is foundation as
15 to any observations if she wasn't onsite.

16 THE COURT: All right. Lay a foundation, Mr.
17 Wright.

18 MR. WRIGHT: I'm having her -- I handed her an
19 exhibit and I'm asking her what it is --

20 THE COURT: Okay.

21 MR. WRIGHT: -- before I move its introduction.

22 BY MR. WRIGHT:

23 Q What is that exhibit?

24 A This is a statement of deficiency for a
25 gastrointestinal diagnostic clinic on 3196 South Maryland

1 Parkway.

2 Q Okay. And is that the inspection we've -- you
3 and I have been talking about?

4 A The one on Maryland Parkway?

5 Q Yes.

6 A Yes, this occurred in February.

7 Q Of 2008?

8 A Yes.

9 Q And that -- and that's a document of your
10 agency; correct?

11 A That's correct.

12 MR. WRIGHT: I move its admission.

13 MS. WECKERLY: Objection. Hearsay.

14 THE COURT: I'll see counsel up here.

15 (Off-record bench conference.)

16 BY MR. WRIGHT:

17 Q Would you look at that page by page and tell
18 me if that appears to be an accurate copy of a record of your
19 agency?

20 A [Witness complied]. Yes, this is a statement
21 of deficiencies from our agency.

22 Q And it's page 1 through 29 and every single
23 page is there; correct?

24 A Yes.

25 MR. WRIGHT: Move it's admission.

1 MS. WECKERLY: Same objection that I previously
2 stated.
3 THE COURT: Basis, why are you --
4 MS. WECKERLY: Foundation.
5 THE COURT: -- admitting it?
6 MS. WECKERLY: Oh, sorry.
7 THE COURT: Mr. Wright?
8 MR. WRIGHT: Pardon? I'm sorry.
9 THE COURT: I'll see --
10 MR. WRIGHT: -- I didn't --
11 THE COURT: -- counsel up here.
12 MR. WRIGHT: -- hear you.
13 THE COURT: I'll see counsel up here.
14 (Off-record bench conference.)
15 MR. WRIGHT: Thank you, Your Honor.
16 THE COURT: Go ahead.
17 BY MR. WRIGHT:
18 Q Do you have Exhibit CCC -- CC-1; correct?
19 A Yes.
20 THE COURT: Two Cs.
21 BY MR. WRIGHT:
22 Q CC-1
23 A Yes.
24 Q The -- these inspections of an endoscopy -- a
25 gastrointestinal diagnostic clinic, is that an ambulatory

1 surgical center?

2 A Yes.

3 Q Okay. And these inspections take place
4 unannounced?

5 A Yes.

6 Q Okay. So it's inspectors walk in the door,
7 watch, and interview?

8 A Yes.

9 Q And look at records?

10 A Yes.

11 Q Okay. And this occurred on February 15, 2008?

12 A That's the date that the investigation was
13 completed. It started on February 13, 2008.

14 Q Okay. Looking at page 25 -- 25 of 29.

15 A Okay.

16 Q Did the observations begin on February 14th,
17 general observations of four patients receiving endoscopy
18 procedures at the facility between 7:35 a.m. and 9:30 a.m.?

19 A Yes.

20 Q And going to page 26 of 29 -- and this is a
21 different clinic in Las Vegas; correct?

22 A Yes.

23 Q It's not -- not Burnham, not Shadow Lane, not
24 associated with the Gastroenterological Center of Las Vegas?

25 A Yes.

1 Q Okay. Now, on page 26, Patient No. 3, okay.

2 A Yes.

3 Q Would you read the paragraph as to Patient 3?

4 MS. WECKERLY: I'm going to just object as to
5 foundation unless she was there and observed this.

6 THE COURT: What was your role as a supervisor on
7 this investigation or document?

8 THE WITNESS: I would have assigned the surveyors to
9 go out to investigate. They would call for any questions or
10 guidance. And then once the investigation was completed, I
11 would review the report, and then I would mail the report out
12 to the facility. And then I would track the inspection
13 process.

14 THE COURT: Okay. When you say track the inspection
15 process, what does that mean?

16 THE WITNESS: I would track as to what facilities we
17 are going at to do any inspections at, which day we started,
18 what day we've completed, did the statement go out, and did we
19 get a plan of correction in.

20 THE COURT: Okay. And then as the supervisor, did
21 you have any role in making sure the plan of correction was
22 actually adhered to or the changed -- the recommended changes
23 were made?

24 THE WITNESS: It looks like I reviewed the plan of
25 correction and accepted it. And this is a federal statement,

1 so because of the conditions we would be then responsible to
2 do a follow up visit to make sure they are in compliance with
3 the regulations.

4 THE COURT: And you do that as a supervisor?

5 THE WITNESS: I would assign --

6 THE COURT: Okay.

7 THE WITNESS: -- the -- the surveyors to go out and
8 do the follow up investigation. But I would not have been the
9 investigator going out to do it.

10 THE COURT: All right. Go ahead, Mr. Wright.

11 MR. WRIGHT: Okay.

12 BY MR. WRIGHT:

13 Q And do you all -- your -- your agency, you do
14 the inspections for the centers for Medicare and Medicaid
15 services, federal government; correct?

16 A Yes.

17 Q I mean, just the way our government is set up
18 here, the feds for Medicare and Medicaid contract to the
19 state, your agency, to do the inspections of their clinics
20 that are qualified for Medicare and Medicaid services?

21 A That's correct.

22 Q Okay. And so that's what was taking place
23 here?

24 A Yes.

25 Q Okay. Now, Patient No. 3, read that

1 paragraph.

2 A Patient No. 3 was brought into the procedure
3 room at 8:35 a.m. The anesthesiologist injected the patient
4 with propofol through the patient's intravenous IV tubing.
5 The anesthesiologist opened a new vial of propofol. The
6 anesthesiologist used an open needle and syringe to draw up
7 additional propofol from the vial. The anesthesiologist was
8 observed putting the used vial with the remaining propofol
9 back on the counter after the case. This was the only used
10 propofol vial observed. The other vials on the countertop
11 were new, unopened vials.

12 Q Okay. And then Patient 4 follows Patient 3;
13 correct?

14 A Yes.

15 Q Okay. And what happened with Patient 4?

16 A Patient No. 4 was brought into the procedure
17 room at 9:15 a.m. The anesthesiologist was observed drawing
18 up propofol in the same -- the anesthesiologist was observed
19 drawing up propofol from the same vial that he had used on
20 Patient No. 3 to inject Patient No. 4.

21 Q Okay. I had -- I had skipped Patient 2 before
22 that, but read the next paragraph about Patients 2, 3, and 4.
23 What then occurred?

24 A Patients No. 2, 3, and 4 were observed being
25 transferred into the procedure room one at a time on a gurney

1 with their intravenous IV bags lying on the gurney with them.
2 An observation was made that one of the patients -- the
3 patient's blood flowed back into the IV tubing. When the IV
4 bag was hung on an IV pole, the blood cleared from the tubing.

5 Q Okay. Next paragraph.

6 A During the observation time frame, the
7 anesthesiologist was never observed opening new syringes.

8 Q Okay. And then was the anesthesiologist
9 interviewed? What's the next paragraph?

10 A On 2/24/08 at 9:45 a.m., the anesthesiologist
11 stated that it was okay to use a single patient use propofol
12 vial on multiple patients because the purpose of the single
13 patient use label on the vial was to prevent bacterial growth
14 in cases that required a long period of time. The
15 anesthesiologist stated that because these cases were of short
16 duration there was not enough time for bacterial growth to
17 occur, that way it was safe to reuse the propofol vials on
18 multiple patients.

19 The anesthesiologist was asked what the process was
20 when he went from a used propofol vial to a new patient. The
21 anesthesiologist stated that he would change the needle and
22 reuse the same syringe. The anesthesiologist explained that
23 because a high port was used on the IV line it was safe to
24 change the needle and reuse the same syringe on multiple
25 patients.

1 Q Okay. And that -- that was an
2 anesthesiologist, M.D., not a CRNA; correct?

3 A That's correct.

4 Q Okay. And the report, the statement of
5 deficiencies, the same syringe was being used by the
6 anesthesiologist, multi-patient, but simply changing the
7 needle; correct?

8 A Yes.

9 Q Okay. And all of the investigation at
10 Burnham, Shadow Lane, the entire investigation, there was
11 never any finding ever of any reuse of needles, reuse of
12 syringes between patients; correct?

13 A At the Shadow Lane, that's correct.

14 Q Okay. I don't recall the Burnham clinic.

15 Q Okay. You would have to look at the report on
16 Burnham?

17 A Yes, I would.

18 Q Okay. But at Shadow Lane no reuse of syringe
19 between patients?

20 A That's correct.

21 Q Okay. And then this on February 15, 2008,
22 reuse of syringe, changing needle between patients and
23 multiple use of propofol; correct?

24 A That's correct.

25 Q Okay. And was a plan of correction filed?

1 A Yes.

2 Q Okay. And plan of correction is propofol used

3 single-use and new needles and syringes?

4 A It would be in the attachments because they

5 attached their policies and procedures. But if I accepted it,

6 then --

7 Q Okay.

8 A -- they would have changed their policies and

9 procedure.

10 Q Now, thereafter was a plan put in place to

11 survey or investigate, inspect, I guess, is the correct word,

12 all of the ambulatory surgical centers in the state of Nevada

13 in 2008?

14 A That's correct.

15 Q And did -- did you -- did your office

16 participate in that?

17 A Yes.

18 Q Okay. Did CDC participate in that?

19 A Yes.

20 Q And do you recall the time frame?

21 A No.

22 Q Look at that document to yourself and tell me

23 if you recognize what that is.

24 A [Witness complied].

25 Q Do you know what that is?

1 A It looks like it's a report that was done by
2 our administrator, Richard Whitley.

3 Q Okay. And who is Richard Whitley?

4 A He is the administrator for the Health
5 Division.

6 Q And is that your division?

7 A Yes, it is.

8 Q He's the boss?

9 A Yes, he is.

10 Q And does -- is that report the -- a report of
11 the results of the inspection of ambulatory surgical centers
12 in Nevada in 2008 regarding infection control practices?

13 MS. WECKERLY: Your Honor, I'm going to object
14 unless she independently recognizes it. It sounds like she --
15 or it looks like she's reading it.

16 THE WITNESS: I -- to be honest, I don't recall
17 seeing this report.

18 THE COURT: Okay.

19 BY MR. WRIGHT:

20 Q Okay. Do you know was it -- let me show you
21 Exhibit R-1.

22 MS. WECKERLY: Can I see that exhibit? I don't --

23 THE COURT: Yeah. It's already been admitted.

24 MS. WECKERLY: Right. I just want --

25 THE COURT: That's fine. He can --

1 MS. WECKERLY: I just want to --
2 THE COURT: -- show it to you.
3 MS. WECKERLY: -- know what it is.
4 THE COURT: And R-1 is what, Mr. Wright?
5 MR. WRIGHT: It's a Nevada State Health Division
6 technical bulletin --
7 THE COURT: Okay.
8 MR. WRIGHT: -- regarding potential exposures to
9 hepatitis C in -- in ambulatory surgical centers in Las Vegas.
10 THE WITNESS: Okay.
11 BY MR. WRIGHT:
12 Q Are you familiar with that?
13 A No, I'm not.
14 Q Okay. Do you -- do you -- who is -- that's in
15 evidence already. That technical bulletin is from whom?
16 A It looks like it was written by Dr. Ihsan
17 Azzam.
18 Q Who is he?
19 A He is the state epidemiologist.
20 Q Okay. And is he in your agency or in a
21 different state agency?
22 A It looks like he's with the Nevada State
23 Health Division, so --
24 Q That's different than you all?
25 A The Nevada State Health Division is a division

1 within the Department of Health and Human Services, and then
2 our bureau is like a program within that Health Division. So
3 he's with -- he's the state epidemiologist, but he's not with
4 the Bureau of Healthcare Quality and Compliance.

5 Q Okay.

6 A Or the BLC?

7 Q Do you recall that as a result of inspections
8 taking place a technical bulletin was sent out to healthcare
9 providers about multi-use vials and reuse of syringes?

10 A I don't recall personally, but this is --

11 MS. WECKERLY: I'm going to object unless she
12 recalls.

13 THE COURT: All right. Okay.

14 BY MR. WRIGHT:

15 Q Now, you do recall that there was -- your
16 agency participated in an inspection of all the ambulatory
17 surgical centers in the state of Nevada; right?

18 A Yes.

19 Q And do you recall how many of them were
20 inappropriately using single-use items, especially syringes?

21 A I don't recall how many of them.

22 Q Let me show you something and see if this
23 refreshes your recollection.

24 A Without seeing the inspection reports --

25 Q That does not refresh your recollection?

1 A No. We have a total of about 60 facilities
2 all throughout the state. So without seeing each of the
3 inspection reports, I really can't say.

4 Q Okay.

5 THE COURT: That's fine. I mean, the question is
6 does that refresh your recollection.

7 THE WITNESS: Yeah.

8 THE COURT: And if it doesn't, then Mr. Wright is
9 going to move on.

10 BY MR. WRIGHT:

11 Q Right. My question was do you recall of the
12 number inspected, like 60 of them, how many of them were found
13 to be reusing syringes?

14 A No, I can't recall how many of them.

15 Q Does looking at that refresh your
16 recollection?

17 MS. WECKERLY: I'm going to object. She just said
18 it didn't.

19 THE COURT: I think she just said it didn't.

20 THE WITNESS: No, it doesn't.

21 THE COURT: All right.

22 MR. WRIGHT: I move the admission of the exhibit.

23 MR. STAUDAHER: Well --

24 MS. WECKERLY: I'm going to object as to foundation.

25 THE COURT: That's sustained.

1 MS. WECKERLY: Among others.

2 THE COURT: That's sustained, Ms. Weckerly.

3 BY MR. WRIGHT:

4 Q So you don't --

5 THE COURT: I don't think that's been --

6 BY MR. WRIGHT:

7 Q -- have any idea --

8 THE COURT: -- marked yet, either.

9 BY MR. WRIGHT:

10 Q Do you remember you were working and
11 participating in it; correct?

12 A Yes.

13 Q Okay. And this is 2008. And an inspection of
14 all the ambulatory surgical centers because we had this
15 outbreak here; correct?

16 A Yes.

17 Q Okay. And can you remember if there was zero
18 found? Do you have any memory whatsoever of the results of
19 this investigation?

20 A Without looking at those inspection reports I
21 couldn't tell you what was found at each of the facilities.

22 Q Okay. So for all you know it was 100 percent
23 reusing; correct?

24 A Without looking at the inspection reports, I
25 can't say.

1 Q Okay. In preparation for your testimony here,
2 have you been interviewed by anyone?

3 A For?

4 Q In preparation for testifying --

5 THE COURT: For coming in today did anyone interview
6 you, like a police officer or investigator or attorneys,
7 anybody like that?

8 THE WITNESS: I met with the DA awhile ago.

9 THE COURT: Okay. By awhile, a week ago, two weeks
10 ago, a month ago, what do you mean?

11 THE WITNESS: Prior to -- prior to jury selection.

12 THE COURT: Okay. So that would have been a couple
13 of months ago?

14 THE WITNESS: Yes.

15 THE COURT: All right. Go on, Mr. Wright.

16 BY MR. WRIGHT:

17 Q Okay. Who did you -- you never met with me;
18 right?

19 A No, I have not.

20 Q Okay. But you met with the District
21 Attorney's office?

22 A Yes.

23 Q Okay. Who did you meet with?

24 A The gentleman here and the lady here.

25 THE COURT: Which gentleman?

1 BY MR. WRIGHT:
2 Q This is Mr. Staudaher.
3 A Mr. Staudaher.
4 Q Ms. Weckerly.
5 A Yes.
6 Q You met with them?
7 A Yes.
8 Q Did you discuss what I'm talking about here
9 today?
10 A No.
11 Q What did you discuss?
12 A He -- we discussed the police officer's
13 interview.
14 Q Okay. That March 5, 2008, interview I showed
15 you?
16 A Yes.
17 Q Anything else?
18 A No, I don't recall.
19 Q Okay. Thank you very much.
20 THE COURT: Nothing else, Mr. Wright?
21 MR. WRIGHT: No, Your Honor.
22 THE COURT: Mr. Santacroce, do you have any
23 questions for this witness?
24 MR. SANTACROCE: I do not.
25 THE COURT: Thank you.

1 Ms. Weckerly, is this your witness?

2 MS. WECKERLY: Yes.

3 THE COURT: Cross?

4 MS. WECKERLY: No cross.

5 THE COURT: All right. Do we have any juror
6 questions for this particular witness? I see no juror
7 questions.

8 Ma'am, thank you for your testimony. Please do not
9 discuss your testimony with anyone else who may be called as a
10 witness in this matter.

11 THE WITNESS: Okay.

12 THE COURT: You are excused.

13 THE WITNESS: Thank you.

14 THE COURT: Thank you.

15 I'll see counsel at the bench, please.

16 (Off-record bench conference.)

17 THE COURT: Ladies and gentlemen, we're going to go
18 ahead and take our lunch break now. We'll be in recess for
19 the lunch break until 1:25.

20 During the lunch recess you are reminded that you're
21 not to discuss the case or anything relating to the case with
22 each other or with anyone else. You're not to read, watch, or
23 listen to any reports of or commentaries on this case, any
24 person or subject matter relating to the case by any medium of
25 information. Please do not do any independent research, and

1 please do not form or express an opinion on the trial.

2 Place your notepads in your chairs and follow the
3 bailiff through the rear door.

4 (Jury recessed at 12:20 p.m.)

5 THE COURT: And before we take our break, I
6 overheard the attorneys commenting that there was an
7 outstanding ruling on something prior to resuming the
8 testimony.

9 MR. STAUDAHER: No.

10 THE COURT: Can you enlighten me as to what that
11 might be?

12 MR. STAUDAHER: Outstanding ruling regarding jury --
13 so it was related to jury instructions where --

14 THE COURT: Is that regarding the statute or --
15 because how can there be an outstanding ruling on jury
16 instructions when we haven't --

17 MR. STAUDAHER: Well, not --

18 THE COURT: -- covered jury instructions?

19 MR. STAUDAHER: -- a jury instruction, but the issue
20 regarding the theft that the Court -- we provided the
21 authority for the Court.

22 THE COURT: Right. I'm expecting argument on
23 that --

24 MR. STAUDAHER: Okay.

25 THE COURT: -- so I don't really think it's fair to

1 characterize that as an outstanding ruling because I was going
2 to give the defense time to argue that, unless they agree that
3 that's an appropriate --

4 MR. STAUDAHER: I think we said that we need a
5 ruling from the Court, not necessarily that there was an
6 outstanding ruling.

7 THE COURT: Okay. Well, I heard outstanding ruling.
8 So I just want to make sure that other than the exhibit that
9 we talked about this morning that there's no outstanding
10 rulings. The only other issue is the graph thing that may be
11 considered outstanding. So I just want to make sure that I
12 haven't neglected to remember anything other than that.

13 And as I said, I don't consider that an outstanding
14 ruling because I'm assuming -- well, first of all, I don't
15 know. Maybe the defense will agree that that's an appropriate
16 statute to use and an appropriate instruction. I would assume
17 not, but, you know, I'm obviously not as wise as they are, so
18 perhaps they'll agree to that.

19 If not, I certainly would anticipate there's going
20 to be some argument on something that critical to a case. So
21 I don't consider that outstanding, as I said, because it
22 hasn't been -- it hasn't been argued, litigated yet, and, you
23 know, whatever. So is that --

24 MS. STANISH: No, Your Honor --

25 THE COURT: Am I missing something? Is there

1 anything else that either side feels they need a ruling on
2 that hasn't been ruled on?

3 MS. WECKERLY: I think we were -- we were discussing
4 jury selection -- or, sorry, jury instructions. And what we
5 were talking about is how we could probably reach agreement --

6 THE COURT: Right.

7 MS. WECKERLY: -- on some things, probably not that
8 issue. I mean, I don't know if Ms. Stanish was talking about
9 something else, but that was my recollection, that we thought
10 we could get agreement on certain parts of the --

11 THE COURT: Right. And you're fine to talk about
12 whatever you want to talk about. All I'm saying is if there
13 is an outstanding ruling, I certainly want to, you know, make
14 sure the record is complete and rule on anything that hasn't
15 been ruled on. So to the extent I may have overheard that, I
16 just want to make sure that I haven't neglected to make a
17 ruling on something that I have forgotten.

18 Like I said, those are the only two things at the
19 forefront of my mind, but it's possible I'm not recollecting
20 something. So if that's the case, then I need to be made
21 aware of that. The only other potential is the Ms. Pomykal
22 issue, which she's been kept here, you know. I'm concerned
23 about the thing -- I was going to review her -- I've reviewed
24 it already. You folks have reviewed it. You know, if we
25 decide to make her an alternate, then it's going to be the

1 next number alternate.

2 I am not going to shuffle the alternates to benefit
3 any particular side. So the next in number alternate, I
4 believe, is the blonde gal that you folks have complained
5 about has been sighing and doesn't appear to like Mr. Wright.
6 That, I believe, is our next in order. And, like I said, I'm
7 not shuffling the alternates unless there is a real reason.
8 And the fact that she may sigh and, you know, express boredom
9 is not a reason to shuffle the alternates.

10 So just to -- I don't know if anyone would have had
11 that idea, but to the extent someone would have, that is not
12 going to happen. The only one -- you know, we could make Ms.
13 Pomykal an alternate because she has -- and I'm going to
14 decide if I'm even going to make that option available. But,
15 you know, she has expressed something that could create, at
16 least in the minds of the defense, a conflict. So there is
17 that.

18 The only other remaining issue that really, I don't
19 know is a remaining issue, is the gentleman in Chair 7 who
20 will be allowed to go on his vacation starting early in the
21 morning on July 4th. So, you know, if we finish up Friday
22 like we think, that would give them three days to deliberate,
23 and my belief is he should remain as one of the main members
24 of the jury.

25 If for some reason it takes longer than that, then

1 we will consider making him an alternate and moving in one of
2 the others because I don't want them to start deliberating and
3 then he leave on his vacation and everything like that. So
4 those are the only issues I can think of that may still be out
5 there in the wind.

6 MS. STANISH: Judge --

7 THE COURT: I just want to make sure I'm not
8 neglecting.

9 MS. STANISH: You know what, I have to apologize if
10 there was something you heard that was offensive. We had a
11 discussion --

12 THE COURT: Well, that's fine. You two are free to
13 discuss whatever you want.

14 MS. STANISH: No, but I wanted to let you know what
15 we discussed because Ms. Weckerly and I started the discussion
16 in the anteroom and then we continued it in the courtroom.
17 And we were discussing the jury instructions. I was
18 describing for them what I had written so far, and we were
19 trying to anticipate what issues we would have.

20 And the issues are, which we may agree on, is the
21 mental element for the criminal neglect statute, and then we
22 are probably going to have issues regarding the -- the theft
23 statute and how to -- whether the jury needs to be instructed
24 specially on whether or not to take into account services
25 rendered, that whole issue that Mr. Staudaher raised. But we

1 agree there has to be argument on it.

2 THE COURT: Right. That's why I'm saying I don't
3 think it's fair to characterize that as an outstanding
4 decision when there hasn't been argument on it.

5 MS. STANISH: No, it's something that still, you
6 know, is --

7 THE COURT: And, to me --

8 MS. STANISH: -- contemplated in here.

9 THE COURT: -- you know, what do I know, that seems
10 to be a relatively big deal, at least with the theft statute.
11 I mean --

12 MS. STANISH: It depends --

13 THE COURT: -- on the insurance --

14 MS. STANISH: -- on the --

15 THE COURT: -- defense it doesn't really matter,
16 but --

17 MS. STANISH: Correct. The great scheme of things.
18 And then the --

19 THE COURT: So, I mean, what's one more if he's
20 convicted. I mean, you know --

21 MS. STANISH: And then just to let Your Honor know
22 what we were contemplating doing is hopefully having tomorrow
23 off so that we can meet with Your Honor to do the jury
24 instructions. We wanted to know -- that's why we were talking
25 about what kind of argument we would expect. And hopefully

1 we'll get that worked out by the end of the day.

2 THE COURT: Yeah, I don't care when you folks meet.
3 I mean, I would -- if you want to meet tonight, that's up to
4 you. If you want to meet tomorrow morning, that's up to you.
5 I would like to go on the record and settling jury
6 instructions relatively early in the day, like 10 or 10:30.

7 So whenever you folks need to meet, you know, if you
8 need to meet at 8:00 to do that or you want to do it tonight,
9 obviously I don't care. What I don't want to have happen is
10 waiting until like 2:00 in the afternoon to settling the jury
11 instructions because there may be typing that needs to be done
12 and whatnot.

13 The Court -- you know, it's my experience that the
14 later we wait, the more burdensome it is on the court staff
15 who then has to do all the typing and corrections. So for
16 that reason I don't want us to be here at 4:30 with my staff
17 having to do all the changes and corrections and everything
18 like that.

19 So for that reason, it's better if we do it earlier,
20 that way we can get a cleaned up packet, we can number them,
21 we can make sure everybody has time to review the changes,
22 that they've been done correctly, and all of those things. So
23 I don't want to -- in other words, the whole point of that was
24 I don't want to wait until the last minute on getting together
25 in the afternoon because I think it could take, based on

1 everything else that's transpired in the case, I think it
2 could take some time.

3 MS. STANISH: And what we were hoping is that we
4 could have the afternoon off so that both parties could
5 prepare for closing and then deliver the closing on Thursday.

6 THE COURT: Right. And you think we can do the
7 closings and the jury instructions in one day?

8 MS. STANISH: Well, I thought we would do jury
9 instructions tomorrow.

10 THE COURT: No, no, I meant read them.

11 MS. STANISH: If you don't do the lengthy
12 indictment.

13 THE COURT: Yeah, that's what I was going to say.
14 Do both sides --

15 MS. STANISH: You already read that.

16 THE COURT: Do both sides stipulate to the Court not
17 rereading the indictment and just saying the indictment is
18 here as part of Instruction No. 3. It's been read to you
19 already. And both sides stipulate to me not reading it again?

20 MR. STAUDAHER: State does.

21 MR. WRIGHT: Who has to read it?

22 THE COURT: I do.

23 THE CLERK: It's an hour and 20 minutes.

24 MR. WRIGHT: You got me. I'll stipulate.

25 THE COURT: Mr. Santacrose, do you stipulate?

1 MR. SANTACROCE: Yes, Your Honor.

2 THE COURT: All right. So that'll save some time,
3 then. And how many proposed instructions including the stocks
4 does the State have?

5 MS. WECKERLY: You know, there really aren't that
6 many. I didn't number them. But when you take out the
7 indictment it's substantially smaller.

8 THE COURT: Okay.

9 MS. WECKERLY: So I think that -- I understand there
10 will be argument on the instructions, but there really aren't
11 -- there's probably less than 30 substantive instructions, or
12 maybe right around 30.

13 THE COURT: Okay. So -- and both sides, we think we
14 can do all the closings on -- in a single day?

15 MR. WRIGHT: Yeah.

16 MS. WECKERLY: Sure.

17 THE COURT: Well, I don't know. I mean, I don't
18 know if, you know, somebody has got a three and a half hour
19 PowerPoint.

20 MS. WECKERLY: Not yet.

21 MR. WRIGHT: I don't PowerPoint.

22 THE COURT: Okay. So then they'll start Friday, so
23 that takes care of the issue regarding Juror 7. That gives
24 plenty of time for him to deliberate and all of those things.
25 And I think those were the only things that we needed to

1 discuss at this point.

2 MS. STANISH: Okay.

3 THE COURT: All right.

4 MR. STAUDAHER: We're to be back, Your Honor, at
5 what time?

6 THE COURT: I told them 1:30.

7 MR. STAUDAHER: 1:30? Okay

8 THE COURT: Oh, should we do the Fifth Amendment
9 admonishment, or do you guys want to do that after lunch?

10 MR. SANTACROCE: Whatever you prefer.

11 THE COURT: Let's do it now.

12 All right. We'll start with Dr. Desai. Everyone
13 listen carefully to make sure I cover everything. I do it
14 from memory.

15 Dr. Desai, I need you to stand up, please. And I
16 need you to respond out loud to the Court. If it takes you
17 some time to speak, that's fine with me. Okay?

18 All right. Dr. Desai, you -- do you understand that
19 you have the right to take the stand and testify on your own
20 behalf? Do you understand that?

21 THE DEFENDANT DESAI: No.

22 THE COURT: All right. Have you had an opportunity
23 to discuss his Fifth Amendment right with him, his right to
24 testify and his right not to testify?

25 MR. WRIGHT: Yes.

1 THE COURT: All right. Do you want additional time
2 to go over those rights with him?

3 MR. WRIGHT: No, it doesn't --

4 THE COURT: Okay.

5 MR. WRIGHT: -- change anything.

6 THE COURT: We'll go over those after the lunch
7 break. You know, I would just note that --

8 MR. WRIGHT: I'll talk to him.

9 THE COURT: -- Dr. Desai's demeanor in terms of his
10 posture, I don't know if demeanor is the right word, and
11 inability to face me is a little different than what I've
12 perceived at the breaks in terms of his posture and whatnot.
13 I'm not accusing anyone of anything. I would just say it's
14 different. So I hope there's not some exaggeration going on.
15 Posture, obviously, is different than his ability to
16 understand and communicate. However, it's curious to me that
17 it's manifesting differently than other times when I've seen
18 movement.

19 MR. WRIGHT: He's not moving.

20 THE COURT: I understand that. But, I mean, you
21 know, he walks out of the courtroom, he walks down the street,
22 he walks down the stairs, and his posture standing here right
23 now and his hunched over appearance and his failure to look at
24 the Court is, I think, different. You know, he's walking in
25 and out of this building unassisted. I know his daughters are

1 with him sometimes, but all I'm saying is I just hope that
2 there is not some exaggeration going on because --

3 MR. WRIGHT: There's no exaggeration --

4 THE COURT: All right.

5 MR. WRIGHT: -- going on.

6 THE COURT: Well, you can say that. We're back --
7 you know, we're kind of a in a full circle here to square one.
8 You know, I think your representations are well intentioned.
9 That does not necessarily make them accurate in terms of what
10 you're accurately perceiving and how you're communicating, I
11 think that's well intentioned. Whether or not that's the
12 ultimate truth, I don't necessarily know that that's -- that
13 that's the case or the -- that that's fact. So we'll cover
14 this again at the -- after the lunch break.

15 And, you know, if the State wants to be heard on
16 some of what I've said and their observations, they will be
17 allowed to -- to do that. But, you know, I don't know why Dr.
18 Desai cannot face the Court, and I think that that could be
19 evidence of some exaggeration going on. Because certainly --
20 well, I'm not going to opine. I'm just saying I don't
21 understand it. So go to lunch.

22 (Court recessed at 12:36 p.m., until 1:45 p.m.)

23 (Outside the presence of the jury.)

24 THE COURT: We'll do the witness, start with the
25 witness, and then at our afternoon recess we'll do the Fifth

1 Amendment admonishment.

2 MS. WECKERLY: Okay.

3 MR. STAUDAHER: Yes, Your Honor. Before we bring
4 the jury in we do have to address the next witness, the scope
5 of that person's testimony.

6 THE COURT: All right. Go ahead.

7 MR. STAUDAHER: We had -- I just want to bring it to
8 the Court's attention and actually try and find out exactly
9 where we plan on going with this witness because this is a
10 witness who testified to the Chanin case, gave a deposition
11 and gave opinions in the Chanin case regarding the fact of no
12 transmission at the clinic and there was no genetic match to
13 that person.

14 That's one of the issues is that he claimed in his
15 attached affidavit that one of the issues as to why that
16 person, Chanin, did not have hepatitis C from the clinic is
17 because there was no genetic link or no genetic match to that
18 one. He testified in a -- and this is not the Endoscopy
19 Center of Southern Nevada. This is the Desert Shadow
20 Endoscopy Center. Sorry, Your Honor.

21 So it's a different clinic, it's a different
22 non-genetically matched patient, and he was directly involved
23 with the review of those records and testimony about that,
24 which we have received a deposition of. So it's a concern,
25 obviously, that the State has as to the scope because in his

1 deposition he talks about having reviewed a number of cases.

2 I don't know which ones he reviewed and didn't
3 review, which if they were genetically linked, if they weren't
4 genetically linked. I know he was involved in Michael
5 Washington, at least, and Patty Aspinwall, I believe there was
6 a reference to that in there, as well as Chanin where he
7 actually did give the deposition. So --

8 THE COURT: So what are you trying to limit?

9 MR. STAUDAHER: I'm not trying to limit anything.
10 I'm just --

11 THE COURT: Okay.

12 MR. STAUDAHER: -- trying to make sure that they
13 know that I feel it's fair cross-examination --

14 THE COURT: Yeah, I mean, if you --

15 MR. STAUDAHER: -- for bias purposes.

16 THE COURT: I mean, they've been pretty scrupulous
17 about not introducing the evidence on the other 109 or 7 or
18 whatever it is. So is what you're saying that if then they
19 get into all this other stuff he's reviewed, it would open the
20 door, then, to that? Is that --

21 MR. STAUDAHER: That's partially it.

22 THE COURT: Okay.

23 MR. STAUDAHER: That's not the main portion of
24 what --

25 THE COURT: Okay.

1 MR. STAUDAHER: -- my concern is. I want to be able
2 to cross-examine him on this that this -- he was involved in a
3 non-genetically matched patient at a different related clinic,
4 and that he opined as to what the infections were or weren't
5 in that case and what he would --

6 THE COURT: This is another --

7 MR. STAUDAHER: -- rely upon.

8 THE COURT: -- another gastro -- one of their
9 centers?

10 MR. STAUDAHER: Yes --

11 THE COURT: And so --

12 MR. STAUDAHER: -- the Desert Shadow, the Burnham
13 clinic.

14 THE COURT: The Burnham clinic. So there was a
15 non-genetically linked patient at the Burnham clinic and he
16 opined that he, what, wasn't infected at the Burnham clinic?

17 MR. STAUDAHER: Right.

18 THE COURT: And, Mr. Wright, do you intend to get
19 into that?

20 MS. STANISH: No, I had indicated earlier to the
21 prosecutors that the primary purpose of Dr. Worman's testimony
22 was to address Mr. Meana's death, and then touch upon, in
23 general, hepatitis C and dementia, and that's it.

24 THE COURT: So he is just testifying strictly as a
25 medical expert relating to the cirrhosis and the cause of

1 death and as to whether or not hepatitis C could cause
2 dementia?

3 MS. STANISH: Correct.

4 THE COURT: Not as to causation of the infection or
5 genetic linkage or anything like that?

6 MS. STANISH: Yeah, we're not challenging the -- the
7 contraction of the hepatitis C by Mr. Meana, but it's to
8 address the proximate cause issue.

9 MR. STAUDAHER: So that -- I mean, that's -- I mean,
10 they've alluded to it, but I've never heard before that
11 they --

12 THE COURT: Okay.

13 MR. STAUDAHER: -- don't challenge the --

14 THE COURT: If that's all they're -- they're -- I
15 mean, if that's what it's limited to --

16 MR. STAUDAHER: My concern was the bias issue, that
17 I felt it was -- especially because he had opined as to the
18 fact that it was not that particular clinic that gave him the
19 infection and that he also said in his affidavit that one of
20 the reasons he based that on was that there was no genetic
21 link to Mr. Chanin and that clinic and that he -- he believed
22 that he must have a risk factor, although none were ever
23 articulated, just that he must have a risk factor so,
24 therefore, he could not have gotten it.

25 He also said that even though in that case Mr.

1 Chanin, I think a few weeks before, at least within the window
2 of incubation, had had a test for hepatitis C that came back
3 negative. He said, well, that could have been within the
4 window of incubation, so the -- the most he could say was that
5 he contracted hepatitis C from somewhere in February of 2007
6 up to the time --

7 THE COURT: So you want --

8 MR. STAUDAHER: -- at the clinic.

9 THE COURT: -- to cross-examine -- do you still want
10 to cross-examine him about all that?

11 MR. STAUDAHER: That he was paid by the -- by the
12 defense to essentially opine in a different case that --

13 THE COURT: But the --

14 MR. STAUDAHER: -- that it was not --

15 THE COURT: -- insurance --

16 MR. STAUDAHER: -- the clinic.

17 THE COURT: -- defense?

18 MR. STAUDAHER: Yes. Not this defense, not these
19 defense attorneys.

20 THE COURT: Okay. So he wasn't retained by -- I'm
21 assuming it was insurance defense or the defense team, maybe
22 -- who was it, Teva? Was it -- was it the endoscopy's
23 defense, was it the pharmaceutical defense?

24 MR. STAUDAHER: Well, I believe --

25 THE COURT: Do you know?

1 MR. STAUDAHER: Let me look.

2 THE COURT: Maybe you guys know, Ms. Stanish.

3 MS. STANISH: Give me a moment, Your Honor, please.

4 MR. STAUDAHER: Yes, this was -- and this was the
5 first trial, as my co-counsel pointed out. This was the one
6 that went to verdict, the Chanin matter against Teva and
7 Baxter.

8 THE COURT: So he would have been the
9 pharmaceutical's paid expert.

10 MS. STANISH: No, I don't think that's correct, Your
11 Honor.

12 MR. STAUDAHER: Actually, I think --

13 MS. STANISH: I believe he was hired by the McFadden
14 law firm that represented the endo center early on. And as I
15 recall, and correct me if I'm wrong, they did depositions in
16 groups. And then -- and then the insurance company settles
17 out with the clinic and doctors and, of course --

18 MR. STAUDAHER: It says here --

19 MS. STANISH: -- Chanin.

20 MR. STAUDAHER: -- that he was hired by the
21 defendants for the Endoscopy Center of Southern Nevada and
22 Gastroenterology Center, as well. So that -- it was Mr.
23 McFadden's.

24 MS. STANISH: Correct.

25 MR. STAUDAHER: But that's who he represented at the

1 time.

2 MS. STANISH: Correct. And then it settled -- the
3 Chanin case went forward to trial, history is made, but he
4 never -- he did not testify at the trial is my understanding.

5 MR. STAUDAHER: At least I don't know if it --

6 MS. STANISH: This is --

7 MR. STAUDAHER: The only thing we have is a
8 deposition. I've asked Ms. Stanish for anything else, and
9 she --

10 MS. STANISH: Right.

11 MR. STAUDAHER: -- doesn't have anything else.

12 MS. STANISH: We -- we received the deposition from
13 the -- in the State discovery. The deposition and a couple
14 reports that we forwarded --

15 MR. STAUDAHER: Right.

16 MS. STANISH: -- since there was --

17 MR. STAUDAHER: He did a report in Washington, he
18 did a report in Chanin, and I don't know if he's done any
19 others.

20 THE COURT: So, what, you want to ask him, oh, you
21 were retained by the defense in the civil case and you
22 provided an opinion that said Mr. Chanin didn't contract
23 hepatitis because it wasn't genetically linked? What do you
24 want to ask him?

25 MR. STAUDAHER: It wasn't genetically linked and he

1 said that there was no -- even though there was reported no
2 risk factors, he opined that there must be one because he had
3 had a hepatitis C test, and even though there was some
4 questioning about the fact that the doctor he went to did it
5 as a routine because his insurance would pay for it, that
6 didn't matter.

7 He just felt that there should be a risk factor that
8 this person was not disclosing and, therefore, he couldn't --
9 he didn't think that he was genetically linked to a reasonable
10 degree of medical probability to that claim. I mean --

11 THE COURT: And you think that shows what? That --

12 MR. STAUDAHER: His bias.

13 THE COURT: -- like he's a hired gun and he'll just
14 say whatever or --

15 MR. STAUDAHER: Well, I think that there is -- in my
16 opinion, based on what he testified to at the deposition,
17 there was no -- there was no basis for him saying that. He
18 gave enough wiggle room. But to come forward with that kind
19 of evidence and say to a reasonable degree of medical
20 probability he did not get the infection at that clinic I
21 think goes to show that he was essentially bias, that he was
22 bias for the defense in that case. He's been hired by the
23 defense in this case and he's -- you know, it goes to his
24 bias, I believe.

25 THE COURT: Okay. So his opinion wasn't to -- his

1 opinion wasn't I can't say that he's linked to a reasonable
2 degree of medical certainty, it was I can say that he's not
3 linked to a reasonable degree of medical certainty?

4 MR. STAUDAHER: That was my understanding of reading
5 his transcript.

6 THE COURT: All right. Ms. Stanish.

7 MS. STANISH: Let me just look to see what words he
8 articulated. They ask how -- how he thinks he was infected
9 and the doctor responds, I can only say that he was infected
10 in that time period, and there are many possible routes of
11 transmission. I'm not seeing where he says to a reasonable
12 degree of certainty that he concludes that he did not get
13 hepatitis C. I think what he was saying was he could not
14 state with -- that there was insufficient evidence to connect
15 him to the clinic with a reasonable degree of medical
16 certainty. Do you find --

17 MR. STAUDAHER: I will -- I will look --

18 MS. STANISH: -- a different line?

19 MR. STAUDAHER: -- for it --

20 MS. STANISH: I guess my other issue --

21 MR. STAUDAHER: -- because the issue --

22 THE COURT: I mean, I think that that's --

23 MR. STAUDAHER: It says did not believe that Chanin
24 got hep C at the clinic, page 13, from February to July. If I
25 go to that page --

1 MS. STANISH: I see where you're looking. The
2 question was do you think he contracted hepatitis C. Do you
3 have an opinion to a reasonable degree of medical probability
4 how Mr. Chanin contracted hep C that was diagnosed at the end
5 of July '06? He contracted it sometime in the time span
6 roughly of six months before the time or from going back a
7 couple week before that time, and I think that there --
8 there's many possible ways that he could have contracted hep
9 C, and I don't believe it was from the colonoscopy.

10 MR. STAUDAHER: So --

11 THE COURT: And then he says that's to a reasonable
12 degree ---

13 MS. STANISH: No, he doesn't say that.

14 MR. STAUDAHER: That's how the question was
15 prefaced, to a reasonable degree of medical probability, and
16 then he says he doesn't think he got it at the clinic. So --
17 or got it from the colonoscopy, which was at the clinic.

18 MS. STANISH: But then I -- you know, to put it in
19 context, I think he continues about the -- the difficulty of
20 trying to pinpoint what occurred. And there was something
21 about --

22 MR. STAUDAHER: He never comes --

23 MS. STANISH: -- he traveled overseas.

24 MR. STAUDAHER: -- off that, though. I mean, he
25 never says get, well, you know, he could have gotten it at the

1 clinic. He maintains that position.

2 THE COURT: All right. I think it goes to bias.

3 I'll allow Mr. Staudaher to question her about it.

4 MR. WRIGHT: Well, but --

5 THE COURT: All right. Kenny, bring them in.

6 MR. WRIGHT: We object.

7 THE COURT: I got that from her --

8 MR. WRIGHT: All right.

9 THE COURT: -- her lengthy argument that she was --
10 I mean, you know, I guess you're objecting that you don't
11 necessarily think it's relevant to anything, but I think if --

12 MR. WRIGHT: I don't think the gastro -- the
13 defendants in there wasn't the defendant here. The defense
14 wasn't -- he had no control over the defense in that case, and
15 if he tries to lump us together, it's -- it's not correct.

16 And secondly, just to bring out he testified to show
17 bias is fine, but I don't understand that you -- to show bias
18 you then bring out what he testified to, and I don't believe
19 what you testified to. That doesn't show bias. The bias is
20 he's held out to give opinions.

21 THE COURT: Well, no, I mean --

22 MR. WRIGHT: So we -- we put on his rebuttal that
23 he's right and his opinion is well founded.

24 MS. STANISH: Plus the standard of proof in the
25 civil case is --

1 THE COURT: Well, except he's saying to a reasonable
2 degree of medical probability, which is what they all testify
3 to, that it couldn't have been caused that way, that he didn't
4 believe. Now, if he had stated it the other way, that he
5 couldn't attribute a cause, I think that's -- I mean, I see
6 that as a significant difference. Whether he's saying it
7 wasn't the cause or, you know what, I just can't attribute a
8 cause. To me, those things are -- are very different and, I
9 think, significantly different.

10 Mr. Santacroce?

11 MR. WRIGHT: But how do we know he wasn't right? I
12 mean, what's the evidence going to be that that was incorrect?

13 MR. STAUDAHER: Well, the evidence he reviewed,
14 clearly. I mean, he listed a whole list of things and he
15 gives -- I'm sorry, Your Honor -- he gives his --

16 THE COURT: Well, how are you going to introduce
17 that?

18 MR. STAUDAHER: He gives his opinion that -- the
19 reason for his opinion is this, that -- just what I said,
20 there was no genetic link, and that because he believed that
21 there must be a risk factor when, in fact, none was
22 articulated that that must be the reason why he got it.

23 THE COURT: Well --

24 MR. STAUDAHER: He has a risk factor that he's not
25 disclosing and that --

1 THE COURT: Well, I don't think that's so out in
2 left field because typically a physician isn't going to test
3 you for hepatitis C. So I think what he's saying is if he's
4 being tested for hepatitis C, he must have articulated a
5 reason to his physician because that's not a standard --
6 that's not one of the standard tests.

7 MR. STAUDAHER: Correct. But then they ask him the
8 questions in follow up, well, do you know if his doctor did
9 that as a routine, if it was because of his insurance. They
10 give the doctor, they give the information, and he goes, no, I
11 don't know any of that stuff. Would it change your opinion?
12 No. I mean, that's -- that's what we're basically at. So if
13 he doesn't take into account that information, if he didn't at
14 least say, well, if that had been the case, that would change
15 my opinion.

16 THE COURT: Well, I don't want to -- okay. Here's
17 the deal. I don't want to get into a lengthy litigation over
18 the Chanin matter and what he should have known or asked or
19 whatever. Now, I mean, I certainly think it's fair for you to
20 bring up that he was retained, just like the defense did for
21 all of the experts that have testified.

22 Kenny, I need a minute.

23 Just like the defense has done for the experts that
24 have testified on the State's side. Oh, you were retained to,
25 you know -- you testified and you -- you know, that the State

1 wound up subpoenaing that. In fact, they had originally been
2 retained by plaintiff's counsel in those cases.

3 So I certainly think it's fair and goes to bias
4 that, just like you guys did or the defense did, for those at
5 least a couple of witnesses that the State learned about
6 through plaintiff PI counsel. So they can certainly bring out
7 that he opined in a civil case and that he was retained to do
8 that and that was by the civil defense attorneys, and this was
9 what he opined.

10 Beyond that there really -- he can't really comment
11 too much because we're not going to litigate the merits of the
12 Chanin case. So, I mean, that's -- that's what he can ask
13 him. You were, you know, a retained expert, who retained you
14 and what was your opinion?

15 Now, beyond that we're not going to -- as I said,
16 we're not going to get into a mini trial over the merits of
17 the Chanin matter. So, you know, do with that -- you know, do
18 what you will with that, but that's the extent of what the
19 State is going to be able to get into.

20 I do think it goes to bias that he was retained and
21 he gave an opinion favorable to the defense attorneys in that
22 matter, just like with the State's witness, the defense got to
23 get into, oh, you were retained by the PI lawyers and you gave
24 an opinion favorable in those cases and you made all this
25 money. You know, certainly I think that that's a fair subject

1 for cross-examination and he can get into it in that limited
2 way. So -- yes?

3 MR. SANTACROCE: I just want, for the record, to
4 state my objection, as well. I think you've stated my
5 objection, so I don't need to go over it again, but I think to
6 introduce another name and an infected patient, we'll have to
7 re-litigate that issue, put it before the jury. This serves
8 to confuse the jury and it's really kind of a backdoor
9 approach of the State to get in more information about
10 infected patients at Burnham.

11 So I think that, yes, it's fair game to go after the
12 bias that he was paid by the defense to testify here today,
13 he's testified for the defense in the past and he's been paid
14 for that. But to go into specific names and diseases and what
15 you testified to as to whether he had hep C or not, I think
16 it's irrelevant, it's confusing to the jury, and it's highly
17 prejudicial over probative.

18 MR. STAUDAHER: We didn't choose the expert. I
19 mean, they picked him knowing full well that he had testified
20 in that case, that it was a non-infected patient, that he
21 actually provided an opinion and that information has been out
22 there, so --

23 THE COURT: It wasn't -- why don't you do this.
24 Here is, I think, balancing everything you can ask -- don't
25 introduce the name because we haven't heard about this name

1 before and I think that that would be unduly confusing.
2 Again, I don't want to litigate the infection of this person
3 and whether he got infected or not. He's not a named victim.
4 You know, we're here at the defense's case. I don't want to,
5 you know, open the door.

6 But, again, you can certainly ask he was retained in
7 one of the civil cases for a non-genetically linked patient
8 who was infected with hepatitis. You can ask what he was paid
9 and that he gave an opinion that -- you know, favorable to the
10 endoscopy center, that he did not contract hepatitis there
11 without getting into the name or who it was or whatever. Just
12 point out it wasn't one of the, you know, genetically linked.

13 MR. STAUDAHER: Can I at least put out that he -- it
14 was at a different clinic, it was at the Burnham clinic and
15 not the Shadow Lane clinic? I mean, that's germane because
16 it's not a genetically linked patient. I don't want to have
17 -- it's a misperception to the jury that it may be one of the
18 patients like Lakota Quannah or somebody like that who was
19 non-genetically linked who is in our case.

20 I mean, I understand this Court's stricture on -- on
21 the name. I don't have an issue with that. But as far as at
22 least a different clinic and that he -- am I going to be able
23 to at least ask him what the basis for his opinion is?

24 THE COURT: Why don't you say this? You know, I
25 don't want to start now -- I mean, I just -- you know, a

1 non-genetically linked patient who is not part of this case or
2 something like that, not part of this case and you were
3 retained, how much did he get paid, and he gave a favorable
4 opinion that he wasn't infected at the center or he didn't
5 receive the infection through a colonoscopy or something like
6 that. That way we're not litigating a side issue, but the
7 State is able to introduce this kind of, you know, hired gun,
8 bias idea if that's -- obviously you can't refer to him as a
9 hired gun because we know that that would be misconduct, so --

10 MR. STAUDAHER: And I did not use those words at
11 all.

12 THE COURT: Right. I'm just saying, I mean, to me
13 that's the gist. Those are my words, for the record, not Mr.
14 Staudaher's words. I'm just cautioning not to use those words
15 because that would be misconduct. But I think that's the
16 idea, that this guy is retained, he's going to say whatever is
17 favorable to the defense.

18 And, again, the defense has been allowed to
19 cross-examine the State's experts on their bias as a result of
20 having been retained by PI lawyers, plaintiff's attorneys in
21 this -- in the related matters and making a lot of money from
22 that. So I think it's the same -- it's the same line of
23 thinking.

24 MR. WRIGHT: That's as far as it went, though. I
25 didn't ask a single one of those witnesses, and what was your

1 opinion and what did you testify to in that other case? The
2 bias is shown by being --

3 THE COURT: Well, no, I think you did because you
4 got into the whole idea, well, who are you suing and it's the
5 propofol and, oh, and if it wasn't the propofol or it wasn't
6 -- if it was the -- I remember on one if it was the saline
7 then that would be against your theory that it's the propofol.
8 So that did come out. Somehow I remember the -- I mean, the
9 idea was, well, you have to say that it was the unsafe
10 injection practices through the propofol because that's where
11 the money is was the gist of it. Not your words, but that was
12 the -- the import of the cross-examination that I took from it
13 that --

14 MR. WRIGHT: You're right.

15 THE COURT: -- that the reason they -- you know,
16 they have to say it is because the saline, there's not --
17 there's not a lot of money there. And, you know, again, I
18 think that goes to the bias and I -- I don't know that we have
19 to discuss anything.

20 Mr. Staudaher, I trust you'll stay within the
21 parameter set by the Court, and I'll bring them in.

22 MS. STANISH: If I may, Your Honor, I just want to
23 tell the witness.

24 THE COURT: That's fine.

25 (Inside the presence of the jury.)

1 THE COURT: All right. Court is now back in
2 session, and the defense may call its next witness.

3 HOWARD WORMAN, DEFENDANT'S WITNESS, SWORN

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

6 THE WITNESS: Okay. Is this the mic here that picks
7 me up?

8 THE COURT: It is.

9 THE WITNESS: I'm fine?

10 THE COURT: The black box. Yes.

11 THE WITNESS: Howard Worman, W-O-R-M-A-N.

12 THE COURT: Howard, H-O-W-A-R-D?

13 THE WITNESS: H-C-W-A-R-D, yes.

14 THE COURT: All right. Thank you.

15 Ms. Stanish, you may proceed.

16 MS. STANISH: Thank you, Your Honor.

17 DIRECT EXAMINATION

18 BY MS. STANISH:

19 Q What do you do for a living?

20 A I'm a professor of medicine and pathology and
21 cell biology at Columbia University.

22 Q And are you a practicing physician?

23 A In New York State I am, yes.

24 Q And what exactly do you do as a practicing
25 physician in New York State?

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1 A Well, my clinical work is focused primarily on
2 liver disease, and I also attend on general medicine in the
3 hospital we're affiliated with. And then I do research and
4 teaching at the medical school.

5 Q And let -- let me have you take us back to
6 your younger days of your medical education. Please describe
7 for the jury your educational background.

8 A Okay. So I got a bachelor's degree from
9 Coronel University. That was 1981. M.D. Degree from the
10 University of Chicago in 1985. Then I trained in internal
11 medicine at what was then New York Hospital for two to three
12 years. Then I did a three year fellowship in cell biology at
13 Rockefeller University with Nobel Laureate whose name was
14 Gunter Blobel.

15 Then I got an assistant professor job at Mount Sinai
16 School of Medicine where for a year I had intensive training
17 in liver disease from someone whose name was Fenton Schaffner.
18 I worked at Mount Sinai for three more years, then started at
19 Columbia in 1995, assistant professor, associate professor,
20 tenured associate professor, full professor, until now.

21 Q And as I understand what you explained to us
22 earlier, you -- you -- are you consulting -- are you a
23 consulting doctor for other doctors who have patients with
24 liver issues?

25 A Well, yeah, my clinical work would be divided

1 up into sort of two groups. One is there's a liver clinic at
2 Columbia where there are probably 1,000 or so patients with
3 hepatitis C where the fellows care for them and I oversee them
4 and that's a large group of patients referred to other doctors
5 at the medical center. And then I have a smaller practice
6 where I see patients for second, third opinions who have
7 usually seen gastroenterologists or hepatologists beforehand.

8 Q And you mentioned that you were involved in
9 research. Could you overview for us what type of research you
10 do in the area of livers?

11 A Okay. Well, in the area of liver disease, if
12 I go back, I first got into that by studying auto-antibodies
13 in a rare liver disease called primary biliary cirrhosis.
14 After that I did some work in the laboratory on hepatitis C,
15 characterizing some of the proteins of what was then a newly
16 discovered virus. I've done clinical trials for hepatitis C
17 back when interferon and ribavirin were relatively new drugs.

18 I did two or three clinical trials to treat patients
19 with hepatitis C with interferon and ribavirin, one trial
20 before the drugs were approved. And I've done some other
21 projects in liver disease in the lab looking at some genes
22 that cause fatty liver, involved in a project like that, and I
23 do basic cell biology research, as well, that relates to
24 diseases other than liver diseases.

25 Q And do you publish articles or review articles

1 in those journals that most of us don't read?

2 A Yes. I mean, shall I elaborate?

3 Q Approximately how many articles have you
4 written in the area of liver disease?

5 A Oh, I can't say. It's in -- all together I've
6 published about 180 medical articles, and maybe 30 to 40 to 50
7 on -- somehow related to liver disease.

8 Q And you are here today as an expert retained
9 by the defense; correct?

10 A That's correct.

11 Q How much of your working life is devoted to
12 testifying in -- in or reviewing cases involving litigation?

13 A It varies from year to year, and I'd say it
14 varies from 10 percent of my time to the most, some years, 15
15 or so percent of my time.

16 Q And had you been previously -- had you
17 previously worked for a civil law firm that represented the
18 corporate corporation at the endoscopy center?

19 A I believe the -- the defendant there was
20 called the Endoscopy Center of Southern Nevada and I worked
21 for a law firm that was defending them.

22 Q And that case involved a non-genetically
23 connected patient that was -- had nothing to do with the dates
24 of September 21, 2007, and July 25, 2007?

25 A The case that I testified in?

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

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

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

11 Q Okay.

12 A -- to make that --

13 Q But didn't --

14 A -- notification.

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

23 A Yes, that's correct.

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

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

3 A Yes.

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

6 A Yes, we did.

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

9 A Yes, that's correct.

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

12 A Yes, he did.

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

19 A Yes.

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

24 A Yes, that's correct.

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

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

3 A That's correct.

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

7 A Yes, that's --

8 Q -- right?

9 A --- correct.

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

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

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

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

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

22 A I don't remember that specific --

23 Q Okay.

24 A -- part of the conversation.

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

1 BY MR. WRIGHT:

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

4 A Okay.

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

7 THE COURT: Is everybody okay?

8 BY MR. WRIGHT:

9 Q -- read that to yourself.

10 THE COURT: Okay.

11 BY MR. WRIGHT:

12 Q See if it refreshes your recollection.

13 A (Witness complied.)

14 Q Does that refresh your recollection?

15 A Yes.

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

18 A Yes.

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

21 A Yes.

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

23 A Yes.

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

1 A Yes, it did.

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

5 A That's correct.

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

10 A Yes, that sounds correct.

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

13 A Yes, I did.

14 Q Okay. What did he say?

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

17 Q Okay.

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

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

23 A Yes.

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

25 A To stop the notification? No.

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

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

5 Q Pardon?

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

8 Q You didn't believe --

9 A -- really --

10 Q -- him?

11 A -- no, I didn't.

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

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

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

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

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

2 A No, I did not.

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

5 A Yes.

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

10 A Yes, that's correct.

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

15 A Yes.

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

19 A Yes, that's correct.

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

23 A Yes.

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

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

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

5 Q Okay.

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

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

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

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

16 MR. WRIGHT: 116.

17 BY MR. WRIGHT:

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

20 A (Witness complied.) Yes.

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

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

25 Q Okay. At most a 6 percent background of

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

3 A Yes.

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

6 A Yes, I did.

7 Q Okay. Do you recall how many occasions?

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

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

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

19 A Yes, that's correct.

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

24 A No, they're not.

25 Q Okay. What are they supposed to do?

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

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

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

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

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

14 Q Pardon?

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

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

21 A No, I don't.

22 Q Patricia Rowley is your boss --

23 A Yes.

24 Q -- was?

25 A Was, yes.

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

3 A Yes.

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

6 MR. WRIGHT: Page 41.

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

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

10 (Off-record bench conference.)

11 BY MR. WRIGHT:

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

15 A Yes, that's me.

16 Q Okay.

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

19 Q Okay.

20 A -- that's me.

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

23 A That's what it says, yes.

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

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

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

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

9 THE WITNESS: Three, four maybe.

10 THE COURT: Okay.

11 BY MR. WRIGHT:

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

15 A Yes.

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

18 MS. WECKERLY: Objection. Hearsay.

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

23 Go ahead, ask your question.

24 BY MR. WRIGHT:

25 Q Do you recall --

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

5 Is that accurate?

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

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

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

10 BY MR. WRIGHT:

11 Q Do you have any memory of this?

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

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

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

21 THE COURT: Well, Mr. Wright --

22 MS. WECKERLY: Objection.

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

1 MR. WRIGHT: Okay.

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

3 MR. WRIGHT: Well, it --

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

5 MR. WRIGHT: -- okay.

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

8 MR. WRIGHT: Well, okay.

9 BY MR. WRIGHT:

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

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

19 Q Okay.

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

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

1 A Yes.

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

5 A Yes, it did.

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

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

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

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

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

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

1 Q Would you look at Proposed R1, sir?
2 A (Witness complied.)
3 Q Is that -- are you familiar with that?
4 A Yes.
5 Q Is that the notification?
6 A Well, you were referring to the second Epi-Aid.
7 This was based off of the first Epi-Aid, prior to that second
8 Epi-Aid was ever initiated. This was right after -- if it was
9 February 2008, it would have been right after our
10 announcement.
11 Q Okay. And it -- so right at -- and the February
12 2008 date is on there, correct?
13 A Yes.
14 Q Okay. And so that was essentially sending out a
15 notice to the State to engage in safe-injection practices and
16 don't multiuse single-use vials of medication, correct?
17 A Yes, that's correct.
18 Q Okay. And that was -- and, in fact, that was
19 sent out, correct?
20 A Yes, it was.
21 Q Okay.
22 MR. WRIGHT: I'd move its admission.
23 THE COURT: Any objection?
24 MS. WECKERLY: No objection.
25 THE COURT: All right. That will be admitted. What

1 was that, R1?

2 MR. WRIGHT: Yes.

3 THE COURT: All right.

4 (Defendant's Exhibit R1 admitted.)

5 BY MR. WRIGHT:

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

11 A Yes, that's correct.

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

16 MS. WECKERLY: Objection. Foundation.

17 BY MR. WRIGHT:

18 Q -- correct?

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

20 THE WITNESS: Yes, that's correct.

21 BY MR. WRIGHT:

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

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

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

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

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

6 Q Okay.

7 MR. WRIGHT: On page 46.

8 THE WITNESS: (Witness complied.) Okay.

9 BY MR. WRIGHT:

10 Q Does that refresh your recollection?

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

13 Q Thank you, sir.

14 THE COURT: Does that conclude your cross?

15 MR. WRIGHT: Yep.

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

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

25 Notepads in your chairs. Follow the bailiff through

1 the rear door.

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

3 THE COURT: I'm sorry?

4 THE WITNESS: The exhibit --

5 THE COURT: Oh, give it to --

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

7 THE COURT: -- me.

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

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

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

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

15 THE COURT: I mean --

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

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

18 MR. STAUDAHER: -- limited on --

19 MR. WRIGHT: -- tomorrow.

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

21 MS. WECKERLY: That's true.

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

23 MS. WECKERLY: That's 90 minutes.

24 THE COURT: -- a good idea.

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

1 to it being played.

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

3 (Outside the presence of the jury.)

4 (Off-record colloquy.)

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

8 MR. STAUDAHER: Well --

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

10 MR. WRIGHT: Good.

11 MS. WECKERLY: That's fine.

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

15 MR. SANTACROCE: Can I use your chart?

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

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

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

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

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

23 THE COURT: Is there any local insurance --

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

25 THE COURT: -- people?

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

3 THE COURT: Oh, yeah.

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

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

7 MS. WECKERLY: Mm-hmm.

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

12 MR. WRIGHT: Yep.

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

17 Ready.

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

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

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

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

25 MR. SANTACROCE: Thank you, Your Honor.

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CROSS-EXAMINATION

BY MR. SANTACROCE:

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

A Yes.

Q -- Doctor.?

A Mister.

Q Okay. So you're not an MD?

A That is correct.

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

A Yes, it is.

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

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

Q Okay. Was the Metropolitan Police Department
involved?

A No, they were not.

1 Q District Attorney's Office?

2 A No.

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

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

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

17 A That's correct.

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

20 THE COURT: Well, overruled.

21 BY MR. SANTACROCE:

22 Q Correct?

23 A Yes.

24 THE COURT: He's already answered.

25 BY MR. SANTACROCE:

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

3 A Yes, that's correct.

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

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

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

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

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

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

21 Q And did you conduct interviews?

22 A Yes, we did.

23 Q Do you know who you interviewed?

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

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

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

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

11 A No.

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

15 A That's correct.

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

19 A Generally, yes.

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

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

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

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

11 A Yes, that's correct.

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

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

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

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

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

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

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

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

21 A Yes.

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

24 A That's correct.

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

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

4 A I did.

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

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

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

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

17 Q And then CRNA?

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

20 Q Okay. And the next one, technician?

21 A The same thing.

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

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

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

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

6 A Yes, we did.

7 Q Did you interview any of those people?

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

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

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

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

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

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

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

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

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

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

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

15 A Yes, we did.

16 Q How long was that?

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

1 or so.

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

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

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

10 BY MR. SANTACROCE:

11 Q What --

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

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

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

16 BY MR. SANTACROCE:

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

19 A Yes, we did.

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

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

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

1 Medivators that clean the scopes were broken?

2 A Yes, we had heard reports of that.

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

5 A I may have.

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

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

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

16 A Yes.

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

20 A Yes.

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

25 A We didn't see any of that.

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

2 A No.

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

5 A It would have been a concern, yes.

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

8 A Yes.

9 Q Had you seen that?

10 A Yes.

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

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

19 A Yes.

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

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

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

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

3 A Yes.

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

7 A No, they did not.

8 Q Would that have been a concern to you?

9 A Yes, it would have.

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

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

18 Q The biopsy equipment was reused?

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

22 Q And you ruled that out because of what?

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

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

4 A Could I see the actual chart itself?

5 Q Sure.

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

7 Q Have you seen that?

8 A Yes.

9 Q Okay. So you know what it is?

10 A Yes.

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

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

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

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

22 Q So this table only applies to September 21?

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

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

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

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

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

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

10 A Yes.

11 Q And the next -- next one?

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

16 Q And bite blocks?

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

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

22 A Yes.

23 Q And the next issue?

24 A That would be the IV placement.

25 Q And why did you rule that out?

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

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

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

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

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

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

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

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

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

1 A In the CDC report --

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

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

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

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

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

10 THE COURT: Okay.

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

15 THE COURT: Okay.

16 BY MR. SANTACROCE:

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

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

1 Q How about on September 21?

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

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

6 A No, we did not.

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

12 A Yes.

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

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

17 Q Do you see Rodolfo Meana?

18 A Yes.

19 Q Started by Lynette Campbell.

20 A Yes.

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

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

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

5 A Okay.

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

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

13 Q Is multidose vials of saline acceptable
14 practice?

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

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

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

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

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

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

7 A Yes.

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

11 A Yes, that's correct.

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

15 A Yes.

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

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

24 Q A contaminated bottle?

25 A Or a syringe that was drawn with contaminated

1 propofol.

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

5 A Yes, I do.

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

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

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

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

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

23 A Yes.

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

1 A That's correct.

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

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

7 Q Had to be one of the two?

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

10 Q Let's look --

11 A -- one of those.

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

14 A Okay.

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

17 A Yes.

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

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

20 Q Let's take a look.

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

22 Q Let's -- actually --

23 A -- that table.

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

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

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

3 nurses' log notes?

4 A Yes.

5 Q Right here?

6 A Yes.

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

8 started?

9 A 9 --

10 Q He's the orange one.

11 A -- 9:49.

12 Q Okay. And what time did he end?

13 A 10.

14 Q And what time did Stacy Hutchinson -- she's

15 right here, Stacy in Room 2.

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

17 is.

18 Q See that?

19 A Yes.

20 Q Stacy, Room 2? Then sliding over to the nurses'

21 notes, what time did she start her procedure?

22 A 9:55.

23 Q So Kenneth Rubino didn't finish his procedure

24 until 10:00. Stacy Hutchinson began before Rubino finished.

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

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

3 A Yes, that's correct.

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

7 A Yes.

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

10 A Yes.

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

13 A Yes.

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

16 A Yes.

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

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

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

24 A Yes.

25 Q And you're aware that their conclusions were

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

3 A Yes.

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

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

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

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

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

15 A Yes.

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

20 A That's correct.

21 Q I have nothing further. Thank you.

22 THE COURT: All right. Redirect?

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

25 REDIRECT EXAMINATION

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1 BY MS. WECKERLY:

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

7 A Yes.

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

10 A No.

11 Q Why is that?

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

15 Q Okay.

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

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

22 A Yes, that's correct.

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

1 that unique, actually?

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

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

6 A Yes.

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

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

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

16 A No.

17 Q Why not?

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

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

25 A Yes.

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

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

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

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

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

20 A Yes, that's correct.

21 Q And why would that be, scientifically?

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

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

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

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

13 A Yes, that's correct.

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

18 A Yes, that's correct.

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

25 A Yes.

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

3 A No, it did not.

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

7 A February 7, 2008.

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

11 A Yes.

12 Q So that was sort of a preliminary warning?

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

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

19 A Yes.

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

23 A Yes.

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

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

3 A Yes.

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

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

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

17 A Yes.

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

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

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

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

4 A Yes.

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

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

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

13 A That's correct.

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

17 A I'm not sure exactly what he based his chart on,
18 but he did have a chart that he showed me.

19 Q Okay. Did anything that he showed you make you
20 doubt your conclusions, or make you think, boy, I got to
21 relook at this whole thing because Dr. Carrol here, you know,
22 seems to have a point? Or was it something that you had
23 already considered or...

24 A I think the biggest thing I took away from him
25 showing that chart was we identified an additional patient

1 that we hadn't identified earlier because he had somebody
2 listed as a case that was a name we didn't see.

3 Q Okay. So it actually --

4 A It gave us one more case, but that really didn't
5 change anything at that point.

6 Q Okay. Did it -- did it at all make you question
7 your conclusions regarding the source of transmission?

8 A No.

9 Q And as -- as you sit here now, you know, some
10 five or so years later, is your conclusion or belief the same
11 regarding what caused the transmission of the hepatitis C
12 virus to these individuals?

13 A Yes, it is.

14 Q It's the same? Thank you.

15 THE COURT: All right. Mr. Wright, any recross?

16 MR. WRIGHT: Yeah, just on that.

17 RECROSS-EXAMINATION

18 BY MR. WRIGHT:

19 Q Questions about the second Epi-Aid and whether
20 it dealt with any findings of reuse of syringes, do you recall
21 that another clinic was closed down because an
22 anesthesiologist M.D. was multidosing with vials and reusing
23 syringes?

24 A Yes, but it wasn't from that report.

25 Q Okay. It -- it was from BLC inspections?

1 A Yes, it was a separate BLC inspection of that
2 facility.

3 Q Okay.

4 A It wasn't the -- the -- I don't think it was the
5 CDC response on that one.

6 Q It -- that -- that incident predated the second
7 Epi-Aid?

8 A I'm not exactly sure. I think so, but I'm not
9 exactly sure.

10 Q Okay.

11 MR. WRIGHT: No further questions.

12 THE COURT: Mr. Santacroce?

13 RE CROSS-EXAMINATION

14 BY MR. SANTACROCE:

15 Q When you said you had no statistical comparison
16 for July 25th as to the biopsy forceps being reused, is that
17 the same analysis for the propofol contamination? If you only
18 had one infected patient, can you do a statistical analysis?

19 A I hadn't done a statistical analysis on the
20 propofol contamination before. All patients received
21 propofol, so there was no non-propofol group. If there were
22 multiple medications used, you could have done a comparison,
23 but I couldn't do it on September 21st because everybody was
24 exposed to propofol. There's no way to compare it to anything
25 else.

1 Q No, I said, July 25th?

2 A The same thing on July 25th.

3 Q Okay. You testified that you had problems with

4 the times, but in front of the grand jury you testified that

5 you came to the conclusion that the nurses' times were the

6 most accurate, correct?

7 A Right.

8 Q Okay. And you testified that the sequence of

9 the patients was correct; is that your testimony?

10 A Yes.

11 Q So we know, for example, that the source patient

12 Kenneth Rubino, was before this patient in yellow, correct?

13 A Yes.

14 Q Okay. And then we know that this next patient

15 happened after that, this one, this one, this one, this one,

16 and down the line, correct?

17 A Generally, yes.

18 Q The -- well, you're confident, and you testified

19 that that was correct. Is it correct or --

20 A Yes.

21 Q -- not correct?

22 A Yes, it is.

23 Q Can you see the CRNAs on -- on what's displayed

24 there?

25 A Yes, I can.

1 Q Okay. Can you point to which column that's in?
2 Because I can't see it from here.

3 A It's the --

4 Q Just point on your screen.

5 A Oh, my --

6 Q Okay.

7 A That's a --

8 Q I want to --

9 A -- CRNA --

10 Q -- move that over --

11 A -- okay.

12 Q -- so we can get -- you can -- tap the bottom of
13 the screen, if you would.

14 MR. STAUDAHER: On the right-hand corner.

15 BY MR. SANTACROCE:

16 Q There you go. Okay. So the sequence is
17 correct, and we know that the CRNAs, according to your
18 testimony, only changed rooms at lunch breaks and at potty
19 breaks, and we know that Kenneth Rubino, Stacy Hutchinson,
20 were contaminated in different rooms, correct? Who were the
21 CRNAs in Room 1 with Kenneth Rubino?

22 A Keith Mathahs.

23 Q Who was the CRNA for Stacy Hutchinson?

24 A Ronald Lakeman.

25 Q And when did -- and if you look down below Stacy

1 Hutchinson, who was the CRNA for that procedure?

2 A Keith Mathahs.

3 Q So Mathahs didn't come over to relieve Mr.
4 Lakeman for a potty break until after Stacy Hutchinson,
5 correct?

6 A These times, yes.

7 Q Times or chronology or sequence of --

8 A Or the --

9 Q -- patients?

10 A -- according to the sequence, yes.

11 MR. SANTACROCE: Nothing further.

12 THE COURT: Ms. Weckerly?

13 MS. WECKERLY: Nothing further.

14 THE COURT: I'll see Counsel at the bench.

15 Any additional juror questions?

16 (Off-record bench conference.)

17 THE COURT: All right. I have a question on --
18 changing a little bit.

19 THE WITNESS: Okay.

20 THE COURT: Did you video or audio record any of the
21 interviews during your investigation at the endoscopy center?

22 THE WITNESS: No, we did not.

23 THE COURT: All right. Is that something you
24 normally do, or no?

25 THE WITNESS: No, that's --

1 THE COURT: Or ever do?

2 THE WITNESS: -- that's not normal in our procedures.

3 THE COURT: Okay. All right. Any followup to that
4 last question? Ms. Weckerly?

5 MS. WECKERLY: No, Your Honor.

6 THE COURT: Any followup, Mr. Wright?

7 MR. WRIGHT: No, Your Honor.

8 THE COURT: Mr. Santacroce.

9 MR. SANTACROCE: No, Your Honor.

10 THE COURT: Any additional juror questions for this
11 witness?

12 All right. Sir, thank you for your testimony. I'm
13 about to excuse you, but I must admonish you not to discuss
14 your testimony with anyone else who may be a witness in this
15 matter.

16 Thank you, sir. And you are excused.

17 Does the State have any other witnesses scheduled
18 for today?

19 MS. WECKERLY: No, Your Honor.

20 THE COURT: All right. Ladies and gentlemen, we're
21 going to go ahead and take our evening recess. We will be
22 reconvening tomorrow morning at 10:30.

23 May I see the bailiff at the bench.

24 We'll reconvene at 10:30. During the evening recess
25 you are reminded that you're not to discuss the case or

1 anything relating to the case with each other or with anyone
2 else. You're not to read, watch, listen to any reports of or
3 commentaries on this case, any person or subject matter
4 relating to the case. Do not do any independent research by
5 way of the Internet or any other medium, and please do not
6 form or express an opinion on the trial.

7 Notepads in your chairs, and follow the bailiff
8 through the rear door. We'll see you back tomorrow at 10:30.

9 (Court recessed for the evening at 3:47 p.m.)
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I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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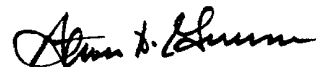

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TRAN



CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA

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| THE STATE OF NEVADA, |) | |
| |) | |
| Plaintiff, |) | CASE NO. C265107-1,2 |
| |) | CASE NO. C283381-1,2 |
| vs. |) | DEPT NO. XXI |
| |) | |
| DIPAK KANTILAL DESAI, RONALD |) | |
| E. LAKEMAN, |) | |
| |) | |
| Defendants. |) | TRANSCRIPT OF |
| |) | PROCEEDING |

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 40

THURSDAY, JUNE 20, 2013

APPEARANCES:

FOR THE STATE: MICHAEL V. STAUDAHER, ESQ.
PAMELA WECKERLY, ESQ.
Chief Deputy District Attorneys

FOR DEFENDANT DESAI: RICHARD A. WRIGHT, ESQ.
MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN: FREDERICK A. SANTACROCE, ESQ.

Also Present Telephonically: NIA KILLEBREW, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
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1 LAS VEGAS, NEVADA, THURSDAY, JUNE 20, 2013, 9:14 A.M.

2 * * * * *

3 (Outside the presence of the jury.)

4 THE COURT: All right. I just wanted to go on the
5 record out of the presence of the jury. We're still waiting
6 for a couple of late arriving jurors.

7 On Mr. Santacroce's motion to strike the testimony
8 of the last witness, that is denied. While the Court is
9 concerned about the fact the State isn't proving up the
10 numbers, I don't think striking the testimony is the remedy.
11 I think the remedy is for defense to point that out in their
12 argument that the, you know, testimony may be incomplete or
13 inaccurate or confused or whatever it is you want to argue.

14 I don't think the remedy is for the Court to
15 evaluate the testimony and then step in and say because I
16 don't, you know, agree with the way the State presented it
17 that it should be stricken. So that motion is denied, and I
18 would remind the State, who is not listening --

19 MS. WECKERLY: No, I'm listening.

20 THE COURT: -- that, you know, basically you need to
21 confine your arguments to what the testimony actually was, and
22 in your closing arguments to be very mindful of what the
23 testimony was and not deviate from that. So that's all I'll
24 -- my only comment on that. But the motion, the joint motion
25 to strike the testimony is denied.

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1 MR. STAUDAHER: And just for the Court, also based
2 on the issue of whether they're -- that document that was
3 attached that she testified to was part of the record. We
4 actually are -- have a photocopy of a .pdf version. We'll
5 have the actual version of a COR production from the company
6 with that document attached as -- as being part of it that we
7 will move to admit to allay that issue.

8 THE COURT: Okay. And then since it's a .pdf
9 version, can you just email that to the other side so they
10 can --

11 MR. STAUDAHER: I think I did already.

12 MS. STANISH: Yeah, we received some --

13 THE COURT: Okay. So you already got that? Okay.

14 MR. STAUDAHER: The actual hard copy is following.
15 It should be here this afternoon --

16 THE COURT: Okay.

17 MR. STAUDAHER: -- or tomorrow. I've got the .pdf
18 now, but I'm -- if -- I'm going to wait to see if we get the
19 actual hard copy by tomorrow to go ahead and -- go ahead and
20 make that as part of the evidence.

21 THE COURT: Okay. And then I think that was the
22 only pending legal issue. Okay. And then as soon as all the
23 jurors get here, we can get started.

24 (Court recessed at 9:17 a.m., until 9:24 a.m.)

25 (In the presence of the jury.)

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1 THE COURT: All right. Court is now back in
2 session. The record should reflect the presence of the State
3 through the deputy district attorneys, the presence the
4 defendants and their counsel, the officers of the court, and
5 the ladies and gentlemen of the jury.

6 And the State may call its next witness.

7 MR. STAUDAHER: The State calls Miriam Alter to the
8 stand, Your Honor.

9 THE COURT: All right.

10 MIRIAM J. ALTER, STATE'S WITNESS, SWORN

11 THE CLERK: Thank you. Please be seated. And
12 please state and spell your name.

13 THE WITNESS: Miriam J. Alter; M-I-R-I-A-M, middle
14 initial J, last name Alter, A-L-T-E-R.

15 DIRECT EXAMINATION

16 BY MR. STAUDAHER:

17 Q Dr. Alter, what kind of a doctor are you?

18 A I have a PhD in infectious disease
19 epidemiology.

20 Q And can you give is a little bit about your
21 background and training in that area? Tell us where you went
22 to school, what you've done, that kind of thing.

23 A Okay. Actually, my original degree was
24 Bachelor of Science in nursing from the University of
25 Pennsylvania in 1971. And then went on, actually, to do

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1 infection control in hospitals. Went to Johns Hopkins
2 University for my master of public health and PhD in
3 infectious disease epidemiology, and then went to work for the
4 Centers for Disease Control and Prevention in Atlanta, where I
5 worked for 25 years in the division of viral hepatitis. And
6 as an epidemiologist, that meant investigating epidemics,
7 which is, you know, just the term for the -- the formal
8 definition basically.

9 Q Well, let's go -- let's go back to the CDC
10 involvement. So when do you actually go to the CDC?

11 A In 1981.

12 Q And you said you were there for --

13 A 25 years.

14 Q -- 25 years? And it's going to be really hard
15 if we talk over each other, so -- because we have to record
16 this.

17 A Thank you.

18 Q If you let me finish my question, I'll try to
19 let you finish --

20 A No --

21 Q -- your answer.

22 A -- it's okay.

23 Q Okay?

24 A Sorry.

25 Q As we go forward, this time that you said you

1 were in the area of viral hepatitis, did you say?

2 A Yes.

3 Q Was that for the entire 25 years, or --

4 A Yes.

5 Q So you -- I mean, that was your whole area the
6 entire time?

7 A Yes. There are --

8 Q Go ahead.

9 A Yes.

10 Q You started to say there --

11 THE COURT: I'm sorry. Was that yes?

12 THE WITNESS: There are -- it is -- there are five
13 different types of known hepatitis viruses. They're
14 transmitted in different ways, they have different risk
15 factors, so it's like being involved in five different --
16 completely different diseases. And their transmission
17 patterns and their public health interventions are also
18 completely different. And there was technology that evolved
19 during the -- all that time that provided a lot of variation
20 in your day to day activities, so it doesn't -- it wasn't
21 boring at all.

22 BY MR. STAUDAHER:

23 Q You said five different areas within that?
24 Five different viruses; is that right?

25 A Yes.

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1 Q Okay. So can you describe for us the
2 differences? And then you said they had different
3 transmission patterns, can you tell us about that?

4 A You're probably familiar with the term
5 hepatitis A, hepatitis B, hepatitis C, you might also have
6 heard of hepatitis D and hepatitis E. And hepatitis is just a
7 non-specific term for inflammation of the liver. And you can
8 have an inflamed liver for many reasons that have nothing to
9 do with infection. You drink too much, you jogged that day, a
10 variety of medications can have a side effect that can infect
11 your liver because your liver detoxifies almost everything
12 that you take into your body. So it's a filter. It's a big
13 filter.

14 And if you have too much of something that is toxic
15 to your body, then the liver can react adversely and it
16 produces chemicals in your blood stream which show that you
17 have liver inflammation or liver disease. And all of these
18 things cause the same symptoms and some of the laboratory test
19 results will be the same. But for infections with these
20 viruses, even though they're all called hepatitis viruses,
21 that's because they all inflame the target organ. Where they
22 go when they first enter the body is to the liver, and that's
23 where they replicate and grow and multiply and then get
24 released into your blood stream. That's it's only
25 commonality.

1 So hepatitis A as you're probably familiar with is
2 very common among young children. It's due to poor hygiene.
3 The route is actually fecal oral, eating contaminated foods,
4 that type of thing, changing diapered children without washing
5 your hands.

6 Q So hepatitis A is not a blood-borne type of --

7 A It can be under very unusual circumstances,
8 but it has a very short period in which the virus is in the
9 blood, so it's unusual. The circumstances under which it's
10 transmitted by blood are unusual and are not part -- are not
11 common -- commonly -- common in the hospital, in the
12 healthcare setting.

13 Q So hepatitis E, if I under -- or, excuse me,
14 A, as I understand it that would be -- the transmission route
15 would be fecal oral from contaminated food and the like, is
16 that fair?

17 A Right. You know, and particularly among
18 contacts in the household where, you know, someone is
19 preparing the meals and, you know, food can get contaminated.

20 Q So what is the next one?

21 A Hepatitis B and hepatitis C are both
22 blood-borne viruses. They're completely different viruses.
23 In fact, all these viruses are completely different. They're
24 only commonality being the term hepatitis. And they're both
25 transmitted by the blood-borne route, which means that virus

1 from the blood of one person goes -- if it gains entrance into
2 the blood stream of another person, it can cause infection.
3 This occurs through breaks in your normal barrier, mucus
4 membrane or skin barriers.

5 So this can happen by, before screening, blood
6 transfusions, injections, contaminated injections both from
7 illegal as well legal drug use, sex are the primary modes of
8 transmission. Now, for hepatitis B, actually, sex is one of
9 the biggest risk factors even though it's a blood-borne virus.
10 And for hepatitis C, direct blood to blood is the most common
11 method, although it is transmitted sexually, as well.

12 Q Is that a lesser component, though, of
13 transmission?

14 A Yes. For C, yes, it is.

15 Q Now, you mentioned the other ones. I think
16 you said D and E, also. What is -- what are they?

17 A Hepatitis D and hepatitis E, again, two
18 entirely different viruses. Hepatitis D is actually -- is --
19 is not as common in the United States, and it's also a
20 blood-borne and sexually transmitted virus. But it's got a
21 problem in its genetic code, and it can only be transmitted
22 along with hepatitis B. So -- but it's not that common. So
23 it has the same transmission modes.

24 Hepatitis E has the same transmission mode as A --
25 see, I told you it was not a boring career -- in that it's

1 transmitted by the fecal oral route. But it's rarely seen in
2 the United States and other western type countries. It's more
3 common in countries that have poor -- really poor sanitation
4 and monsoon rains that then swell the rivers and you've got a
5 lot of refugee camps and the rivers -- the drinking water is
6 downstream from the latrines and you see the point. So they
7 become contaminated and you get large outbreaks.

8 Q I'm going to focus primarily on the hepatitis
9 C aspect of things, maybe B if it -- if it's germane to
10 whatever you need to tell us. But you had mentioned that you
11 did over this 25 year period outbreak investigation; is that
12 -- is that correct?

13 A Yes, that is correct.

14 Q Can you tell us what that means and how you
15 typically go through when you get a call, or how -- how does
16 it happen? How does it work?

17 A Being a federal agency, the Centers for
18 Disease Control and Prevention has to be invited by the state
19 health department to come into the state and investigate
20 whatever it is the state thinks is a problem, unless, of
21 course, those rules are suspended in an emergency. But other
22 than that we usually receive a call from the state or county
23 health department telling us they think they have a problem
24 and they'll describe it to us, and we -- and -- and then after
25 usually a few discussions they will invite us in.

1 And so several -- usually several people from the
2 division that's appropriate for that disease will -- who have
3 been trained in epidemic investigations will go to the state
4 and assist the state and local health departments in the
5 investigation. So you want to confirm that, in fact, they
6 have an outbreak. You want to confirm what the outbreak is
7 due to, in other words you want to confirm the case, the case
8 diagnosis and -- before going any further.

9 Q And before I go any further, I neglected to
10 ask you are you still working at the Center for Disease
11 Control?

12 A No, I am not.

13 Q Where is -- are you still working at all at
14 this point? And when I say that as in an academic or any
15 other setting?

16 A I retired from CDC in 2006 and went to the
17 University of Texas medical branch in Galveston as the Robert
18 E. Shope professorship in infectious disease epidemiology.

19 Q And you were there until what year?

20 A The end of 2011.

21 Q And then did you completely retire, at least
22 from that aspect of your career?

23 A From the -- well, I still teach. I'm an
24 adjunct professor. I teach, I consult, help people with study
25 design and making sure that -- you know, helping them with

1 their methods for researching any kind of disease, which is
2 what epidemiology is. And -- and I also do a little private
3 consulting.

4 Q In this particular instance, I mean, were you
5 asked to consult regarding an outbreak that here occurred
6 locally?

7 A Yes.

8 Q And we'll get to that in a moment, but I want
9 to go back to the -- the beginning, the --

10 A Right.

11 Q -- outbreak investigation that we started
12 with, you know, the process that you go through. You said
13 that one of the things that you do is -- I mean, you being the
14 CDC, and I'm having you wear that hat for the moment, if you
15 would. When you get the information and you decide if you're
16 -- what you're going to do to help the state that's asking for
17 your assistance, you mentioned that you had to do some sort of
18 confirmation or confirmatory testing. Can you describe what
19 that is?

20 A Well, in this particular instance?

21 Q Well --

22 A Or in any --

23 Q -- in general.

24 A -- instance?

25 Q For hepatitis C, let's say.

1 A Actually, in any instance you would want to
2 make sure that the test results were consistent with the
3 diagnosis that you were being told these people had. So you
4 either rely on a formal laboratory report from local health
5 departments, or from the local laboratories, whoever did the
6 testing, as well as usually, if you have time, asking them to
7 send samples to the CDC so the CDC can begin its own testing,
8 just in case additional testing is required.

9 Q So what kind of testing would the CDC do over
10 and above whatever was done locally?

11 A Well, that depends on what was done locally.
12 But for hepatitis C, often the screening antibody test is the
13 only test that can -- may be done initially. And that test
14 needs to be confirmed that it's actually real and not a false
15 positive. And then you want to go on to determine whether or
16 not that person continued to -- had recovered or continued to
17 circulate virus in their blood.

18 Q Do you ever do any kind of genetic sequencing
19 and matching to try and see if you can source the patient, so
20 to speak?

21 A We do, yes. We often are called upon to do
22 genetic sequencing to determine the relatedness of viruses
23 from different patients. Under those circumstances -- under
24 most circumstances we only do that -- see, I still talk like I
25 work at CDC -- we only do that if an investigation is also

1 being carried out.

2 Q Assuming an investigation is being carried
3 out, I know we kind of jumped the gun with that a little bit.

4 A No, that's okay.

5 Q But assuming that has occurred and the testing
6 -- you've confirmed whatever you needed to confirm at that
7 level, now we're onto the genetic sequencing. What kind of
8 information are you trying to get out of that kind of work?

9 A That's really -- you really -- you want to
10 jump that -- because you wouldn't -- you want to jump that
11 far? Q Then let -- then let's back up, then. I don't
12 want to jump that far.

13 A Okay.

14 Q So let's go back to the investigation stage
15 and let's pick up where we left off and you continue on.

16 A Okay. So -- so we arrive, you know, and we
17 look at the information about the cases that they already know
18 about. And then we try and identify additional cases from a
19 variety of sources. In this particular disease, many people
20 don't show any symptoms initially. So it's really hard. So
21 you may not get a lot of clinical case reports, but there may
22 be some that were overlooked. And you -- so you'll do a
23 variety of surveillance over on different day to day basis or
24 by surveying physicians most likely to see people with
25 hepatitis and determine if there are additional individuals.

1 Most importantly, however, you then interview or at
2 least review the records of these patients to determine their
3 characteristics. What is it about them that might be common?
4 Are they -- you know, this is the first thing you want to do.
5 You want to find out everything you can just about the cases
6 you know about because that will allow you to generate
7 hypotheses that you can then test with your studies, with the
8 study you're going to end up performing.

9 Q Okay. So you -- you go through that process.

10 A Right.

11 Q What would be the next logical step, then?

12 A Well, then because of the disease being non --
13 subclinical in a lot of cases, meaning people don't have any
14 symptoms, they -- we would -- if we can focus in, in this
15 instance you can usually -- you can focus in on two days, one
16 a date in September and a date in July.

17 And so you then want to test all the patients who
18 had procedures around that area to see if you can identify
19 additional infections. Which the more cases you have, the
20 more you have to analyze, the more robust, in essence, your
21 analysis is, not with respect to the laboratory sequencing,
22 but with the epidemiological analysis. And I'll explain that.

23 So we would go and focus in on what we think might
24 be the exposure period and what was common to the patients, in
25 this case it was those two days, and attempt to identify the

1 infection status of all the patients before, during, after to
2 see if we could identify additional infections.

3 Q Okay. And once you start going through that
4 process?

5 A After we've done that, and you never get
6 everybody, after you do that then you start looking at the --
7 in this case since the only common factor among the original
8 cases was -- were their procedures at this particular clinic,
9 you're going to look at the clinic and what all of those
10 patients had in common during their procedures while they were
11 at the clinic.

12 And you -- and then you start thinking about, well,
13 what exposures would cause blood-borne transmission?
14 Remember, blood has to get into the blood stream of a
15 susceptible individual. So it has to -- there are only
16 certain ways that can happen. So it has to get through your
17 natural barriers of skin or mucous membrane.

18 And so you start generate -- so you then -- you look
19 at all the clinic's procedures and you observe the procedures
20 that might be an issue or different exposures that might --
21 and you go through everything written, procedures, you
22 interview the staff, you interview the patients, and you
23 observe and you read the -- yeah, and you observe. And then
24 that helps you focus your formal study, which will compare
25 infected patients with uninfected patients to see what was

1 different. And that -- that's the essence of epidemiological
2 methods. And can I give an example that might be --

3 Q Sure.

4 A A new drug, someone is developing a new drug
5 to treat diabetes, let's say. So in order for the drug to be
6 licensed by the FDA, they have to test it to make sure that it
7 works and that it's safe. But let's just go to the work part.
8 In order -- they need to show that if they treat people with
9 diabetes with this drug they get better more often than if
10 they're not treated with that drug, okay. But it's never 100
11 percent. I mean, in other words, no drug is 100 percent
12 effective.

13 So let's say they treat people with a certain type
14 of diabetes with this drug and 60 percent get better. But of
15 the people who weren't treated with the drug, only 10 percent
16 got better. Well, that's a pretty big gap. And, you know,
17 it's a very simple explanation, but you can -- you know,
18 that's in the news all the time about -- nothing is ever 100
19 percent is the point.

20 And so you can see that the drug actually did have
21 an effect, even though -- on people who took it versus people
22 who didn't with the same disease. So that's an example of
23 what you are doing here. You are comparing the types of
24 exposures patients who got infected with had versus patients
25 who didn't get infected. What's different?

1 Q So what kinds of things in a -- and you know
2 the setting that we're talking about.

3 A Yes.

4 Q An endoscopy clinic, outpatient setting,
5 patients having basically two types --

6 A Right.

7 Q -- of procedures.

8 A So obviously you're going to look at the date
9 of the procedure, you're going to look at the timing of the
10 procedure compared with everything you know about the
11 infection status of the patients who had the procedures during
12 the time period of interest. You're going to look at specific
13 procedures such as the type of procedure they had, what scope
14 was used, what the -- what medications they received, how they
15 received them, and the process of giving them the medications.
16 You'll look at the staff members who were assigned to those
17 individuals. You'll look at the timing of the cases relative
18 to the potential source patient because presumably you had to
19 have a source patient, someone who was infected in order to
20 serve as a source for transmission to other patients.

21 Q Along those lines, I mean, do you -- when you
22 look at various things related to -- and let's -- let's talk
23 about an endoscopy clinic type thing, what types of things
24 would you look at as possible modes of transmission in that
25 setting?

1 A Well, the first thing people look at are the
2 scopes themselves to see if they've been properly disinfected
3 between patients. And -- as well as what type of procedure
4 the person had. Because if you have an upper GI versus a
5 lower GI, they're two different scopes. So someone who gets a
6 colonoscopy has a scope that's completely different from
7 someone who gets an upper -- an upper GI. So even if the
8 records were not accurate, you would know that the same scope
9 was not used. Plus, it requires time to perform high-level
10 disinfection on each of the scopes that are used.

11 So basically the first thing you would do besides
12 looking at the procedure for disinfect -- cleaning and
13 disinfection of each scope is what procedures the patients had
14 and compare the frequency, let's say, of colonoscopy in the
15 infected patients versus the frequency with which uninfected
16 patients had that procedure, the frequency of biopsy in the
17 infected patients versus the frequency of biopsy in the
18 control patients, and whatever else is involved, let's say, in
19 -- you know, that might be unique to these procedures.

20 And what you're looking for is a -- well, when I say
21 a statistically -- a statistical, significant -- significant
22 statistical difference between the frequency in the infected
23 and the frequency in the uninfected to point you in the right
24 direction, point you in the direction of where the
25 contamination might have originated.

1 In this situation it was not the scopes because the
2 frequency of procedures, the different procedures were not
3 different between infected patients and uninfected patients.

4 MR. SANTACROCE: Objection as to that conclusion.
5 If she's making a personal opinion, that's fine. But if she's
6 making a definitive statement as to the legal conclusion, I
7 object to that.

8 THE COURT: All right. Well, I think it's clear
9 it's her opinion as to --

10 MR. STAUDAHER: Yes.

11 THE COURT: -- based on reviewing the records.

12 Correct?

13 THE WITNESS: That's correct.

14 THE COURT: Okay.

15 BY MR. STAUDAHER:

16 Q And you're not here to make legal conclusions;
17 correct?

18 A No, I'm here for science --

19 Q So you're just going to --

20 A -- and medicine.

21 Q -- tell us what you know based on your
22 analysis and 25 years of doing this --

23 A Yes.

24 Q -- is that fair? Okay.

25 THE COURT: And, ladies and gentlemen, at the

1 conclusion of the trial when I give all of the instructions,
2 there will be an instruction pertaining to this type of
3 testimony, which will cover not only testimony you've heard
4 from this witness, but, you know, other witnesses that we've
5 heard through the course of the trial. And it will describe
6 -- I'm not going to paraphrase the instruction because I get
7 in trouble for doing that, or could get in trouble.

8 So, Mr. Staudaher, go on.

9 MR. STAUDAHER: Thank you.

10 BY MR. STAUDAHER:

11 Q So at least your opinion based on the issue of
12 the scopes was that it was not the scopes in this case?

13 A From an epidemiological point of view, it was
14 not the scopes.

15 Q Now, there were other areas. You mentioned
16 biopsy forceps, things like that.

17 A There was no difference in the frequency with
18 which the patients who were infected got biopsies compared
19 with patients who were not infected. Now, often an overall
20 comparison like that might not show you -- might not show
21 anything. And based on observations and information that you
22 get while you're there, you might say to yourself, well, I
23 don't know, I don't feel like I've looked at this sufficiently
24 and you might then want to, you know, cut it down into
25 different categories like that morning, that afternoon, or the

1 next day, or by a certain person, you know, to see if these
2 procedures, for example, either the scope or the biopsy had
3 any relationship to the infections on a smaller scale or a
4 different scale just to make sure that you've covered your
5 bases.

6 Q Okay. Did you see anything along those lines
7 that cause you concern?

8 A No.

9 Q So at least from that perspective the same
10 analysis for the scopes and the snares, did that, is it fair
11 to say, eliminated those as --

12 A Yes.

13 Q -- transmission possibilities?

14 A Yes.

15 Q What about the issue of cleaning? What if it
16 was not what was believed to be the case?

17 A Well, despite -- even though they did cite
18 some -- some small, minor deficiencies, their high-level --
19 their cleaning and disinfection of the scopes was according --
20 was very strictly followed.

21 Q So --

22 MR. SANTACROCE: I'm sorry. I didn't hear that.
23 Very strictly what?

24 THE WITNESS: Followed.

25 MR. SANTACROCE: Followed.

1 BY MR. STAUDAHER:

2 Q According to the records and so forth that you
3 reviewed; right?

4 A Yes.

5 Q What if that had not been the case? What if
6 the scope cleaning had been less than, well --

7 A Optimal?

8 Q Optimal. That's a good word.

9 A Well, one, you would have made them change,
10 and, two, you would have -- you're looking at it, but still
11 you'd have to consider the epidemiological -- see, to me,
12 that's very -- epidemiology is a very powerful tool all by
13 itself. And if it's done right, when you can make that
14 comparison of patient, the frequency of a procedure in -- in
15 the infected patients versus those who didn't get infected and
16 you see absolutely no difference, then even though
17 disinfection may not have been ideal, you've got to look
18 elsewhere. You have to look elsewhere for other types of
19 exposures. And, in fact, I don't think we've ever had an
20 actual outbreak related to -- of a blood-borne virus related
21 to the scope itself.

22 Q Let me talk to you about the --

23 A At least hepatitis C anyway.

24 Q Since you've done this for -- for quite some
25 time, are you familiar with the literature in the area?

1 A Yes.

2 Q And when I say that, I mean records of and
3 reports of infections across the United States.

4 A Yes.

5 Q For many years?

6 A Yes.

7 Q Have you actually been involved in outbreak
8 investigations pertaining to endoscopy type clinics or centers
9 or transmissions in that setting?

10 A Yes.

11 Q Have you done a number of them in that regard?

12 A Yes.

13 Q Now, as far as the investigation, I mean, I
14 imagine that over the 25 years that you were there that your
15 role at least in the process maybe changed a little bit,
16 supervisor, actually in the trenches, that kind of thing, is
17 that fair?

18 A That's fair.

19 Q Did you actually go out and do investigative
20 work at some stage of your career?

21 A Yes. Early in my career, which is true for
22 everybody at CDC, you get to go out and actually do the
23 investigations. And as you remain at CDC and keep getting
24 promoted, then you're in a supervisory capacity and on the
25 phone usually every day with your what we call epidemic

1 intelligence service officers who are sent out, you know, who
2 are the ones you're supervising who are actually onsite doing
3 the investigations.

4 Q So what is the purpose of that interaction
5 that you have with the people that were actually in the field
6 once you're in that role as a supervisor?

7 A Well, presumably we know more than they do
8 because they're young and we're not, and we have a lot of
9 experience. And so we're making sure that they are getting
10 all the information they should be getting, they're drawing
11 the proper conclusions, they're doing the types of comparisons
12 that they need to do, that they've covered all the bases that
13 they need to cover at each step along the way because you
14 don't want to have to go back.

15 Q So if you are -- if you have somebody even
16 that's relatively new in the field, a year or less, whatever,
17 and you're having communication with that person, I mean, how
18 does that -- how does that work? What do they -- what kinds
19 of things do they tell you and then what do you respond as far
20 as follow up?

21 A If they're listening to me or not?

22 Q Well, I mean, is there a way to determine if
23 they listened to you? Do you follow up --

24 A If they're listening to me --

25 Q --and say did --

1 A -- then they --

2 Q -- you do that?

3 A Well, hopefully they're, you know, on the
4 right track. They'll be telling me -- first they're telling
5 me all about the cases, and they're going to be telling me how
6 they're going about identifying the steps that I described
7 earlier. I want to hear that they've done all those --
8 they've gone through all those steps and what the results have
9 been, okay. And so if anywhere along the way I think that
10 they need to delve further, I will tell them to do that.

11 Q And then do you ask them in follow up what was
12 the result of that?

13 A Absolutely. And then as they start to -- when
14 they generate -- for example, then they're going to have to
15 design a question of some type. So they'll send it to us,
16 email is a wonderful thing, and we will look it over and offer
17 suggestions. And probably they've taken some examples of
18 questionnaires used in previous outbreaks with them, as well
19 as publications of previous outbreaks to help them, you know,
20 along the way, and they'll revise it and, you know, use that.
21 And then we'll decide upon it together upon a method of study,
22 how the study will be conducted to determine the source of the
23 outbreak, the extent of the transmission, and what we need to
24 do to prevent it, either prevent it from continuing or prevent
25 it from occurring someplace else.

1 Q Whether you've been in situation where you're
2 a supervisor or actually in the field doing the actual
3 investigative work, do you -- as part of your epidemiologic
4 investigation, do you ever have a situation where you see
5 something that is -- you know, you've got your, I assume, your
6 likely causes, or the possibilities anyway for a situation
7 like we're talking about here, correct, as far as how it would
8 actually occur?

9 A Right.

10 Q If you see one of those things in practice,
11 you're out there and you see them do something like that, do
12 you stop there, or do you continue to look at other things to
13 make sure?

14 A You continue to look at everything that could
15 possibly be a cause. And this actually has been an issue
16 between supervisors and young investigators. Because the
17 young investigator who hasn't completed their training in
18 epidemiology will say, well, it's so obvious, you know, it was
19 this or that. And we'll say, no, you have to do the study.
20 You have to show definitively that it was this or at least,
21 you know -- you have to show that it was likely this versus
22 something else in order for your investigation to be useful.

23 Q Is that invariable in all cases that you go
24 through that process?

25 A Yes.

1 Q Okay. Have you ever been involved in a case
2 where you did not go through that process, you just
3 shortchanged it and --

4 A Not at the CDC, no. Not when the CDC was
5 involved onsite, no,

6 Q Now, as far as the literature that you
7 described or that you said that you have at least been aware
8 of over the years, I mean, are we talking about one, two,
9 three studies? I mean, how many studies are we talking about?

10 A That I'm aware of, hundreds, but that I've
11 been involved in, many. But, you know, since -- especially in
12 the last decade, 10 to 15 years because they've been
13 increasing in -- there's been an increased reporting of these
14 episodes of transmission in outpatient healthcare settings.
15 So it's many. I don't know how many, but many.

16 Q Does that have to do with anything related to
17 whether testing was available back then versus now?

18 A I think -- I think that for hepatitis C it is
19 -- there's an increased awareness, and also I think a health
20 department that identifies a case that tests positive may be
21 -- and the only -- and someone without traditional risk
22 factors might be more likely to call us and say we have this
23 case that might have had a healthcare exposure, but we don't
24 know. Whereas, now that we have the ability to go in and test
25 people so we can determine the extent of the problem as

1 opposed to relying on just clinical symptoms probably makes it
2 more likely that they will report it or recognize it.

3 Q With regard to those studies, have -- and I'm
4 talking about the -- not necessarily just the ones you've been
5 involved with --

6 A Right.

7 Q -- but the hundreds of studies that you've --
8 you've looked at over the years, have a number of those been
9 in areas involving colonoscopy, endoscopy, that kind of thing,
10 in a -- in a setting where those kind of procedures are done?

11 A Yes, a number have been.

12 Q Have you been directly involved in any of
13 those?

14 A Yes, I have. In fact, directly involved in
15 the first one we ever investigated for hepatitis C.

16 Q Can you tell us about that one?

17 A That one occurred in New York City.

18 Q And the year, roughly, if you know?

19 A 2001.

20 Q Okay.

21 A And it was actually interesting because four
22 people developed acute symptoms of hepatitis, symptoms of
23 hepatitis and were actually hospitalized. And they were
24 middle-aged people without traditional risk factors. And it
25 just so happens that the gastroenterologist on call that

1 weekend was their gastroenterologist and he recognized that
2 all four of them had had procedures at his -- in his practice,
3 at his private practice. And so he called the health
4 department and reported it. And that was the initiation of
5 the investigation.

6 And what we found is that these four patients had
7 procedures over a three-day period. It was actually about 48
8 hours, but a span of three days. And so we -- in order to
9 look for more patients in addition to existing data, like
10 surveillance, etcetera, we chose that week before, during, and
11 after those three days to find as many patients as we could
12 and test them to determine if we had any other infections.

13 And to make a long story short, we did find a source
14 patient. Someone known to be chronically infected who had the
15 first procedure of the day on the first of those three days.
16 And we found -- and then we found that all of the patients who
17 became infected, newly infected, followed that patient, but
18 also over a 48-hour period. So they began on different days.
19 They had their procedure on different days, but consecutively.

20 And after an intensive investigation in which we
21 compared all types of exposures, including the scopes and the
22 injection practices, the anesthesiology, the sedatives, we
23 couldn't identify a difference, something that stuck.
24 Everybody -- the procedures and writing were correct, the
25 observation of personnel actually performing procedures was

1 correct. There were some problems with the high-level
2 disinfection, but nothing that would -- everybody had a
3 different procedure, particularly the source patient had a
4 colonoscopy and the next infected patient -- next patient to
5 become infected did not.

6 So, you know, there were a lot of -- they just --
7 there was not commonality. And because everyone gets sedation
8 from, you know, the same sedation, you really can't -- you
9 can't compare them with respect to that. And so on the last
10 day that the team was there it was suggested to them that they
11 might want to look at the purchasing records for needles and
12 syringes for the anesthesiologists. And they did.

13 And they found that while the IV catheters, number
14 of IV catheters coincided with the number of patients who had
15 procedures, not one to one, but close, however, the number of
16 needles ordered compared with the number of procedures didn't
17 even come close. So there were like 600 needles, new, you
18 know, sterile needles ordered that attach to syringes compared
19 with, I don't know, over 2,000 procedures.

20 And since we know that patients got multiple doses
21 of sedation during their procedure, they should have been
22 using a sterile needle, especially because they had multiple
23 dose vials. In this case it was a different type of sedative
24 than the one involved here which actually comes in multiple
25 dose vials, but the anesthesiologist had denied reusing

1 syringes and needles. Well, this suggested that, in fact,
2 that was not true.

3 And when confronted with the purchasing information,
4 the anesthesiologist admitted to reusing syringes and needles
5 on one patient, discarding the syringe and -- and going back
6 into a multi-dose vial with the same needle and syringe that
7 he used to inject that one patient with subsequent dosages --
8 doses of sedative, and then that multi-dose vial was then used
9 for the next patient, with a new sterile syringe and needle.
10 But that vial was now contaminated, presumably contaminated.
11 And it turns out that they had just switched to large vials of
12 this particular sedative.

13 And we were able to show that if -- if a new vial
14 had been opened on the day for the first patient who was the
15 source of the outbreak, it would have let -- given the average
16 dose that the patients received of this particular drug, would
17 have lasted the 48 hours or over the three-day period that the
18 patients became infected. And -- and the procedure was that
19 these vials would be used if they were -- if they were not
20 used up at the end of the day, they were kept for the next
21 day.

22 So it was actually only that way that we were able
23 to determine that in fact there were unsafe injection
24 procedures being used in the clinic that put patients at risk
25 of -- of transmission. It was the only thing we could

1 identify, and, it turns out, is a common problem. Much more
2 common than we'd like to believe.

3 Q So when you looked at that, I mean, that's
4 2001. I mean, that information gets published, I assume?

5 A Yes.

6 Q Okay. So 2001, fast-forward to you and this
7 case today, did you see similarities, striking similarities
8 between the two cases?

9 A This -- these practices of reusing needles and
10 syringes or even just syringes and contaminating vials that
11 are then used on subsequent patients is -- has been the source
12 of many outbreaks, and continue to be primarily, but not
13 exclusively, in outpatient settings.

14 Q So in the studies you've looked at in
15 outpatient settings, just so I'm clear, this issue of
16 contaminated multi-use vial being used on the next patient
17 kind of thing is something that has been reported multiple
18 times --

19 A Right.

20 Q -- before?

21 A Yes, it has.

22 MR. SANTACROCE: I'm going to object. Asked and
23 answered. Your Honor, can we approach?

24 THE COURT: Sure.

25 (Off-record bench conference.)

1 THE COURT: All right. Mr. Staudaher, please
2 proceed.

3 MR. STAUDAHER: Thank you, Your Honor.

4 BY MR. STAUDAHER:

5 Q And I'm not even sure where we left off, but
6 I'll try to pick up. I was -- at one point I was asking you
7 about the various studies related to these types of clinics.
8 Are you with me again?

9 A Yes.

10 Q This type of thing, the 2001 study that you
11 mentioned, as well as your review of this particular case, are
12 there other like outbreaks that have occurred with similar
13 results?

14 A Yes.

15 Q Okay. And in the studies that you have looked
16 at over the years, I think if I -- I just want to make sure
17 the -- the scope issue that you mentioned, has that ever been
18 shown to be a source of transmission in any of those?

19 A No.

20 Q What about some of the other items that were
21 -- that were looked upon by the CDC as possible modes of
22 transmission?

23 A No. The only -- other than an infected
24 healthcare worker who was abusing narcotics and therefore
25 contaminated a multi-dose vial of a narcotic by self injecting

1 and then contaminating the -- you know, using the contaminated
2 needle and syringe so that it was the healthcare worker's
3 virus that was transmitted from patient to patient. Other
4 than that, all of them have been the result of what we now
5 refer to as unsafe injection practices.

6 Q Can you describe for us what you -- what you
7 view as an unsafe injection practice?

8 A Well, anything that enters the body through
9 your normal barrier, skin or mucus membrane, should be
10 sterile. You would expect to go into an operating room and
11 everything that they use would be sterile if it was entering
12 your body, and injections are no different. And so once a
13 needle and syringe have been used to access your blood,
14 whether it be through IV tubing or direct, you know, through a
15 vaccine injection or something, it's now contaminated. It's
16 no longer sterile.

17 So if you reuse it on the same patient with the same
18 medication, that's fine. But if you reuse it and any part of
19 that is used on another patient, you've broken the barrier of
20 sterility and that next patient is exposed to a non-sterile
21 product.

22 Q In the -- in the literature and training and
23 so forth, and I'm talking about primarily here nurses, nurse
24 anesthetists, things like that, are you familiar with the
25 training that those individuals go through on that issue?

1 A Yes.

2 Q Can you tell us about that?

3 A Nursing, when you go to nursing school, no
4 matter what school you go to, they actually have in textbooks
5 and in practice a curriculum that specifically addresses the
6 safe way to provide injections or injectable therapy, whether
7 it be directly, you know, into your -- you know, like by
8 vaccine or through an intravenous setup of some type, and
9 they're very specific about the fact that these practices must
10 be what we say must conform to aseptic technique. Aseptic
11 meaning the lack of any contamination.

12 Q So is it fair to say that in that information
13 that you've reviewed, the textbooks and the like, is that part
14 of the basic training?

15 A Yes, it's part of basic nursing training.

16 Q With regard to that, even though there are
17 outbreaks that have occurred over time, is that information
18 continuing to be disseminated on each one of these outbreaks?

19 A Yes, the information continues to
20 disseminated.

21 Q So not only in training. I mean, I'm talking
22 about the textbook kind of thing.

23 A I must -- I may have misunderstood your
24 question. When you say after the outbreak -- when we do the
25 outbreak investigation, we then disseminate the information

1 that unsafe practices are being used and this is what you
2 should do. But in a continuing medical education you mean?
3 Like yearly --

4 Q Actually, the first part is what I was asking.
5 After an outbreak --

6 A We publicize in various ways what it is that
7 people are doing and what they -- what they're doing wrong and
8 what they should be doing.

9 Q So I want to ask you about another outbreak,
10 if you're familiar with it. In August of 2002 in Oklahoma
11 there was another outbreak of hepatitis C related specifically
12 to actions of a CRNA. Are you familiar with that?

13 A Yes.

14 Q Can you tell us about that?

15 A Is this the pain clinic or the oncology
16 clinic?

17 Q If there's a document that you need to refresh
18 your memory, I can provide it to you.

19 A Just -- yes, would you mind? I'm just like --
20 right now I just --

21 MR. STAUDAHER: May I approach, Your Honor?

22 THE COURT: Sure.

23 MR. STAUDAHER: And, counsel, I'm showing the MMWR,
24 Morbidity and Mortality Weekly Report, September 26, 2003,
25 Volume 52, Number 38.

1 MR. WRIGHT: Thank you.

2 BY MR. STAUDAHER:

3 Q And this is page, I believe, 903 of that.

4 A Okay. It was the pain -- pain clinic.

5 Q If you -- if you need a moment to look at that
6 you can do so and then I'd like to ask you a couple of
7 questions.

8 A Oh, yes.

9 Q Okay. Can you tell me about this?

10 A In this instance the -- this was a pain
11 remediation clinic where people go to get pain meds for
12 chronic pain, like back pain and a variety of other maladies.
13 And the individual providing -- who was providing the pain
14 medication to these patients through a heparin lock, actually,
15 which is -- you've probably already heard that described --
16 with a -- filled a large syringe with the pain medication, and
17 then went from one patient to another with the same syringe
18 and injected them with the appropriate amount.

19 I think the same needle, too. That I'd have to
20 double check; regardless, from one patient to the next using
21 the same syringe which was filled with the pain medication
22 until it was empty. And they could trace the infections that
23 were transmitted by virtue of who was there that day, what bed
24 they occupied, etcetera.

25 Q So another unsafe injection practices

1 outbreak?

2 A Yes.

3 Q And in that same article, I can bring it up to
4 you again if you need to, was there a dissemination of that
5 information through the actual organization of CRNAs at that
6 time?

7 A Yes.

8 Q I mean, nationwide dissemination?

9 A Yes.

10 Q Now, related specifically to some other
11 articles that you may be familiar with, and the next article I
12 want to ask you about is a entitled -- for counsel -- multiple
13 clusters of hepatitis C virus infections associated with
14 anesthesia for outpatient endoscopy procedures. And I think
15 one of the officers is -- excuse me, authors, is a Bruce
16 Gutelius?

17 A Uh-huh.

18 Q I don't know if I pronounced that correctly.
19 Can you tell us what this is about?

20 A A case of acute hepatitis C was identified
21 and, in fact, possibly more than one by the clinician, again,
22 who noticed that the only commonality between the patients was
23 procedures at this particular -- at actually two different
24 gastroenterology practices. And when they did the
25 investigation, actually, the transmission involved both

1 hepatitis B virus as well hepatitis C virus. So they had
2 clusters in each clinic setting with both viruses.

3 And in this instance it was a similar scenario in
4 which a -- they were reusing syringes, but needless. You
5 know, they now have needless devices so that healthcare
6 workers are protected from sticking themselves, essentially,
7 and so you're only using the syringe.

8 And they put a vent -- they put a little spike in
9 the multi-dose vial, although this might have been
10 single-dose, but multi-dose vial and they stick the syringe in
11 and then they pull out the medication and then they -- the IV
12 may also be needless, in which you can inject just directly
13 with the syringe. And the syringe was being reused on the
14 same patient to get additional doses, and even though it was
15 discarded and a new syringe used for the next patient, the
16 vial was already contaminated from the source patient.

17 Q So -- and I've got the article here if you
18 need to look at it. It appears as those propofol was the
19 drug.

20 MR. WRIGHT: Where was that?

21 THE COURT: That is this article here.

22 MR. WRIGHT: Which -- no, I mean, which city?

23 THE WITNESS: New York City.

24 MR. WRIGHT: Okay. A different New York one?

25 THE WITNESS: Pardon?

1 MR. WRIGHT: A different New York one than the first
2 one?

3 THE WITNESS: Yes, but a different one.

4 MR. WRIGHT: Thank you.

5 THE WITNESS: It occurred much more recently.

6 BY MR. STAUDAHER:

7 Q As a matter of fact, the date of this article
8 is -- it looks like it was published in 2010, but it's talking
9 about a report in 2007, March of 2007; is that correct?

10 A Yes.

11 Q And I don't want to -- if you need to look at
12 it --

13 A No, it's -- usually there's quite a lag
14 between.

15 Q Okay. So it's not unusual --

16 A But although, is that the -- no, you're
17 looking at the actual publication. It was probably in an MMWR
18 prior to that.

19 THE COURT: Why don't you show it to her so we can
20 make sure --

21 THE WITNESS: Sorry.

22 THE COURT: -- that --

23 MR. STAUDAHER: It's okay.

24 THE COURT: -- it's correct.

25 THE WITNESS: No, that is -- those are the dates.

1 BY MR. STAUDAHER:

2 Q Okay. Yes.

3 A Yes, those are the dates of publication and
4 when the outbreak occurred.

5 Q March of 2007 outbreak, publication 2010?

6 A Yes, in a peer reviewed journal.

7 Q Will you confirm that -- that it was propofol?

8 A Yes.

9 Q Yes, it was?

10 A Yes, it -- I'm sorry. I tend to be long
11 winded, so I try and be short. Yes, it was a single patient
12 use vial of propofol for multiple patients with reuse of
13 syringes to re-dose patients.

14 Q So, again, some --

15 MR. SANTACROCE: I'm going to -- I need a
16 clarification. If you're reading, I'd like to know what
17 you're reading -- where you're reading from exactly.

18 THE WITNESS: Actually, right now I'm just reading
19 from the abstract, but I just read this article again for the
20 10th time last night.

21 MR. SANTACROCE: Well, it appeared to me you were
22 reading an answer from that document. If that is, in fact,
23 the case I'd like to know which page.

24 THE WITNESS: Okay.

25 THE COURT: Is it the front page that --

1 THE WITNESS: The front page, first --

2 THE COURT: -- has the abstract?

3 THE WITNESS: -- page of the article, which is page
4 163 of this journal. And I was reading from -- not -- I was
5 reading from the last sentence of the results.

6 MR. SANTACROCE: And, again, the article? The
7 article name?

8 THE COURT: The name of the article.

9 THE WITNESS: Multiple clusters of hepatitis virus
10 infections associated with anesthesia for outpatient endoscopy
11 procedures.

12 MR. SANTACROCE: Thank you.

13 BY MR. STAUDAHNER:

14 Q But in this particular case, the same type of
15 sort of reuse is what we're talking about in --

16 A Yes. The only difference is it was
17 needleless.

18 Q So a vent spike or something was used?

19 A Yes.

20 Q Why is that not protective to have a spike
21 versus a needle going into the bottle?

22 A It's for protection -- these are -- have been
23 put -- these are a variety of measures or technological
24 advances have been developed and employed in healthcare
25 settings to protect healthcare workers from accidental needle

1 sticks. So the less needles they handle, the less likely they
2 themselves will get stuck with a contaminated needle. A lot
3 of this resulted from HIV in the '80s, so -- concerns about
4 transmission of HIV to healthcare workers in the '80s. So
5 there have been a lot of these sort of technological advances
6 in equipment use in order to reduce the amount of needle use
7 by the healthcare worker. But it had to do with protection of
8 the healthcare worker.

9 Q So the -- no difference in risk for vent spike
10 versus needle?

11 A No. No.

12 Q If it's used in that way that was described?

13 A No. Presumably -- no.

14 THE COURT: Mr. Staudaher, I'm going to stop you.
15 Some of the jurors need a break, so we're going to take our
16 morning recess.

17 Ladies and gentlemen, we'll take about ten minutes
18 for our morning recess. During the recess you're reminded
19 that you're not to discuss the case or anything relating to
20 the case with each other or with anyone else. You're not to
21 read, watch, or listen to any reports of or commentaries on
22 this case, any person or subject matter relating to the case.
23 Don't do any independent research, and please do not form or
24 express an opinion on the trial. Notepads in your chairs and
25 follow the bailiff through the rear door.

1 (Jury recessed at 10:29 a.m.)

2 THE COURT: I'll see counsel at the bench.

3 (Off-record bench conference.)

4 THE COURT: Ma'am, before we let you take a break
5 and we take our little break, out of the presence of the jury,
6 Mr. Wright needs to ask you some questions regarding the basis
7 of your opinions. Okay?

8 THE WITNESS: Okay.

9 THE COURT: All right. Mr. Wright, go ahead.

10 VOIR DIRE EXAMINATION

11 BY MR. WRIGHT:

12 Q Ma'am, have you read the Southern Nevada
13 Health District report on this matter?

14 A Yes.

15 Q Okay. And the CDC trip report?

16 A Yes.

17 Q Okay. Any other reports on this one?

18 A There was a peer reviewed article published
19 from the CDC in collaboration with the county health
20 department.

21 Q Okay. Other than that?

22 A No.

23 Q Okay. And you're aware of the notifications,
24 patient notifications that took place in this case?

25 A Yes.

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1 Q Okay. And it basically went back four years
2 and all patients who had been there who may have been exposed
3 to this ongoing practice were sent letters and test -- and
4 tested. And then there were results laid out, not in CDC's
5 reports because this took place --

6 A Uh-huh.

7 Q -- after they had been here, after their trip
8 report, but in Southern Nevada Health District's report. And
9 do you, in reaching your -- the firmness of your convictions,
10 let me put it that way, you've made a determination as to
11 likely cause of transmission in this case; correct?

12 A Yes.

13 Q And that's the combination of unsafe injection
14 practices and multi-patient use of propofol vial; correct?

15 A Yes.

16 Q Okay. Does -- does the later testing -- the
17 -- the later patient notification and the results of that
18 enter into your determinations?

19 A No.

20 Q Okay. Why do they do that if it has no basis
21 whatsoever on --

22 A For the --

23 Q I mean, the correctness of my conclusion.
24 Because I noticed in your New York case, in various cases like
25 in the New York case when an anesthesiologist -- I think it

1 was the second one readily admitted to his behavior. And then
2 letters were sent out, a couple thousand of them, and then
3 other patients were found to -- to have been infected.

4 A Can I also tell you that in the first outbreak
5 in New York -- New York has had actually quite a few -- and
6 they also -- when they realized how long the practice had been
7 going on with the one anesthesiologist, they also sent many,
8 you know, patients over several years letters of notification
9 to get tested.

10 Q Okay.

11 A Okay. Why do they do that?

12 Q Right. And -- and it seems to me, I'm not an
13 epidemiologist, but it seems to me if certain conduct is going
14 on and I believe it caused on two days these events occurred,
15 okay, the transmission of hepatitis C and that the conduct has
16 been ongoing for, say, a year, then I would look to the other
17 363 days of the year expecting to find other cases the same,
18 other clusters, whatever you want to call it. Because if
19 those were the two things on those two days that caused the
20 transmission and the precise same thing was happening every
21 other day of the year, it would seem to me I would find that
22 on the other days of the year. And then that would confirm
23 for me, bingo, I found the right thing and I -- what am I
24 missing epidemiologically in my analysis?

25 A Well, the fact that they had sufficient

1 numbers of cases actually on one of those days to draw an
2 epidemiological conclusion even separate from the laboratory
3 sequencing, on the July date they only had one new case and
4 the one source patient. And the only way to prove that that
5 was the -- that they were related was by viral sequencing. I
6 mean, if you only have two people -- okay. So wait, I'm
7 getting there.

8 Q Okay.

9 A However, the purpose of the notification was
10 knowing that this practice was going on for a long time and
11 that many patients might have been exposed, it was the ethical
12 -- the obligation of the health department to notify these
13 individuals that they may have been infected and they should
14 get tested.

15 Q I -- I got that. I --

16 A Okay. So for their own -- for their own
17 purpose, the resources -- to be quite honest, the resources
18 involved and then taking all of those patients and doing the
19 same kinds of studies that were done on those two days was
20 probably not available.

21 Q Okay. And I'm not --

22 A And that's true for most of the large
23 notifications that are done. If you're not -- you know, in
24 this -- in many instances now, even without evidence of
25 transmission, if a hospital or a healthcare facility notices

1 -- finds that a practice is -- some practice has not been done
2 correctly, they will send notifications, even though there's
3 been no evidence of infection.

4 THE COURT: So in other words, the point of sending
5 the notification had nothing to do with confirming their
6 hypothesis or their theory, but it was to give patients notice
7 so that they could be tested and get treatment or modify their
8 behavior --

9 THE WITNESS: That's correct.

10 THE COURT: -- or whatever they were going to do.
11 Is that --

12 THE WITNESS: That's correct.

13 THE COURT: Is that a summation?

14 THE WITNESS: Very good.

15 THE COURT: Okay. Thank you.

16 THE WITNESS: Yes.

17 THE COURT: Is that fair?

18 THE WITNESS: That's exactly correct.

19 BY MR. WRIGHT:

20 Q Okay. The problem with that is there's
21 testimony to the contrary in depositions. Not -- not yours or
22 anything, but of -- of the Health District and what they
23 expected to find. I mean, I'm not faulting anyone --

24 A No, no, no, no, no.

25 Q -- for notification whether you found it or

1 not. My -- what I still don't have an answer to is if I'm the
2 epidemiologist and I say here's two days out of a year in
3 which hepatitis C was spread by this method of transmission
4 and then I look and say -- and that identical conduct occurred
5 on the other 363 -- 62 days, whatever, of the year, I would
6 expect to see other -- the same conduct. In other words, I'd
7 expect to see --

8 A I understand, the same set of circumstances.
9 You would expect --

10 Q Right.

11 A But that -- in order to -- it may have been
12 the initial intent to do that, but given the frequency of
13 positives, hepatitis C positives in the general adult
14 population, particularly in that age range getting, you know,
15 GI studies, you're going to find a lot of positives. And I
16 think it might -- and I -- now I'm speculating that while the
17 original intent might have been to identify other clusters,
18 the number that they came up with made it impossible for them
19 to actually do that kind of investigation because, remember,
20 you have to find the source patient, a source patient, you
21 have to determine what the differences in -- they would have
22 had to go through everything that they did for those two days
23 just for -- for all those other positives.

24 And actually in New York, the first outbreak I
25 investigated, that we investigated in 2001, they did the same

1 thing, and they went back four years. And they found a lot of
2 positives for both B and C, but they could -- you know, I
3 think they identified a cluster, maybe, but they couldn't do
4 the same kind of analysis. But that's not the purpose of the
5 investigation. The purpose of the investigation is to
6 identify what happened, how it happened, and if it's -- it
7 shouldn't happen, prevent it from happening in the future.

8 Q I -- I --

9 A Yeah, so --

10 Q I follow all that.

11 A Right.

12 Q I just still -- I told you --

13 A The purpose of -- the real --

14 Q -- I'm not an epidemiologist --

15 A Right. But that --

16 Q -- but it seems to me if -- if it happened
17 this way and this is my conduct and then I did the identical
18 thing --

19 A Yeah.

20 Q -- 100 times --

21 A Uh-huh.

22 Q -- and it's convinced because I did it this
23 way it caused it to happen --

24 A Uh-huh.

25 Q -- then on the other 99 days I would expect to

1 see it again if that was truly the cause.

2 A You wouldn't necessarily see it every day.

3 You have to have someone --

4 THE COURT: You have to have --

5 THE WITNESS: -- who is infected --

6 THE COURT: -- hepatitis to start --

7 THE WITNESS: -- as a source.

8 BY MR. WRIGHT:

9 Q Well, right. I'm saying --

10 A Okay. So -- yes, but how would you show that
11 and how -- what amount of resources should the health
12 department when they have many other things that they have to
13 consider, dedicate to this? This is not for, no offense,
14 legal reasons. This is for public health. So to protect the
15 public they have done their due diligence by identifying the
16 potential source, who was at risk, and notifying them --

17 Q I understand.

18 A -- to get tested. And that was the -- that's
19 really the overall purpose.

20 Q This is a criminal case.

21 THE COURT: I think we're getting --

22 BY MR. WRIGHT:

23 Q And I understand --

24 A I know that, but I'm not --

25 Q Let me ask --

1 MR. WRIGHT: Pardon?
2 MR. STAUDAHER: Your Honor, I think --
3 THE COURT: Mr. Staudaher is objecting. I think
4 we're getting beyond --
5 MR. WRIGHT: No, I --
6 THE COURT: -- the focus.
7 MR. WRIGHT: Just one wrap up question.
8 THE COURT: Okay. One more question.
9 MR. STAUDAHER: He can do this on cross-examination.
10 THE COURT: Well, no, there was --
11 MR. WRIGHT: I can't do it on cross.
12 THE COURT: Wait a minute.
13 THE MARSHAL: Counsel, enough.
14 THE COURT: There was a purpose --
15 MR. WRIGHT: I --
16 THE COURT: Excuse me. There was a purpose for
17 allowing this questioning to go on and it was a limited
18 purpose and I think we're getting beyond the purpose. And so,
19 Mr. Wright, you say you have one more question.
20 MR. WRIGHT: Yes.
21 THE COURT: You can ask your final question. Again,
22 because the questioning was dedicated to a particular issue --
23 MR. WRIGHT: I understand.
24 THE COURT: -- and I think we're getting beyond
25 that. And so ask your final question and then we're going to

1 take a little break.

2 BY MR. WRIGHT:

3 Q As I understand it, if it was conclusively
4 shown that over the four years all 63,000 persons were tested,
5 okay, every one of them was tested and there wasn't any hep C,
6 it turns out it was below the threshold level that would have
7 been expected, okay, if I could show that no one in four years
8 got hep C at that clinic it would make no difference to you in
9 reaching your determination that for those two days the method
10 of transmission was what you found; correct?

11 A That's correct.

12 Q Okay.

13 A But unlikely.

14 THE COURT: Okay. Well --

15 THE WITNESS: Unlikely that that would be the case.

16 THE COURT: All right. If you need to take a break,
17 ma'am, just exit --

18 THE WITNESS: I'm okay.

19 THE COURT: -- through those --

20 THE WITNESS: Do you want me to just --

21 THE COURT: You can sit there if you want to.

22 THE WITNESS: Fine. I'm fine.

23 THE COURT: We're going to take a break.

24 (Court recessed at 10:42 a.m., until 10:46 a.m.)

25 (Outside the presence of the jury.)

1 THE COURT: Yes?

2 MR. WRIGHT: I just want -- I just wanted to tell
3 the witness that that exchange was outside of the jury's
4 presence. So when I examine you in the courtroom --

5 THE COURT: And ask the same things again --

6 MR. WRIGHT: -- we don't act like they've heard it.

7 THE COURT: -- don't --

8 THE WITNESS: Don't sound as if why are you asking
9 me the same --

10 THE COURT: Yeah.

11 MR. WRIGHT: Right. We don't discuss it.

12 THE COURT: Sure. Yeah, so obviously don't say --
13 don't say as I just told you five minutes ago --

14 THE WITNESS: Yeah. Okay.

15 THE COURT: -- blah blah blah.

16 THE WITNESS: No, I appreciate -- I appreciate that.
17 Really, I have to be reminded. I don't do this as a routine.

18 (Off-record colloquy.)

19 MS. STANISH: Judge, I'm on the phone with Nia
20 Killebrew --

21 THE COURT: Okay.

22 MS. STANISH: -- and she's out and about. And I
23 thought if we could just put her on speaker phone if you could
24 make the order to her to reveal Mr. Meana's --

25 THE COURT: Okay.

1 MS. STANISH: You ready, Nia, or are you in the
2 check out?

3 THE COURT: What, is she like at Vons or something?

4 MS. STANISH: Yeah, that's fine. Can we just --
5 just to put on the record --

6 THE COURT: She can call in. I mean --

7 MS. STANISH: Let's see if this works. Nia, can you
8 hear me?

9 MS. KILLEBREW: I can.

10 THE COURT: Can you hear me? This is Judge Adair.

11 MS. KILLEBREW: I can, Judge. How are you?

12 THE COURT: Good, thanks. Basically, I need to
13 direct you to disclose to all of us the amount that the Meana
14 family received in settlement of the various claims and
15 lawsuits they may have filed. So if you could do that.
16 Hello?

17 MS. KILLEBREW: I can do that. I don't have the
18 amount that I can tell you right now. I can email it or have
19 someone bring it in an envelope to the Court today.

20 THE COURT: Okay.

21 MS. KILLEBREW: The only thing that I need, you
22 know, is some minute order or some kind of documentation on
23 the record that you're ordering me to do so --

24 THE COURT: Right.

25 MS. KILLEBREW: -- so my client's --

1 THE COURT: -- Ms. Husted is making that --

2 MS. KILLEBREW: [Inaudible].

3 THE COURT: Ms. Husted is making that part of the
4 minutes right now. And you don't need to, you know --

5 MS. KILLEBREW: Okay.

6 THE COURT: -- rush it over today, as long as we get
7 it, you know, by an email or something like that. We don't
8 have to put that on the record today. So, you know, don't
9 worry about sending over a runner or rushing back to your
10 office or anything like that. You know, just sometime today
11 or tomorrow morning if you get that over to the lawyers, that
12 would be great.

13 MS. KILLEBREW: Okay. I'm out of town, but would it
14 be easier for me to just -- I mean, my office is right across
15 the street -- to have a runner bring it over in an envelope to
16 your -- to your chambers?

17 THE COURT: Sure. That --

18 MS. KILLEBREW: Or would you rather have me disclose
19 it to counsel?

20 THE COURT: Sure. That's fine.

21 MS. KILLEBREW: Okay.

22 THE COURT: All right.

23 MS. KILLEBREW: I'll just do that.

24 THE COURT: Okay.

25 MS. KILLEBREW: Not a problem.

1 THE COURT: Okay. Great. Thank you.
2 MS. KILLEBREW: Thank you so much.
3 THE COURT: Okay.
4 MS. KILLEBREW: Bye, everyone.
5 THE COURT: Bye.
6 MS. STANISH: Bye.
7 THE COURT: Okay. We can bring the jury back.

8 (In the presence of the jury.)

9 THE COURT: All right. Court is now back in
10 session.

11 And, Mr. Staudaher, you may resume your direct
12 examination.

13 MR. STAUDAHER: Thank you, Your Honor.

14 DIRECT EXAMINATION (Continued)

15 BY MR. STAUDAHER:

16 Q With regard to your review of the records in
17 this particular case, we're talking about the Health District
18 report. What else did you review?

19 A The trip report from the CDC, which is their
20 initial follow up report right after they return from the
21 investigation, and then their publication in a peer reviewed
22 journal of their -- of the final analysis of the CDC's
23 investigation portion.

24 Q So the -- in the chronology of things that you
25 looked at, did you look at them in a particular order, did one

1 build on itself, that kind of thing, or did it matter? Was
2 the trip report first and then the article, or vice versa?

3 A Oh, definitely. The trip report definitely
4 because that comes out right after they return from their
5 investigation, like within a short period of time.

6 Q Is it typical to have an outbreak
7 investigation published in a peer review journal after such an
8 outbreak?

9 A Yes.

10 Q So the trip report is -- how would
11 characterize that report?

12 A Well, it's publicly available, but it is -- it
13 is part of CDC's procedure that you summarize, even though
14 they might be preliminary, the results of your investigation
15 immediately upon return so that that's communicated back to
16 the inviting state and they have everything that you have at
17 that moment.

18 Q Is it fair to say that are there sometimes
19 errors in those initial reports?

20 A Yes, probably. Yes.

21 Q When it gets to the stage where you actually
22 publish the paper, though, in the peer review journal, does
23 that go through some sort of vetting process with other
24 investigators? I mean, how is the journal sent out before
25 it's actually published?

1 A The draft or the manuscript, which is what we
2 call the prepublication report is sent out to the co-authors
3 on the -- on -- on the paper to read and make any suggested
4 revisions. It doesn't necessarily mean that all errors, if
5 there were errors, would be caught at that time, but hopefully
6 everything that's in the -- in the manuscript is accurate as
7 far as the co-authors know. In addition, when it gets
8 submitted to a journal for peer review, which is a separate
9 process, it is reviewed by individuals who were totally not
10 related in any way to the -- whatever the study was that's
11 being reviewed. So the journal sends it to its own peer
12 reviewers to decide whether it's of importance and worthy of
13 publication in the journal.

14 Q And once it finally gets published, it's been
15 through that whole process; is that correct?

16 A Yes, including, I should say, clearance at the
17 CDC level.

18 Q So in this particular case you looked at those
19 particular parts of the -- that sort of detailed the
20 investigation; is that correct?

21 A Yes.

22 Q Now, we've talked about some of your kind of
23 conclusions about scopes and the -- or the biopsy forceps,
24 things like that up to this point.

25 A Yes.

1 Q In general, looking at the results in this
2 particular case, did you come to a conclusion as to how you
3 believe the transmission occurred through the records that you
4 reviewed?

5 A Yes.

6 Q And what was that?

7 A My conclusion is that the unsafe injection
8 practices used routinely in this clinic resulted in
9 contamination of medication vials, in this case propofol, with
10 hepatitis C virus that was then transmitted to other patients.

11 Q Okay. Anything in the reports related to that
12 that called into question that analysis or that conclusion?
13 Any results that you saw? Anything in there?

14 A I don't know. I'm thinking.

15 Q -- in there?

16 A I just want to make -- no.

17 Q Have you ever heard of the term serial
18 contamination?

19 A Yes.

20 Q Do you know -- can you tell us what that is,
21 first of all?

22 A Basically you have a source and it's
23 transmitted down the line. I mean, you know, it's transmitted
24 to each subsequent individual who is exposed.

25 Q Have you seen this actually in your own

1 investigations?

2 A Yes, I have.

3 Q Have you -- I mean, is this something that has
4 been around for awhile?

5 A The idea of it, yes, and having seen it in the
6 context of hepatitis B virus because it's so infectious and so
7 much more easily transmitted that we've seen it in a variety
8 -- and we've been able to test for it for a much longer period
9 of time and we've seen that in a variety of settings and done
10 experimental studies to show that it can happen, but it
11 doesn't have to.

12 Q Okay. What do you mean it doesn't have to?

13 A When you refer -- I'm assuming when you mean
14 serial transmission that every single individual after the
15 source gets infected?

16 Q No, not necessarily.

17 A Oh, okay.

18 Q And let's talk about that. Serial
19 contamination meaning just people downstream of the source
20 patient --

21 A Right.

22 Q -- are contaminated serially.

23 A Yes.

24 Q And do you know how that could happen in a
25 situation like that?

1 A Well, if you have a common source of virus
2 like a multi-dose vial or several contaminated vials of
3 medication, then people who are exposed to that vial of
4 medication downstream, so to speak, from its point of
5 contamination will be exposed and potentially infected.

6 Q Is there a dilution effect that involves that
7 sort of serial contamination that might have a play here?

8 A Yes, there is because, you know, there's a
9 certain amount of virus that is in the contaminant, and as the
10 vial gets used up, presumably the level of contamination will
11 go down or you really don't have any idea which dose is going
12 to contain virus and which isn't.

13 Q Now, in this particular case there were two
14 specific days; correct? We're talking about a July date, July
15 25th and a September 21st date. Your -- go ahead. Did you
16 want to say something?

17 A May I correct what I just said? It just
18 occurred to me the question you're asking. I didn't answer
19 the question you were asking about how the serial
20 contamination might occur, whether or not you would get --
21 whether it would be different the further downstream. If you
22 were -- if the source was in the same -- if you only had one
23 source of virus, then presumably as the -- as the vial gets
24 used up you'll have less contamination and lower infection
25 rates the further out you go.

1 However, if it's from different vials, if multiple
2 -- if you have multiple sources of potential contamination,
3 then that might be difficult to see. In an experimental
4 setting, however, that's exactly what happens is you --
5 because you have -- as you go along, downstream you have less
6 and less, your infection rates start to drop.

7 Q So at some point you wouldn't expect there to
8 be infection rate with a common initially contaminated source,
9 or -- or can you --

10 A Presumably, but not always.

11 Q Now, on the two days in question that we're
12 talking about here, and you've reviewed the information
13 pertaining to those; is that correct?

14 A Yes.

15 Q You said that you believe -- if I -- I'm not
16 trying to reiterate, but is it the same conclusion for both
17 days?

18 A Yes.

19 Q And what do you base your conclusions off of?

20 A The only -- first of all, the only significant
21 result that the CDC could find was that all of the patients
22 who became infected received procedures on the same day as a
23 chronic -- you know, as the source patient. And all of their
24 procedures occurred after the source patient. In the
25 September -- on the September day they have a few infections

1 that can actually look at it in an analysis using numbers and
2 statistical techniques. On the July day, there is only one
3 infection downstream from the source patient. So the only way
4 to link those is by genetic sequencing.

5 However, the fact that the only -- the only
6 technique or procedure that could be implicated, that they
7 could identify as being inappropriate and not according to
8 good aseptic technique was how the multi-dose vial -- how the
9 anesthesia was delivered, essentially, and to multiple
10 patients. And so since that had been occurring all along,
11 there was no reason to believe that wasn't the source in July
12 as it was in September.

13 Q Now, the source in July, let's talk about that
14 day just for a second. You said there was just one infected
15 patient from the source patient on that day. You said the
16 only way that there could be a link is through genetic
17 sequencing --

18 A Right.

19 Q -- correct?

20 A Yes.

21 Q Was that -- was that done in this case?

22 A Yes, it was, and they were -- they were
23 genetically related.

24 Q And are you -- I mean, you've -- I assume
25 since you've been at CDC you've seen that kind of analysis

1 done in the past, is that right, where they do linking?

2 A Yes.

3 Q Is there any issue with regard to the methods
4 or procedure that you saw employed in this particular study
5 for that work, for the sequencing work that called into
6 question the results?

7 A No, it only gets better as time goes by.

8 Q Okay. Now, on the 25th date, the July 25th
9 date, were you aware based on the records that the CRNA
10 involved on that day was the one who administered the heplock
11 and administered the medication?

12 A Yes.

13 Q Is there -- although the infected patient on
14 that day did not fall under the same category, it was a nurse
15 that put in the heplock initially --

16 A Yes.

17 Q -- at least according to the records, is there
18 any issue there with regard to, you know, potential error in
19 what the transmission was or the source of the transmission
20 based on that information?

21 A I don't -- I don't think so. The reason being
22 that the procedures that the nurses use to put in the heparin
23 locks were correct, and they were observed to be correct, they
24 routinely were correct, and so there is no reason to believe
25 that the placement of the heplocks were related. They

1 certainly didn't find that in September, and when they
2 investigators were onsite observing the staff, one of the
3 CRNAs continued to administer anesthesia in the same way, in
4 an unsafe way by using -- you know, reusing a syringe on a
5 single patient and then using that vial on multiple patients.

6 Q Were you aware that a communication was made
7 to a second CRNA about that same practice?

8 A Yes.

9 Q And you were aware of the results of that, the
10 admission of the reuse there?

11 A Yes.

12 Q Those two things combined, those are
13 different, if I understand you, that in that New York 2001
14 study where you didn't have any observed mechanism by which
15 you could see or determine transmission?

16 A Until -- that's correct, until we looked at
17 the purchase records.

18 Q So that's what led you to your conclusions?

19 A To confront the person who had been denying
20 the unsafe practices, yes.

21 MR. STAUDAHER: I pass the witness, Your Honor.

22 THE COURT: All right. Cross.

23 CROSS-EXAMINATION

24 BY MR. WRIGHT:

25 Q Good morning. My name is Richard Wright. I

KARR REPORTING, INC.

1 represent Dr. Desai. You did not participate -- let's see,
2 you left CDC in 2006.

3 A Yes.

4 Q And so you had no participation in this
5 investigation in Las Vegas in January?

6 A Other than talking to Brian Labus over the
7 phone

8 Q Okay.

9 A Over the telephone.

10 Q Okay. And the -- when did you talk to him?

11 A It was in the middle of the investigation,
12 just before they -- just before they went public to -- did the
13 public notification.

14 Q Okay. So that would be -- I mean, we know
15 from dealing with all the dates here in the courtroom it went
16 public February 27. It went public and notifications went out
17 to patients February 27, 2008. So prior to then; correct?

18 A Yeah, like the day before.

19 Q Okay. And you -- you had received -- were you
20 contacted by lawyers from the clinic to consult with them? I
21 read that.

22 A Let me think a minute, only because I do get
23 contacted a bit. Yes, I think so. Yes.

24 Q I -- I read somewhere of efforts to reach out
25 to you by civil litigator -- civil lawyers for the clinic at

1 the time seeking to use your expertise --

2 A You're absolutely --

3 Q -- and consult.

4 A Thank you. You actually brought it back.

5 Yes, that's correct. And, in fact, because I knew nothing
6 about the outbreak at the time, it was early on, they did --
7 they were referred by a colleague and I turned them down when
8 I -- when they described the situation. And then I
9 immediately called my contacts at CDC to see what was going on
10 because it sounded, you know -- sorry, from an
11 epidemiologist's point of view, it was quite exciting.

12 Q I -- I read --

13 A I'm sorry.

14 Q I read the articles you forwarded. Okay? All
15 of these articles and the Morbidity -- what's that thing
16 called?

17 A Morbidity and Mortality Weekly Report. It's
18 CDC's public health notification of important events.

19 Q It sounds like a Halloween magazine. But it
20 is really dry reading.

21 A To you.

22 Q Correct.

23 A The rest of us can't wait to get our hands on
24 it, and it's embargoed, too.

25 Q The -- I mean, this is esoteric stuff we're

1 dealing with. The -- I read your article about, and I had
2 nightmares, about the testing the chimpanzee dried monkey
3 blood to see how long the virus lives in dry chimpanzee monkey
4 blood. And the results were how long does the hepatitis C
5 virus live outside, like when it's -- some blood is left on an
6 instrument. What's the results?

7 A The results were that the -- the only way you
8 can demonstrate infectively is with an animal model because
9 you really can't do it in -- in the laboratory, so -- and only
10 non-human primates. So the results were that we had three
11 time points to look at, 16 hours, four days, and seven days.
12 And only the 16-hour sample was infectious. So we know that
13 it persists for at least 16 hours outside the human body. It
14 could be dried on a surface, not visible to the human eye, and
15 still cause infection.

16 Q Okay. And the three-day old -- three-day old
17 blood, using my --

18 A Four-day.

19 Q -- layman's terminology --

20 A It's okay.

21 Q Four-day?

22 A Four days.

23 Q Four days the -- it was no longer infectious,
24 the virus had died.

25 A Right.

1 Q And the same with the seven-day?

2 A That's correct.

3 Q And -- and that's -- learning from your
4 article, that's different than the hepatitis B, where that --
5 it -- the hepatitis B virus survives when exposed to the
6 environment for --

7 A It was only looked at for seven days, okay,
8 because of the limitations of doing these kinds of studies.
9 So its infectivity was demonstrated seven days, but it's a
10 very hardy virus. It's easy to kill, you know, if you use
11 disinfectants on it, bleach does a great job, but it survives
12 a long time. And when people ask -- actually ask our opinion,
13 if they call and say, you know, I've had this thing with blood
14 on it for two years, should I consider it infectious with B?
15 We would probably say, yes, you should just consider it
16 infectious. They've actually found evidence of the virus, not
17 necessarily its infectivity, seven years after it was dried.
18 But unknowing -- you know, we don't know if it's infectious.

19 Q Okay.

20 A Hepatitis C clearly does not survive that long
21 because you have to combine your experimental work with
22 reality and what you see in terms of transmission patterns.
23 And it was clear from transmission patterns that hepatitis C
24 was not like HIV, which does, once it leaves human body, it --
25 it's no longer infectious. But because of its transmission

1 patterns, we suspected it had to live for some period of time
2 outside the body, and that's why we did the experimental
3 study.

4 Q Okay. As -- as a hepatitis expert, I contract
5 hepatitis C today, and the odds are like seven out of ten
6 times I will have no symptoms, asymptomatic. Is that what
7 it's called? Is that right?

8 A Yes.

9 Q Okay.

10 A Right.

11 Q Like three out of ten times I will get the
12 classic symptoms that we've heard about testified here,
13 jaundice --

14 A It'll send you to the doctor.

15 Q Right. Okay. And so I may not -- I may not
16 know I even have it --

17 A Yes.

18 Q -- seven out of ten times.

19 A That is correct.

20 Q And the -- how -- how quickly -- and I guess
21 once I'm past six months and I'm most -- once I'm past six
22 months, I just acquire it today, six months from now, assuming
23 I knew I acquired it, six months from now it's quite clear I'm
24 not going to get the classic symptoms; is that right?

25 A That's correct. I mean, the classic symptoms

1 -- the incubation period is short. It can be as short as 14
2 days, supposedly as long as six months. But likely within two
3 to three months of exposure, if you haven't become symptomatic
4 you're not going to be for the first phase of infection, the
5 new phase of infection.

6 Q Okay. So once -- and then the -- we've heard
7 testimony here in the courtroom, I'm past six months so it's
8 what we've called -- we're calling chronic hepatitis C. And
9 chances are I will end up dying of old age and not hepatitis
10 C.

11 A From an odds point of view, absolutely.

12 Q From a what?

13 A From an odds -- look where we are. From an
14 odds point of view, yes.

15 Q Okay.

16 A Likely you will.

17 Q Okay.

18 A It depends on a variety of factors.

19 Q Okay.

20 A Whether you drink, you know, do other things
21 that might harm your liver that all of that potentiates.

22 Q Okay.

23 A You know, it puts different risks on it, but,
24 yes, that's correct.

25 Q Okay. And if I contract it today, the -- like

1 what do -- what do the studies show or what's your analysis of
2 how quickly I may develop cirrhosis of the liver from
3 hepatitis C?

4 A Presuming you're over 40?

5 Q That I am.

6 A Age --

7 Q And drink.

8 A Age -- well, if you had hepatitis C your
9 doctor would tell you not to drink at all, but -- except maybe
10 champagne at your daughter's wedding. But depending on your
11 age and a variety of other factors, you're male so it
12 increases your risk, as well, and that you can't do anything
13 about. So all other factors being equal, you could develop
14 cirrhosis in 5 years, 2 years, 20 years, or 40 years.

15 Q You just don't know.

16 A No. I mean, there's an average.

17 Q What's the average?

18 A 20, 30. 20 we'll say. And that most of those
19 -- that -- that's -- also includes a range of -- you know,
20 averages always have ranges. So that's the average, but it
21 can be much shorter, and I've observed that directly.

22 Q Okay.

23 A In my follow up studies that I conducted at
24 CDC. So -- but it has usually -- often, in moist people it
25 has a long what we call latent period where nothing happens

1 and you don't know you have it until you have that yearly
2 physical. The doctor finds you have liver -- elevated
3 abnormal liver enzymes, meaning your liver is inflamed. They
4 test you for hepatitis C, and you just found out you have it.

5 Q Okay. And if I have it and I didn't know I
6 had it, I had a blood test and the doctor says you've got
7 hepatitis C, and I don't have any symptoms at all from it,
8 didn't even know I had it, I could still undergo the
9 treatments we've heard about here in the courtroom, which is a
10 48-week interferon and ribafarbon (sic) or something.

11 A Ribavirin, yeah.

12 Q Okay. I -- I could do that even if I had
13 chronic and no symptoms?

14 A Actually, that makes you a better candidate
15 for --

16 Q Okay.

17 A -- resolving your infection. However, there
18 are guidelines for treating people and the guidelines have to
19 do with the severity of your liver disease, which may not be
20 manifest or clear based on your lack of symptoms. So they do
21 laboratory testing, possibly imaging studies, possibly a liver
22 biopsy to determine the stage of your liver disease. And
23 people with mild disease may not have been treated in the
24 past. They may be more likely to be treated now because some
25 of the drugs -- because the treatment is more effective and

1 can be shorter. But in general you have to sort of show that
2 you're progressing in your liver disease to be treated. On
3 the other hand, some physicians treat everybody.

4 Q Okay. Have you heard of Dr. Richard Perrillo,
5 a neuropsychologist?

6 A I know a Robert Perrillo who is a
7 hepatologist.

8 Q Nope, this is Richard Perrillo.

9 A And he's a what, neuroscientist?

10 Q Neuropsychologist.

11 A Neuropsychologist, no.

12 Q Okay. He testified here in the courtroom
13 about hepatitis being neuroviral and attacking the brain and
14 causing -- hepatitis C causing dementia which he distinguished
15 from brain fog.

16 A You mean like the rest of us have.

17 MR. SANTACROCE: I'm sorry. I didn't hear you.

18 THE WITNESS: It wasn't a scientific comment. Can I
19 take it back?

20 MR. SANTACROCE: No.

21 THE COURT: No.

22 THE WITNESS: Like the rest of us have.

23 THE COURT: Oh, okay.

24 BY MR. WRIGHT:

25 Q He testified that he reached this conclusion

1 of hepatitis C causing dementia, as well as the treatment
2 causing dementia. And he based it upon he had seen 19
3 patients with hepatitis C and they had dementia. Do you --
4 are you familiar with any -- any of his work or studies or
5 does any of that ring a bell with you?

6 A No.

7 Q Okay. The --

8 A But I can comment.

9 Q Give me your comment.

10 A Okay. This is a common misconception,
11 particularly by physician researchers. I don't know if he's a
12 physician, but they look at cases only and they don't end up
13 doing a study. They look at case reports or just people with
14 the disease and they see that they all have this in common,
15 whatever it might be, in this case hepatitis C and dementia,
16 and they come to a conclusion about the cause or some
17 association. But you can't. Case -- case reports can be very
18 useful because they can -- you know, they can show that
19 further study might be necessary in that area, but they can't
20 -- you can't draw any conclusions from cases, just looking at
21 cases.

22 Q And that's the difference between association
23 and cause and effect.

24 A No.

25 Q No?

1 A Association --

2 Q Well, let me -- let me ask it this way. I
3 mean, the way it was explained to me the -- why an association
4 doesn't prove cause and effect, let me put it that way. I was
5 told in the late 1940s before there was a polio vaccine, that
6 there was an anti-polio diet put out by the government that
7 you should not eat ice cream or soft drinks because everyone
8 that had polio had been eating a lot of ice cream when they
9 caught polio. They were eating a lot of ice cream and soft
10 drinks. And so ultimately it turned out that polio was
11 transmitted in the summer when it was hot, and so the -- they
12 had misinterpreted. There is merely an association. Everyone
13 caught polio when -- when it was hot and that's when you eat
14 ice cream and drink soft drinks.

15 A Actually, I'm sorry if I interrupt. That is
16 not an association. That's actually -- it's called an
17 ecological fallacy in scientific terms and from an
18 epidemiological point of view. I'm sorry. That's exactly
19 what it is. It's like there are more telephone poles in -- or
20 people -- there's a higher risk of getting -- or a higher rate
21 of cardiovascular disease in places that have more telephone
22 poles. Why is that? That is not an association. It's an
23 ecological fallacy.

24 People who have -- who don't live in -- well, when
25 this was used as an example, telephones were not exactly as

1 common as they are now, and in urban areas where people had
2 less exercise and ate -- and had worse diets had more
3 cardiovascular disease than in rural areas where they worked
4 out, worked on the farms or whatever, and had fewer telephone
5 poles. It's an ecological -- it's a misinterpretation.

6 THE COURT: So it would be a coincidence that has --

7 THE WITNESS: It's a coincidence.

8 THE COURT: -- no bearing on actually the cause of
9 disease or the symptoms of --

10 THE WITNESS: That's right.

11 THE COURT: -- the disease or anything like that.

12 Okay.

13 THE WITNESS: And as a scientist an association has
14 the same implication as a cause and effect if you use it -- if
15 you use it in the same way. Like something is associated with
16 infection, a particular event or -- means in epidemiological
17 terms that there is some kind of cause and effect.

18 So when you do studies that can't establish a cause
19 and effect, what we do is say we found a characteristic
20 related or associated with positivity, testing positive, which
21 is a little -- it may be -- it may be a very obscure kind of
22 -- but it's very important in our line of work to be very
23 clear about what we consider studies that can demonstrate real
24 associations with getting infected or getting a disease and
25 those that are just a characteristic of populations, for

1 example, with the disease. I know it sounds esoteric, but
2 it's important.

3 BY MR. WRIGHT:

4 Q And some -- some of the statistical -- do you
5 -- do you all compute it like statistically, the probability
6 that it was this or that?

7 A Yes, after having done an appropriate study.
8 So the study methods have to be just as appropriate as the
9 analysis. And bad data in, bad data out. You know, good data
10 in, hopefully your results are valid. But there have been --
11 there's a lot published, not necessarily in hepatitis C,
12 that's not valid.

13 Q Okay. The -- Brian Labus stated in -- in his
14 -- in the report that the likelihood of getting hepatitis C --

15 THE COURT: Keep your voice up.

16 BY MR. WRIGHT:

17 Q The likelihood of getting hepatitis C for a
18 patient who went to the clinic on September 21, 2007, was 38
19 million times the likelihood of a person who didn't go to the
20 clinic on September 21, 2007. Okay?

21 A Uh-huh.

22 Q What does that show?

23 A I've read the sentence, too. I don't know --

24 Q I mean, I presume --

25 A -- what calculation --

1 Q -- it's true.

2 A I agree. I -- no, I read the sentence, too.

3 I don't know what calculation he was making or the report was
4 making, what calculation that was based on.

5 Q Okay.

6 A And it wasn't explained.

7 Q It -- it is fair to say that you -- you simply
8 read the reports and you concur with the conclusion of CDC?

9 A Yes.

10 Q Okay. And their conclusion was that the most
11 likely cause was the combination of unsafe injection practices
12 with the multi-patient use of propofol vials?

13 A Right, which is also considered under the
14 overall phrase of unsafe injections.

15 Q Oh, okay. That -- that -- somehow I was
16 viewing an unsafe injection as the actual --

17 A No, it also involves the reuse of a vial for a
18 multiple -- or the reuse of the vial for multiple patients.

19 Q Okay. And the --

20 THE COURT: Keep your voice up.

21 BY MR. WRIGHT:

22 Q Your -- on that New York, your first case of
23 New York 2001, was that your first colon --

24 A My first -- the first investigation of an
25 outbreak of hepatitis C in a GI practice.

1 Q Okay.

2 A Private GI practice, yes.

3 Q Okay. And that -- and was that an
4 anesthesiologist?

5 A Who was reusing syringes and needles. Reusing
6 needles and syringes and on the same vial and going back into
7 a multi-dose vial, actually.

8 Q Okay. And was he -- was it a he, the
9 anesthesiologist?

10 A It was.

11 Q Okay. Was he using -- reusing needles and
12 syringes between patients or simply to re-dose a single
13 patient?

14 A Simply to -- to re-dose. He was discarding
15 between patients.

16 Q Okay. The -- and --- and he had denied it?

17 A Yes.

18 Q Okay. And then ultimately admitted to it?

19 A Yes.

20 Q Okay. And the Oklahoma case you talked about,
21 the one you talked about here, that was a reuse of syringes --
22 reuse of needle and syringes on multiple patients?

23 A That was taking one syringe, filling it with
24 enough medication for ten patients, and going from bed to bed
25 administering the medication.

1 Q That's what I'd call serial.

2 A Yes, that's serial.

3 Q Okay. And so that -- you all call that overt
4 syringe -- needle and syringe reuse? I saw that in one of
5 these articles.

6 A Oh, you mean like direct versus indirect
7 contamination?

8 Q Right.

9 A Yeah, that would be direct contamination of
10 the syringe as opposed to indirect. Indirect being through --
11 through the vehicle of a multi-dose, like contaminating the
12 medication vial. Right.

13 Q Okay. And you -- you were asked about serial
14 contamination. And what does that mean to you?

15 A It means that a line of people, so to speak,
16 or patients, have received -- have been exposed serially.

17 Q Okay.

18 A You know, in --

19 Q I got it. And the --

20 A -- a sequence of some time.

21 Q Okay. And I think it was your New York
22 investigation there was a multi-dose common vial and that
23 appears to have been contaminated with hep C by a source
24 patient, and then that -- that one vial was used over three
25 days and that one vial, which was contaminated, thereafter

1 transmitted hepatitis C to other patients getting out of that
2 same vial, is that fair?

3 A That's correct. Although, there were some
4 patients in sequence who did not become infected.

5 Q Okay. And the -- here, and I'm unsure if it's
6 that clear in the Southern Nevada Health District report, but
7 Brian Labus testified that he had two theories by which the
8 transmission, talking about September 21st, could have
9 occurred where it went from room to room because there were
10 two different procedure rooms.

11 And he said it could have been a single --
12 theoretically it could have been a single 50 cc contaminated
13 vial, one vial of propofol contaminated because if you add it
14 up, all of the dosage for all of the infected patients and you
15 just gave them each like their first dose out of the one vial,
16 there was enough total that it could have all happened through
17 one vial. That was one theory he testified to. Second theory
18 dealt with contaminating multiple vials because the -- and
19 having open multiple vials at the same time. And he called
20 that serial contamination of vials. Okay?

21 A Uh-huh.

22 Q Okay. Have -- have you, in the cases you have
23 seen and studied, have you come across serial -- using that
24 definition of serial contamination of vials? Did any of your
25 cases involve that?

1 A I'm thinking.

2 Q Take your time.

3 A I don't think so. I don't remember that being
4 the case, but the practices at this clinic of having multiple
5 vials open at the same time in the same procedure room and
6 some of the -- and their techniques in general were pretty,
7 well, unfortunate. And so, you know, there is really no
8 reason to have multiple vials open at the same time,
9 particularly if you don't have more than one anesthesia person
10 in the room at the same time. So -- but my understanding is
11 that they did. And --

12 Q Okay. Well, where do you get that
13 understanding?

14 A From the report of the observation --

15 Q Okay.

16 A -- of what they were doing at the time the
17 investigators were there.

18 Q Okay. Well, that was Linda Hubbard. I mean,
19 you don't know that, but Linda Hubbard was not there on
20 September 21st or July 25th. And she --

21 MR. STAUDAHER: Objection. Mischaracterizes the
22 evidence. She was present on July 25th.

23 THE COURT: I'm sorry?

24 MR. STAUDAHER: July 25th.

25 MR. WRIGHT: Okay.

1 THE COURT: All right. So --

2 MR. WRIGHT: Okay. I didn't remember her being
3 there. I'll accept that --

4 THE COURT: And the jury --

5 MR. WRIGHT: -- clarification.

6 THE COURT: -- will recall --

7 MR. WRIGHT: Okay.

8 THE COURT: -- what it recalls. And that's what
9 it's important, what the jury remembers.

10 BY MR. WRIGHT:

11 Q Okay. Linda Hubbard wasn't involved with the
12 source patient or infected patient on July 25th, and Linda
13 Hubbard was not involved on September 21st. Other CRNAs did
14 not testify to you opening multiple vials. They -- they have
15 testified to pre-loading, for lack of a better word. I mean,
16 in the morning drawing up out of one 50 cc, filling five
17 syringes, and other than that simply using a vial until it's
18 empty. Multi-patient, I'm not arguing that, but if you take
19 that open vials out of the equation on September 21st, meaning
20 having more than one vial open at the same time sitting there,
21 do you follow this serial contamination of the vials theory?

22 A I don't think I understand the question --

23 Q Okay.

24 A -- actually.

25 Q Okay.

1 A If you don't have more than one vial, then --
2 Q Open.
3 A Open? Well, you can serially -- you can
4 contaminate it if you open another vial and use a contaminated
5 syringe. Or if you use a new syringe, withdraw some -- some,
6 you know, whatever is left in the contaminated vial into a
7 syringe, and then go into a new vial to get a little more.
8 Q Okay. The --
9 A But, you know, these are all hypotheticals,
10 and my understanding was that, you know, the vials, multiple
11 vials were open at the same time. I mean, there's no reason
12 why either of those scenarios couldn't have happened. I don't
13 know if they did. They also --
14 Q Right.
15 A They may carry, you know, their own -- I mean,
16 it's common in some settings. I'm not saying this one. But,
17 you know, you put what you drew up in your pocket when you
18 change rooms.
19 Q Okay.
20 A Or a vial, you stick the vial in your pocket
21 that you're using and you change rooms and you then use that
22 vial as opposed to whatever is in that room available.
23 Q The CDC trip report noted that there was no --
24 based upon observations and interviews, they didn't haul
25 propofol room to room.

1 A That's true. However, that may not be the
2 case.

3 Q Right. We're -- we're --

4 A I'm just saying a --

5 Q Right. I mean --

6 A It's possible.

7 Q It maybe had --

8 A I don't know.

9 Q Okay.

10 A I don't even know if they had pockets.

11 Q I don't either. We've heard about tackle
12 boxes, but not pockets.

13 A Fanny packs I've seen now, you know.

14 Q So you were -- you're aware of no published
15 articles or cases involving serial contamination of vials, and
16 the evidence in this case --

17 A In which -- what are you -- tell me again your
18 definition of serial contamination of vials?

19 Q Having multiple vials get contaminated by all
20 with the virus of the original source patient, and that's how
21 it moves from room to room into later in the day.

22 A I don't --

23 MR. STAUDAHER: Objection, Your Honor. That
24 mischaracterizes --

25 THE WITNESS: Yeah.

1 MR. STAUDAHER: -- Brian Labus's testimony.

2 THE WITNESS: It's --

3 MR. STAUDAHER: -- about that.

4 THE WITNESS: It's not serial contamination of vials
5 in my mind.

6 BY MR. WRIGHT:

7 Q Okay. The -- the evidence in this case has
8 been that Brian Labus in March 2009, before -- still having
9 not written his report in December 2009, contacted CDC to ask
10 them if there was any case or any published literature that
11 could document serial contamination of vials as he presumes
12 happened in Las Vegas. And the response was --

13 MR. STAUDAHER: Objection, Your Honor. Hearsay.

14 THE COURT: Well, overruled. She's testifying as an
15 expert.

16 Mr. Wright.

17 MR. STAUDAHER: So hearsay is allowed?

18 THE COURT: Well, Mr. Staudaher, that's enough. I
19 said she could answer the question.

20 Mr. Wright, state your question and be mindful to
21 speak into the microphone --

22 MR. WRIGHT: Okay.

23 THE COURT: -- because you start off strong, and
24 then you start drifting away and we -- we're having trouble
25 hearing you.

1 BY MR. WRIGHT:

2 Q Brian Labus contacted CDC in March 2009 asking
3 if they had any articles or cases in the published literature
4 that document serial contamination of vials as we presume
5 happened in Las Vegas. And the CDC responded that they didn't
6 have any such thing other than one pooling incident, and the
7 CDC stated that they thought there was enough information from
8 your investigation that this is clearly a plausible
9 explanation.

10 THE COURT: Is there a question?

11 BY MR. WRIGHT:

12 Q Does -- would you concur with that response
13 from CDC?

14 A What I would concur is that they were using
15 practices that would -- could result in contamination of
16 medication vials with a blood-borne virus, and that that virus
17 could serve as a source for transmission to multiple patients.

18 Q Okay.

19 A So why couldn't -- I'm -- I still don't
20 understand exactly what definition we're using for serial
21 contamination.

22 Q We -- these are -- this is Brian Labus's --

23 A I know. But I -- I don't know what he meant,
24 either, so --

25 Q I don't either.

1 A Well --

2 Q Six years later.

3 A I -- you know, there -- I don't really know
4 what you're asking. I don't see why multiple vials, if
5 they're out, couldn't have become contaminated if they use the
6 same -- either pooled them into a contaminated syringe or --
7 or used -- reused a syringe on a different vial that was open.

8 Q Okay.

9 A But I don't know what you -- that's the --

10 Q What I'm asking, and I'll ask it again.

11 A Okay.

12 Q Their response was there is no case like it,
13 and there is nothing in the published literature regarding his
14 presumed contamination of vials by serial contamination. Do
15 you agree with that?

16 A I agree with I can't think of a published
17 study involving a specific contamination of different vials --

18 Q Okay.

19 A -- in the same place. However, I can say that
20 we have had an out -- we -- that there have been serial
21 transmission from a common source to multiple patients
22 downstream.

23 Q Right.

24 A But I can't -- I don't know why -- I don't --
25 or -- or contamination of medication vials from blood

1 splatter, which would have contaminated multiple medication
2 vials, even if they weren't being reused.

3 THE COURT: Would the contamination of, say,
4 multiple vials all have had to come from the source patient,
5 meaning the source patient --

6 THE WITNESS: Yes.

7 THE COURT: -- contaminated all the vials --

8 THE WITNESS: Given the --

9 THE COURT: -- as opposed to --

10 THE WITNESS: -- incubation period --

11 THE COURT: -- patient to patient to vial to patient
12 to vial to patient? Do you understand my question?

13 THE WITNESS: Say it again.

14 THE COURT: Would the single source patient have had
15 to contaminate all of the vials in your theory?

16 THE WITNESS: No.

17 THE COURT: Okay.

18 THE WITNESS: One vial could have contaminated
19 another.

20 THE COURT: Okay. As long as you're using the same
21 syringe from -- or mixing the two vials together.

22 THE WITNESS: With the same way that you breached
23 the sterility of the product --

24 THE COURT: Okay.

25 THE WITNESS: -- by using something for one patient

1 on another, yes. So one vial could have served as a source
2 for another vial.

3 THE COURT: If you mix the dosage or the syringes.

4 THE WITNESS: Right.

5 THE COURT: Okay. I get it.

6 BY MR. WRIGHT:

7 Q So a fellow named Priti with CDC --

8 A A woman.

9 Q Oh. I'm sorry. A young lady named
10 P-R-I-T-I --

11 A Patel.

12 Q Okay. Responded that there are no articles or
13 cases like it, but you're theory seems to be a plausible
14 explanation.

15 A It could happen. I don't really see --

16 Q Okay. I'm just --

17 A -- whether it's -- you know, it could.

18 Q Okay.

19 A Given how --

20 Q And that's a plausible explanation as to
21 what --

22 A It's a plausible scenario for contamination.

23 Q Okay.

24 A Is the best --

25 Q And plausible means?

1 A It could happen.

2 Q It could happen. Okay. Now, on -- on 7/25,
3 July 25 -- I don't understand why we don't look at the two
4 events separately like what happened on July 25th and what
5 happened on September 21st.

6 A Is there a question? Are you asking me?

7 Q Yeah, why -- why -- if September 21st hadn't
8 even occurred and we're just investigating July 25th where
9 there was a source patient, there's genetic connection
10 sequencing, in other words the victim, the infected patient
11 received the hepatitis of the source patient; correct?

12 A Yes.

13 Q And the -- we conclude that it must have been
14 unsafe injection practice.

15 A Okay. So you're asking me how we -- well,
16 first of all, they did the same kind of investigation that
17 they tested patients to see if there were any other infections
18 around the same time. So they conducted the same kind of
19 investigation separately. I mean, clearly, two different time
20 points. And -- but they didn't -- they only had the one
21 infection, which from an epidemiological point of view, you
22 wouldn't have been able to, quote, associate it with the
23 source patient unless you did genetic sequencing.

24 Q Okay. But then it happened that it was
25 connected.

1 A Yes.

2 Q Okay.

3 A So how could that happen? Well, there has to
4 be some break in technique for a blood-borne virus to go from
5 one patient to another. And having been able to associate the
6 -- or having observed the unsafe injection practices which
7 were ongoing at this clinic, it would stand to reason that the
8 July 25th incident had the same -- was likely to have been
9 caused by the same mechanism as the September incident --

10 Q Okay.

11 A -- transmission episodes.

12 Q But it -- it could have happened that way.

13 A Yes. You can't prove it, but, yes --

14 Q Okay.

15 A -- it makes perfect sense. And from a public
16 health point of view, that's what -- it's important to know
17 what it is that needs to be changed or communicated to prevent
18 it from happening in the future. That's the purpose of the
19 investigation.

20 Q Okay. And it -- and it's not a -- have you
21 ever participated in a criminal investigation?

22 A No.

23 Q Okay. And you all -- you all, meaning you
24 healthcare epidemiologists, CDC, are going in and you want to
25 as quickly and thoroughly as possible find out what is

1 occurring so that you can both stop it, correct it, and notify
2 anyone who is potentially at risk; correct?

3 A That's correct.

4 Q And are -- are you aware that Brian Labus --
5 you testified on direct about the importance, especially with
6 the new investigators, the newbies who were out there in
7 field, don't jump to conclusions, don't -- don't zero in on
8 one cause, or likely cause, and stop. You have to do
9 everything; correct?

10 A Yes.

11 Q Brian Labus has testified that the
12 investigation started at the clinic on Wednesday, the 9th of
13 January, late in the afternoon, and the next day on Thursday
14 they did chart review, they meaning CDC and Brian Labus and
15 BLC and all these team members.

16 A Uh-huh.

17 Q And the next day on Friday they knew of the
18 propofol multi-patient use and observed reuse of syringe on
19 patient to redose, and by Friday evening, two days into the
20 investigation, he had determined the likely cause. Does that
21 make sense?

22 A That's the question, does it make sense, or
23 did it --

24 Q Yes.

25 A -- is it -- could it have -- did it happen

1 that way? I can't --

2 Q Okay.

3 A I don't know. Since, I can see that that's
4 happening -- that happening, especially given the history of
5 consistency of these outbreaks being due to the same cause
6 over and over and over again. However, the CDC did do a
7 complete analysis of all the other kinds of exposures that
8 could have occurred regardless of what his conclusion was on
9 Friday afternoon.

10 Q Okay. His -- I mean, he testified that he had
11 determined that --

12 A I can't -- I can tell you that in their
13 publication they presented the data showing the other types of
14 exposures that they looked at and ruled out because there was
15 no association between those other exposures and getting --
16 and acquiring hepatitis C.

17 Q Okay. Now, the -- the unsafe practices that
18 keep going on and on and on in the literature and in real life
19 practice, here the evidence has been that the -- the -- on
20 Wednesday afternoon when the -- Mr. Labus and Dr. Fischer and
21 Dr. Schaefer went in, the clinic told them they are multi --
22 they are injecting with multi-dose propofol, multi-dose vials,
23 whatever the terminology was, multi-dose --

24 A Single-dose vials used on multiple patients --

25 Q Correct.

1 A -- is actually what they were.

2 Q And is -- is what they acknowledged and
3 exactly what their practice was. And this -- and the evidence
4 has been here in this courtroom that that was a common
5 practice throughout this community in outpatient settings.

6 MR. STAUDAHER: Objection, Your Honor. I don't
7 believe that's the testimony or evidence as it is right now.

8 THE COURT: Don't spin the evidence, Mr. --

9 MR. WRIGHT: I'm not spinning the evidence.

10 THE COURT: Mr. Wright.

11 And, ladies and gentlemen, once again, it's your
12 recollection of what the testimony was and how you interpret
13 that in terms of, you know, common --

14 MR. WRIGHT: Okay.

15 THE COURT: -- uncommon. It's up to you. Again,
16 I'll remind you.

17 That's what I meant, Mr. Wright.

18 BY MR. WRIGHT:

19 Q Keith Mathahs is a CRNA, okay, who was
20 observed, and he testified here in this courtroom that it was
21 the same practice at Sunrise, it was the same practice at
22 Southwest, it was the same practice everywhere he was
23 involved.

24 MR. STAUDAHER: What practice are you referring to
25 specifically? That's the point that I'm --

1 MR. WRIGHT: Multi --

2 THE COURT: Can you be more specific in your
3 questioning, Mr. Wright.

4 MR. WRIGHT: It was specific before he said --

5 THE COURT: All right. Well --

6 MR. WRIGHT: -- it wasn't --

7 THE COURT: -- Mr. Wright --

8 MR. WRIGHT: -- the evidence.

9 THE COURT: -- state your question again.

10 BY MR. WRIGHT:

11 Q We are talking about using a single-dose
12 propofol vial on multiple patients, acting like it's a
13 multi-dose vial rather than single-dose vial.

14 A The problem, if you just look at it that way,
15 is bacterial contamination and has nothing to do with serial
16 virus contamination.

17 Q Okay.

18 A Because a single-dose vial, something labeled
19 for single-dose has a very short period in which it can be
20 opened and used. It has no bacteria static preservative in it
21 to prevent contamination and when it's -- after it's been
22 opened. So it's bacterial contamination that is intended, a
23 multi-dose vial that's -- excuse me, a vial that's labeled as
24 multi-dose versus single-dose. And I think -- and the package
25 insert is very clear about this for propofol. But not every

1 outbreak has involved propofol, and some have involved vials
2 that are labeled for multi-use. The issue here is the
3 re-dosing with the same syringe.

4 Q I'm going to get to that.

5 A Well, yes, but --

6 Q Okay. Well, I just --

7 A Okay.

8 Q No --

9 A Okay.

10 Q We'll get -- we'll get where you want to go.

11 A But it isn't -- it isn't necessarily the -- I
12 mean --

13 Q Well, I'm --

14 A Well, that might not --

15 Q You're not going where I'm going.

16 A Well, okay.

17 Q I'll drive, and then you can get what you
18 want. And if you think I'm asking unfair questions or
19 something, I'm -- I'm trying to focus in on this why this lack
20 of recognition, this lack of understanding, this lack of
21 awareness in the community of the danger involved in using
22 like a 50 cc propofol vial as multi-dose. Okay? I mean, do
23 you understand that just -- the things just keep going on
24 despite your -- all -- all the best efforts to say don't do
25 it? Do you agree with that?

1 A What I -- you're not in isolation. Well, you
2 shouldn't use a single-use vial unless you use all of it at
3 once. You shouldn't use it for, you know -- you shouldn't
4 have it open for more than the time. It has nothing to do
5 with -- I mean, it has very little to do with the fact that
6 it's labeled for single-use in terms of virus transmission.

7 Q Is that --

8 A Then it has --

9 Q -- part of --

10 A -- more to do --

11 Q -- the confusion?

12 A Well, you can't take it -- in my opinion it's
13 not -- you can't take that as an isolated event, reusing the
14 vial.

15 Q I'm not isolating it.

16 MR. STAUDAHER: Your Honor, I'm going to object to
17 letting -- I would like him to let her finish her answer
18 before he --

19 THE COURT: Were you -- okay.

20 Were you finished with your answer, ma'am?

21 THE WITNESS: Yes, that I can't -- that his -- the
22 question is not answerable in that way.

23 BY MR. WRIGHT:

24 Q Okay. As part of --

25 A It has no significance.

1 Q Okay. The significance I'm asking is -- is
2 why do these -- we've had a CRNA in this courtroom, Mr.
3 Sagendorf, who is presently a CRNA practicing in California
4 for two large outpatient clinics and he testifies right here
5 within the past month that they still use propofol as --
6 single-use on the label, they use it as multi-dose in their
7 clinics. They use it for multiple patients.

8 A Uh-huh.

9 Q Okay. And I --

10 A I'm not shocked.

11 Q You're not shocked. I'm not shocked either.
12 And -- and we understand best practices. We've heard all
13 about best practices. And all I'm focusing on, we'll get to
14 the needles in due course, but the -- somehow, and this may be
15 the confusion between the multi-dose and single-use has to do
16 with the preservatives and how long it can last once it's
17 open; is that fair?

18 A Yes.

19 Q Okay. Because, I mean, you talk to
20 practitioners and they say I'm using it quickly. Once I open
21 propofol, it -- it says right in there if you read everything
22 that it's good for six hours. And if I am using it all within
23 that time frame, there is no harm in me using it all up. Do
24 you understand what I'm saying?

25 A Yes, I understand perfectly.

1 Q And they -- and if you read the propofol
2 vial --

3 MR. WRIGHT: Where is our propofol vial? It's an
4 exhibit.

5 BY MR. WRIGHT:

6 Q We've had witnesses testify that it's safe to
7 use it if once you open it, if you use it all within six
8 hours. And none of that -- none of it -- if you can --

9 A See it?

10 Q See it. None of that is explained on that
11 label. Is it?

12 A I have to read the label.

13 Q Okay.

14 A However, anyone who uses a drug, any drug,
15 should be -- a professional who uses a drug, any drug, should
16 be fully familiar with that drug.

17 Q Agreed.

18 A Okay. So --

19 Q Best practices. I agree.

20 A Now, the other issue is I think in my opinion
21 there is confusion regarding multi-use and single-use vials
22 and how they contributed. This outbreak could have just as
23 easily occurred with a multi-dose, a vial that was labeled for
24 multi-use. Because the issue wasn't so much that it was a
25 single use vial. It's that they contaminated the vial and

1 then used it on multiple patients. And that could just as
2 easily have occurred with a vial that's labeled for multi-use.
3 Okay.

4 Q Okay. I agree. But why -- why do we have --
5 we had another CRNA testify in here named McDowell. McDowell,
6 I don't remember his first name. But he wanted to argue with
7 the investigators --

8 A I bet he did.

9 Q -- when they told him you use that 20 cc, and
10 then you throw it out and you can't use it on another patient.
11 And he literally argued that as long as I am using aseptic
12 technique and I use a new needle, new syringe every time I
13 enter that vial, there is no way on Earth you can ever show me
14 I will contaminate a patient. And he wants to argue with them
15 to -- to use the vial up and not throw any away. And so why
16 doesn't it sink in?

17 A I have no idea why it doesn't sink it.

18 Q Okay. But --

19 A I have no knowledge or data --

20 Q Okay.

21 A -- to tell you why it doesn't sink in.

22 Q Who in CDC --

23 A It says single patient infusion vial. That's
24 what it says.

25 Q I found it on there, but I needed a magnifying

1 glass.

2 A I can't believe I can read it myself.

3 Q I can't either. But --

4 A It does say it. And the package insert is --
5 it says it in big letters.

6 Q But no package inserts come with this.

7 A No.

8 Q They come in flats of 20 with no --

9 A However, if you were a physician or a nurse
10 and you were using this routinely on patients, you would
11 hopefully have looked it up in the PDR and know everything
12 about it.

13 Q I don't disagree with best practices.

14 A I'm just saying. However, the issue here, in
15 my opinion, is not the fact that this says it's for single
16 patient infusion. It's the fact that they contaminated it.

17 Q We're going to get to the --

18 A But, you see, it's irrelevant
19 epidemiologically --

20 Q Epidemiologically, but --

21 A -- and scientifically.

22 Q -- this is a criminal case --

23 A I know --

24 Q -- okay --

25 A -- but I'm science.

1 Q -- and people's knowledge matters. It matters
2 whether they are mistaken in their judgment or are they
3 consciously, knowingly doing something they're not allowed to
4 do. So I understand epidemiologically it may not matter,
5 but --

6 A Well, then that wouldn't -- that also would
7 not -- if they didn't know that they were doing something
8 wrong, then it would apply to whether it was -- they were --
9 it wouldn't matter if it was single-use or multi-use, they
10 would still be contaminating the vial.

11 Q Right. Because I may think I am engaging in
12 proper practices. Let's move on to your favorite, the
13 contamination. Okay. Needle and syringe usage. What was
14 observed here? Keith Mathahs is the fellow who -- who is in
15 the report who was observed by Dr. Fischer. In the clinic, in
16 front of the CDC inspector with her little -- I don't want to
17 call it her badge, her little plastic badge on, knowing there
18 is a hepatitis outbreak, she is observing his practice.

19 And this CRNA takes a new propofol vial, I'm
20 presuming he wiped the top off, you know, with the alcohol,
21 all of the aseptic stuff, inject the patient, procedure is
22 ongoing, patient needs another dose. He takes the same needle
23 and syringe, holds it up, takes off the needle, puts it in the
24 Sharps container right in front of the CDC inspector, gets out
25 a brand new sterile needle, puts it on, and redraws out of the

1 same propofol vial.

2 A Uh-huh.

3 Q Procedure ends, Dr. Fischer steps in,
4 interviews Keith Mathahs, and her testimony is he was not
5 aware that his practice was risky or dangerous. And he
6 believed that he was being aseptic by changing the needle.
7 Okay. Why does -- where -- why does he think something like
8 that?

9 MR. STAUDAHER: Objection. Speculation, Your Honor.

10 THE COURT: Yeah, that's sustained. You need to
11 phrase that --

12 MR. WRIGHT: Okay.

13 THE COURT: -- a different way. If there's anything
14 in the --

15 BY MR. WRIGHT:

16 Q Why do those instances like him -- I mean,
17 have you seen a situation like that during your investigations
18 where the person just wasn't cognizant, aware, understanding
19 of the improper behavior the person was engaging in?

20 A Yes. Not this specifically, but other
21 investigations --

22 Q Okay.

23 A -- involving unsafe practices, we'll say.

24 Q Okay. And you're dealing with Keith Mathahs,
25 got out of CRNA school before Dr. Fischer was born in the late

1 '60s. Okay.

2 A But not before I was born or graduated. And I
3 can tell you that his -- his original nursing degree is based
4 on a practice taught to him in nursing school, and that
5 practice routinely involves -- or the curriculum routinely
6 involves aseptic technique for -- for giving injections, for
7 preparing and administering injectables.

8 Q Right. But those techniques have evolved.

9 A No.

10 Q Well, in the late '90s, in these articles I've
11 read, in the late '90s, 1990s, you still had between 20 and 35
12 percent of the practitioners believing you could multi-use a
13 needles and syringe on multiple patients if you change the
14 needle.

15 A I know. It's unbelievable, isn't it?

16 Q Right. And -- and what were the standards
17 then?

18 A The standards have been the same all this
19 time. I cannot -- the standards -- aseptic technique is not
20 something that has evolved over time. Although, obviously,
21 disinfection and sterilization techniques have changed, the
22 term and what it implies, asepsis, you know --

23 Q Clean.

24 A -- has not changed. Okay. So the fact that
25 they believe that by changing the needle they are maintaining

1 a sterile connection, I don't under -- I have no idea why they
2 believe that.

3 Q Well, who in the CDC -- I mean, you keep
4 putting out -- I'm talking not you --

5 A It's okay.

6 Q -- but the CDC --

7 A I'm used to it.

8 Q -- puts out these common myths, puts out
9 posters on misperceptions, and -- and keeps trying to drive
10 this in to the practitioners, and it still persists. And so
11 who is studying the why it doesn't trickle in to the
12 perception of the practitioners? I mean, something is wrong
13 in the teaching, something is wrong in the delivery of the
14 message. I mean, I can't believe that like -- I'll show you a
15 study where 28 percent of the --

16 A I saw the --

17 Q -- practitioners --

18 A -- same study --

19 Q -- still believed it was okay to reuse needle
20 and syringe on -- on the same patient. All I'm doing is
21 reusing needle and syringe on same patient, and then threw it
22 away. 28 percent of the practitioners.

23 A Actually, you can do that. You can reuse a
24 needle and syringe on the same patient.

25 Q Not CDC. We heard best practices was you go

1 in, you use it once, once, once, and it's gone. That's what
2 we heard here from Dr. Fischer and -- and Dr. Schaefer.

3 A Once only.

4 Q Okay.

5 A It all -- it's a package. It's not -- you're
6 isolating the events. They're referring to a package. They
7 are trying to drive home a point or a practice and they're
8 trying to make it simplistic. And, you know, I'm -- what we
9 used to say, and still do, is you have two choices. You can
10 either keep your -- if you want to use a multiple-dose vial on
11 multiple -- on more than one patient, or a single-use vial,
12 whatever, you better keep it separate from the treatment area
13 so that people cannot go back into it with a used syringe or
14 needle. You keep it separate in a centralized medication
15 area. What, they're going to walk out of the room to get
16 another dose? I don't think so. So -- or you don't reuse.
17 That's the bottom line and has been for -- since the --
18 well --

19 Q Okay.

20 A -- since I came to CDC. So we've been pushing
21 this home and dialysis centers forever. And the only -- that
22 is one area where I do know, or I can speculate, rather, why
23 staff are not carrying out appropriate infection control
24 practices that have been recommended since the 1970s.

25 Because there -- the cohort of personnel who were

1 there in the '70s, '60s and '70s and early '80s who saw all
2 these transmission episodes that are now being -- that were
3 then prevented by good infection control practices, as well as
4 a little vaccine, have never seen an outbreak because they
5 were prevented. So they don't understand the need for some of
6 these recommendations that are made for that specific setting,
7 okay, which are very -- much more extreme than for other
8 settings.

9 And that was the only -- I mean, they just are --
10 it's like parents who don't want to vaccinate their children
11 against childhood diseases. They have never seen a case of
12 polio or a case of measles and don't know how severe it can
13 be. And, therefore, they would -- you know, they can't
14 appreciate what vaccines to, you know, for the population.
15 It's somewhat of a familiarity. On the other hand, would you
16 operate with an unsterile -- well, yes, actually, I've seen
17 that, too.

18 Q Okay. Well, I get --

19 A I've seen that, too.

20 Q I understand.

21 A Where a surgeon thinks that if he washes it in
22 the sink, his instrument, with soap and water, he can use it
23 on the next patient because it's his instrument and he's very
24 attached to it, he/she. So I -- it's -- I can't explain why
25 it doesn't get through.

1 Q But -- but -- maybe I'm Pollyanna-ish, but I
2 just don't think 28 percent of the healthcare providers in
3 this one study appreciated the risk. I mean, I misstated
4 that. 28 percent of them, I think, misapprehended,
5 misunderstood the behavior they were engaging in, as opposed
6 to 28 percent of them were just saying hell with it, I don't
7 care if I'm going to harm someone.

8 A That I can't say. I have -- I don't know the
9 rationale for reusing. I just know that they did. When they
10 surveyed outpatient surgical centers, 28 percent were reusing.

11 Q It was shocking.

12 THE COURT: Can I see counsel at the bench.

13 (Off-record bench conference.)

14 THE COURT: Ma'am, we're not going to finish with
15 your testimony at a reasonable time before lunch.

16 So, ladies and gentlemen, we'll just go ahead and
17 take our lunch break now. We'll be in recess for the lunch
18 break until 1:30.

19 During the lunch recess you're reminded that you're
20 not to discuss the case or anything relating to the case with
21 each other or with anyone else. You're not to read, watch, or
22 listen to any reports of or commentaries on this case, any
23 person or subject matter relating to the case. Do not do any
24 independent research by way of the Internet or any other
25 medium. And please do not form or express an opinion on the

1 trial.

2 Notepads in your chairs, and follow the bailiff
3 through the rear door.

4 (Court recessed at 12:22 p.m., until 1:34 p.m.)

5 (In the presence of the jury.)

6 THE COURT: All right. Court is now back in
7 session. And, Mr. Wright, you may resume your
8 cross-examination.

9 MR. WRIGHT: Thank you.

10 BY MR. WRIGHT:

11 Q Doctor, one of the articles you forwarded,
12 U.S. Outbreak Investigations Highlight the Need for Safe
13 Injection Practices and Basic Infection Control. In -- in
14 talking about the practitioners continuing to utilize
15 single-dose vials as multi-dose vials despite best practices
16 recommendations, what -- I'm going to read you a portion of
17 this article and then ask you if you agree with it. Okay?

18 Transmission potential is magnified when facilities
19 use vials or bags of medication and infusates that contain
20 quantities in excess of those needed for -- for routine single
21 patient use. Although these medications are often labeled as
22 single use, i.e., single dose, the large volume in the
23 container may lead to the perception that they are suitable
24 for multi patient use. Do you agree with that?

25 A Yes.

1 Q Okay. And that -- that was a long -- I'm not
2 sure of the infusates and all of the words there, but when it
3 comes in a big package, like 50 cc and it's utilized in an
4 outpatient setting where you normally use 10 to 20 ccs for a
5 procedure, having that big vial invites the belief that you
6 can use it for more than one patient; is that fair?

7 A The belief? I don't know if I agree with
8 that, or rather misperception.

9 Q Okay. The misperception that it can. And in
10 this case, the evidence that has been introduced thus far was
11 that 20 cc vials of propofol were initially being purchased,
12 and then the purchase person, a fellow named Jeffery Krueger,
13 the charge nurse, talked to a Baxter representative who said,
14 hey, we have 50s, do you want some of those. Okay? And 50s
15 were then introduced to the clinic. Had -- had that not
16 happened and they just kept with 20s, that would have
17 decreased the opportunity for something like this to happen?

18 A If 20 milliliter vials were used up on a
19 single patient, then the opportunity for contamination of the
20 vial for the next patient would not be there.

21 Q Okay. And I think, as you made clear this
22 morning, if I just stuck to using one vial per patient and
23 throwing it away, or if I just stuck to using one needle and
24 one syringe one time, either of those -- this -- this type of
25 transmission wouldn't occur; correct?

1 A Likely not.

2 Q Okay.

3 A Correct.

4 Q Okay. Most likely this -- this type --

5 A Yes.

6 Q -- of transmission. And you, I think, agreed

7 that using the same needle and syringe to redose the same

8 patient for propofol would be okay as long as that propofol

9 vial is then thrown out?

10 A That's correct.

11 Q Okay. Now, is part of the confusion that

12 continues to manifest itself by lack of following best

13 practices in the practitioners, is part of the confusion due

14 to the varying definitions of single patient use, single use

15 and single-dose vials?

16 A No.

17 Q No?

18 A I don't believe so.

19 Q Okay.

20 A In my opinion it's not the vial that's the

21 problem. The vial -- we're human. Sometimes we actually make

22 policies because we're human. And so we might go a little

23 further with our policy in order to prevent human error, okay,

24 from affecting a particular procedure --

25 Q Okay.

1 A -- knowing that we're human. So it isn't the
2 fact that the vial -- this would still have happened even if
3 the vial was labeled multi-use given their other practices.

4 Q Correct.

5 A Okay.

6 Q I mean, but -- I'm with that. The -- I mean,
7 because if you had simply tossed the vials at the end of each
8 use for a patient, no problem. If I had reused syringes on
9 every patient and tossed the vials, no problem; right?

10 A That's correct.

11 Q And if -- if I use the vials as a multi-dose
12 vial, despite what it says on it, and I used a new needle and
13 syringe every single time I entered it, every single time I
14 dosed a patient, no problem; correct?

15 A As long as there wasn't blood splatter, yes.

16 Q Right. I'm just giving it a -- okay.

17 A Yeah. All things being equal, yes.

18 Q Okay. And the -- my -- I'm -- I'm more
19 confused about the interchangeability of calling a vial single
20 dose, single use, and single patient use. Okay?

21 A Uh-huh.

22 Q And maybe I'm too literal and I'm not a
23 healthcare practitioner, but I -- I read something and I see
24 distinctions between a dose and a patient use. Do you?

25 A No.

1 Q Okay. Well, see, I do. When I think of
2 something as a single dose, to be used once, that means I take
3 it -- I take out a dose, I throw it away, and I use it. And
4 if the patient needs another one, I get out another one for
5 another dose. Am I wrong?

6 A You're interpretation, yes, is incorrect.

7 Q Okay. Okay. Because dose and use are
8 synonymous --

9 A In this instance.

10 Q -- in CDC land?

11 A Yeah, in -- no, in medicine In this instance
12 in medicine. Remember, the FDA approved this packaging.

13 Q For good or bad.

14 A I'm just pointing that out. I mean, they
15 approved the wording that is on these kinds of
16 pharmaceuticals. So I'm just telling you what we -- that's --
17 that's the interpretation.

18 Q Okay. Because I'm going to show you an
19 exhibit. But now maybe it'll make sense since a use is the
20 same as a dose. Do you recognize that?

21 A No.

22 Q Okay.

23 A I mean -- I mean, I haven't been on the
24 website recently to look at their recommendations.

25 Q Okay.

1 A So I have no idea when it went up, but I know
2 they have a major campaign on their website.

3 Q Right. This is off the CDC website --

4 A Yeah. No, I can see that.

5 Q -- last night. And tell me if everything on
6 there look -- looks accurate.

7 A Okay.

8 Q Does that look accurate?

9 A It's an -- it's actually preventing human
10 error. It's a little -- in other words, one could look at
11 this and say that I was incorrect when I said on the same
12 patient you could reuse that needle and syringe on that --
13 with that medication vial, for example, as long as you threw
14 it out.

15 Q Okay.

16 A Okay. That not what this says. This says you
17 shouldn't do that.

18 Q Okay. I wasn't --

19 A No, no, no. I know. I didn't mean --

20 Q Okay.

21 A I didn't mean anything by that. And all I'm
22 saying is what they're trying to do is reduce the opportunity
23 for anyone to -- to -- reducing the opportunity for human
24 error by making it just one policy and that's it.

25 Q Okay. The --

1 MR. WRIGHT: I'm going to move its admission.

2 MR. STAUDAHER: No objection.

3 THE COURT: All right. What number is that, or
4 letter and number?

5 MR. WRIGHT: What exhibit?

6 THE WITNESS: S1 or -- S1.

7 THE COURT: S1. That would be right.

8 (Defendant's Exhibit S-1 admitted.)

9 BY MR. WRIGHT:

10 Q The part that throws me is the single dose,
11 this differentiation between multi and single, okay. And as I
12 read this, this is a patient safety threat syringe reuse. And
13 it says a single-use vial is a bottle of liquid medication
14 that is given to a patient through a needle and syringe. That
15 part I get. Single-use vials contains only one dose of
16 medication and should only be used once for one patient using
17 a clean needle and clean syringe. Okay? See, I -- I read
18 that literally as meaning --

19 A I would --

20 Q -- a single-use vial has only one dose in it.
21 And after I use one dose, I toss it, which is inconsistent
22 with the label; correct?

23 A The label on -- well, the label doesn't really
24 say, does it?

25 Q What's it say?

1 A I'm sorry. I'm not laughing because --
2 because I can see the -- I mean, I don't happen to agree with
3 that statement. I don't know if it's correct. Because, let's
4 face it, why would you make a vial that contains -- you know,
5 that's not consistent because you don't give all of this at
6 once.

7 Q Right.

8 A You might give it twice or three times in the
9 course of the procedure. So you could then draw it up. But
10 -- and it says it's okay for 12 hours. It says use strict
11 aseptic technique. It says single patient infusion vial.

12 Q Okay. Single patient infusion vial.

13 A I'm telling you, if my computer was working, I
14 would boot it up -- which it isn't somehow. I don't know. I
15 must have -- I left it on. I would boot it up, I would go to
16 the FDA, and I would see what their definition was. I think
17 -- I mean, I can't honestly address the veracity of this
18 statement --

19 Q Okay.

20 A -- because we know this contains more than one
21 dose. In other words --

22 Q Right.

23 A -- you're not going to give them, the patient,
24 all of this at one time probably, unless maybe they weigh 300
25 pounds. Okay. So --

1 Q See, when I looked at the --

2 A No, I -- so I see your point. And the only
3 reason I can, you know -- again, I'd like to see what the FDA,
4 what their definition is. But also, as I said, sometimes in
5 relooking at policies or recommendations, I mean, this wasn't
6 a CDC recommendation to begin with technically. It's an
7 aseptic practice that's part of -- should be part of routine
8 medical care, but anyway. We go -- we -- CDC will go a little
9 more to the extreme to, as I said, prevent human error. On
10 the other hand, that is a definition. And that's why the only
11 way I would know is if I looked it up.

12 Q Okay.

13 A And I actually don't think of it that way
14 myself. So -- but on the other hand, you know, I think
15 they're trying to make it so simple that no one has to think
16 about it.

17 Q Right. And it's -- and it's -- what you think
18 is simple is confusing when you --

19 A Right. I understand that, but when you find
20 that people are not following a procedure that's been in place
21 for 50 years, then you have to decide what is it you need to
22 do to make sure that they follow it, even though you might be
23 going a little more -- a little overboard, so -- in some
24 people's minds. Maybe they just want them to think single,
25 single, single, and that's it.

1 Q See the -- see the next definition of
2 multi-dose says a multi-dose -- a multi-dose vial is a bottle
3 of liquid medication that contains more than one dose of
4 medication. Now, if I'm applying this CDC directive, I would
5 look at that propofol vial there as a multi-dose vial because
6 it contains more than one dose. Agree?

7 A That's your -- see, but -- I can't comment.

8 Q Okay.

9 A Because I can't comment. It's a single --
10 it's a single -- because I don't know the -- as I said, I need
11 to find -- I would need to know how the FDA -- you know, this
12 is an FDA approved label, otherwise it wouldn't be licensed.
13 And it says single patient infusion vial.

14 Q Okay.

15 A So but I honestly don't -- don't know why you
16 couldn't give multiple doses in a short period of time to the
17 same patient from this vial.

18 Q Okey-doke.

19 A But there's a lot of pooling going on with a
20 lot of medications in different settings.

21 Q The -- your -- not your, but one of the
22 articles you sent that talked about the New York -- 2010
23 article about the New York outbreak.

24 A The -- oh, yes, the later one.

25 Q Yes.

1 A Uh-huh.

2 Q Multiple Clusters of Hepatitis Virus
3 Infections Associated with Anesthesia for Outpatient Endoscopy
4 Procedures. The conclusion of it, if I may go through with
5 you, outbreak similar to the one described here -- of course
6 it's talking about the second New York outbreak --

7 A Right.

8 Q -- you commented on. Outbreak similar to the
9 one described here would not have been possible if intravenous
10 anesthesia medications were not administered from a single
11 vial from multiple patients; correct?

12 A True.

13 Q Absolutely. Black and white. For this reason
14 we advocate, now that's the authors of this; correct?

15 A Yes.

16 Q For this reason we advocate eliminating use of
17 all multi-patient vials for anesthesia medications to the
18 greatest extent possible, and educating clinicians on the
19 risks associated with their use. Would you agree with that?

20 A Yes, and it's been stated in many previous
21 publications, even while I was at CDC.

22 Q Okay. And so one thing to do was just plain
23 no multi-use vials at all for anesthesia. That's just taking
24 out human error and misperceptions.

25 A Uh-huh.

1 Q And educating clinicians on the risks
2 associated with their use; correct?
3 A Correct what?
4 Q That that's -- that's something that needs to
5 be done.
6 A Yes.
7 Q Even in --
8 A Yes. Yes.
9 Q This is three years later, three years after
10 the events in this case and still in June of 2010, it's still
11 a lack of understanding on the part of clinicians. Is that
12 fair?
13 A Well, tactfully, yes.
14 Q Tactfully?
15 A Tactfully.
16 Q Okay. This can be accomplished by more
17 clearly labeling medications, e.g., propofol as single patient
18 use only. Would you agree with that?
19 A It is labeled as single patient use.
20 Q Okay. Well, this says this can be
21 accomplished. I mean, you may disagree with --
22 A Those are the --
23 Q -- these authors.
24 A Well, I'm just saying that, you know, they're
25 offering suggestions, but that is what this vial says and --

1 Q Okay. And improving pricing of unit dose
2 single patient use medications to encourage their use. What
3 did that mean?

4 A I can tell you exactly what that means.

5 Q Good.

6 A Multiple-dose vials are much more economical
7 than single-dose vials. The larger the quantity, the cheaper
8 it is per dose, the less expensive it is per dose. And, in
9 fact, that's somewhat how they came to be multiple dose.
10 Larger vials can be used for multiple doses. But it also then
11 led to this problem, contamination, when used along with
12 improper preparation techniques.

13 Q Okay. So improving pricing of unit dose
14 single patient use medications to encourage their use.

15 A Right. Because, actually, when we -- when I
16 was still there we -- you know, we said, you know, wouldn't it
17 be great to get rid of all the multi-dose vials. But in -- in
18 the absence of that you have two choices. You know, two
19 things that you can do is restrict them to a centralized area
20 where you can't go back into those, or -- you know, with a
21 used syringe, or, you know, just not use them at all. So the
22 first works quite well, but it's much more economical,
23 particularly for large corporations, to purchase the multiple
24 dose vials.

25 Q Why do you think that?

1 A Why do I think that?

2 Q Yeah.

3 A From my experience working in hemodialysis
4 settings where I did a lot of very specific activities. It's
5 an area of high specialization, particularly in terms of
6 preventing transmission, and there are a lot of issues with
7 economics in those settings, and that is part of the reason
8 for purchasing large amounts of very expensive drugs that
9 aren't supposed to be reused.

10 Q Okay. How about -- I mean, this is a propofol
11 case.

12 A I know, but --

13 Q No, I mean --

14 A -- really, aren't economics --

15 Q No, I meant --

16 A You know --

17 Q Okay.

18 A -- but that is -- it is an economical issue --

19 Q Okay. Do you --

20 A -- I think.

21 Q Do you --

22 A In many cases it is less expensive per dose to
23 buy in large volume than in small volume.

24 Q Do you -- do you have any -- do you believe
25 like 50 cc propofols are cheaper by volume than 20 ccs?

1 A I have no knowledge in that area.

2 Q Okay. One article I didn't get from you, but

3 you may be familiar with,

4 A Yes.

5 Q Okay. It's called Injection Practices Among

6 Clinicians in United States Healthcare Settings.

7 A First off, that's from the place called the

8 Premier Safety Institute, so it's a private organization.

9 Q I can't find where these things are from.

10 A I can tell you.

11 Q Melissa Schaefer is one of the authors.

12 A The first author is Gina Pugliese. The

13 journal is American Journal of Infection Control. It's aimed

14 at nurse -- infection control nurses in the healthcare

15 facilities.

16 Q Bedside reading for --

17 A Well, for --

18 Q -- your kind.

19 A -- some of us.

20 Q This study or survey in 2010, or at least it

21 was published December 2010, study during --

22 MR. STAUDAHER: Could I at least see the article?

23 BY MR. WRIGHT:

24 Q -- May and June.

25 MR. STAUDAHER: I'd like to see the article, if I

1 could.

2 THE COURT: I'm sorry? Oh, you want to see it.

3 MR. WRIGHT: I'm sorry.

4 BY MR. WRIGHT:

5 Q May and June of 2010 is a survey of
6 approximately 5,446 clinicians, 90 percent of whom were
7 registered nurses. Okay?

8 A Uh-huh.

9 Q The -- and it was a survey dealing with
10 injection practices, syringe reuse, and multi-use of vials.
11 The respondents reuse -- I'm going to ask you a question after
12 this -- reuse syringe for additional doses from the same
13 multi-dose vial. Did you follow that?

14 A Uh-huh.

15 Q Okay.

16 A Yes.

17 Q A total of 797 respondents, 15 percent,
18 indicated that they are sometimes or always reusing a syringe
19 for additional doses from the same multi-dose vial for the
20 same patient. Okay?

21 A Yes.

22 Q And then of that group they were then asked --
23 that was 797 respondents -- were then asked about reusing the
24 vial that they had just reused the syringe on. In our study,
25 797 respondents, 15 percent, indicated that they sometimes or

1 always reuse a syringe for additional doses from the same
2 multi-dose vial for the same patient. They were then asked to
3 indicate the disposition of the multi-dose vial. 51 of the
4 797, 6.5 percent, who answered the question on disposition of
5 the vial indicated that they save the vial for reuse on
6 another patient. Okay?

7 A Uh-huh.

8 Q So that -- that's 51 of the practitioners in
9 this survey in 2010 did the double -- double danger; correct?

10 A Yes.

11 Q Okay. And that -- and that double danger
12 being not -- not only did they reuse needle syringe, same
13 patient, to redose, they then put it together with using the
14 remnants, the leftover in the vial on the subsequent patient;
15 correct?

16 A That's 6 percent of those whose said that they
17 reused, or is that 6 percent of the total?

18 Q No, no, 6 percent of the 15 percent.

19 A Okay.

20 Q 51 -- no, I'm -- 51 out of what I told you,
21 5,446.

22 A Actually responded to the survey.

23 Q Right, that's the --

24 A Is that the number of respondents?

25 Q Yes.

1 A And of those 15 percent said they sometimes
2 reused syringes to go to -- to back into a multi-dose vial.

3 Q Right.

4 A And of those 15 percent, 6 percent said --
5 said what they had done with the multi-dose -- but they reused
6 the multi-dose vial.

7 Q Right. So that would work out like 1
8 percent --

9 A Right.

10 Q I mean, 51.

11 A Right.

12 Q I mean, there's 51 practitioners in 2010, I
13 mean, still mixing together these --

14 A That's 1 percent.

15 Q Yes.

16 A Uh-huh.

17 Q Does that surprise you?

18 A It surprises me that it's that low.

19 Q Okay. Because?

20 A Because injection practices are so bad in --
21 in the places that we do the investigations that -- I
22 shouldn't actually -- I shouldn't say that it surprises me in
23 -- if these are general hospital based nurses, then I should
24 say it doesn't surprise me. It should be low. It's never
25 going to be -- I mean, I would be surprised if it was zero.

1 Then I would be suspicious. But it's a small number.

2 Q Well, it's -- it said the --

3 A No, we should be happy with that result.

4 Well, zero is not -- you know, as much as --

5 Q Okay.

6 A -- people would -- as much as we would all
7 like things to either be 100 percent or zero percent, that's
8 not reality. And I think that the fact that it's 1 percent is
9 quite good.

10 Q Okay. Where -- where would you think those
11 infractions were, outpatient or in the hospital?

12 A It could have been either.

13 Q You're right. It said although non-hospital
14 settings --

15 MR. STAUDAHER: Your Honor, I'm just going to move
16 to admit this if we're going to read from the whole document.
17 I mean --

18 MR. WRIGHT: I'm not --

19 MR. STAUDAHER: -- I don't have a problem with that.

20 THE COURT: Well, he can ask her specifically from
21 the document, or he can speak to admit it without your
22 opposition.

23 Go ahead, Mr. Wright.

24 BY MR. WRIGHT:

25 Q Our data indicates that some of the most

1 flagrant -- flagrant infractions, syringe reuse on multiple
2 patients with only a needle change and reentry into the
3 multi-dose vial, leaving it for reuse on another patient, are
4 being reported at least half of the time by professionals in
5 hospital settings. So it's about what you thought; correct?

6 A I said it could be either.

7 Q Right.

8 A That's what I said. It could be either.

9 Q Now, it identifies mistaken beliefs that
10 account for this failure of appreciation of the risks, and I
11 want to go through a couple of them. There are a number of
12 mistaken beliefs about the risks associated with syringe reuse
13 and aseptic technique when handling injectable medications
14 during preparation and administration that likely contribute
15 to many of the outbreaks of healthcare associated viral
16 infections such as hepatitis B and C. For example, there is a
17 belief that contamination is limited to the needle portion
18 when a syringe and needle are used together as a unit. Has
19 that been your experience that there is this mistaken, this
20 misapprehension out there?

21 A Yes, which means there's something wrong with
22 our education, medical education system.

23 Q Okay. And there is also an incorrect belief
24 that the syringe does not become contaminated if the plunger
25 is only pushed to inject, and not pulled to aspirate or

1 withdraw. What's aspirate mean?

2 A Withdraw.

3 Q Oh, okay. Okay. So they're -- they're --
4 this is an ongoing misperception or myth --

5 A Or ignorance. I mean, I really don't know
6 what to say that -- I don't know what to call it, but I will
7 tell you that I -- yes, I agree that they say -- they will say
8 that. And they will say, well, there's no blood in the
9 tubing. Well, you know, the germ theory of disease was
10 discovered by someone who was trying to explain that just
11 because you couldn't see it didn't mean it wasn't there. And
12 it's -- I honestly do not know why they believe this. They
13 really should know better.

14 Q Despite the availability of guidance on best
15 practices from CDC and other groups, it remains a lack of
16 awareness and implementation of these recommendations by many
17 clinicians. Agree with that?

18 A Yes. I don't think the -- yes.

19 Q Hold that thought. Have you seen M-1?

20 A Not recently.

21 Q Okay. You've seen it before?

22 A In different formats.

23 Q Okay. And is that -- well, you tell me what
24 that -- that's dealing with the persistent myths and what the
25 truths are to try to address the people who still aren't

1 onboard.

2 A That's correct. It's part of the campaign,
3 the one and only campaign.

4 Q Yeah, that's --

5 A One needle --

6 Q -- the name on it.

7 A -- one syringe, only one time.

8 Q Okay. Thank you very much.

9 MR. WRIGHT: I have no further questions.

10 THE COURT: Mr. Santacroce.

11 MR. SANTACROCE: May I proceed?

12 THE COURT: You may.

13 CROSS-EXAMINATION

14 BY MR. SANTACROCE:

15 Q Good afternoon, Doctor. I represent Mr. Lakeman
16 back there, and I'm going to ask you a few questions and try
17 to clarify some of your direct testimony. But before I do
18 that, I'm trying to understand exactly what the purpose of
19 your testimony is here today as you understand it. We've had
20 three epidemiologists testify in this case. All of them have
21 participated physically in the investigation of this outbreak.
22 And as I understand it, you haven't done that; correct?

23 A That's correct.

24 Q So what did you understand the purpose of your
25 testimony to be here today?

1 A I'm one of the world's experts on the
2 epidemiology of hepatitis C, and in particular it's
3 transmission patterns and in particular in healthcare
4 settings. And my understanding was to speak to those issues
5 as they relate to this particular outbreak.

6 Q And is this part of the consulting business
7 that you said you have?

8 A You might -- a business? It's like -- yes, I
9 suppose, except that I agreed to do this in 2008.

10 Q Okay. So while you were still employed at the
11 University of Texas?

12 A Yes, I was contacted by the sheriff's office

13 Q Clark County?

14 A Uh-huh. Yes.

15 Q And you were contacted in 2008 by the
16 Metropolitan Police Department?

17 A Yes.

18 Q Who contacted you?

19 A I would like to be able to tell you who it was
20 and, unfortunately, I can't remember his name.

21 Q Okay. And then in 2008 --

22 A Don't tell him.

23 Q I won't tell him. Well, is he sitting here?

24 A I have no idea.

25 Q Did you ever meet with him face to face?

1 A Did I meet -- no, actually, I didn't. Someone
2 else from -- they had a task force, I think, and someone else
3 came to see me at the university. Again, it would have been
4 at least a year later because Hurricane Ike occurred in
5 between.

6 Q Was it after the CDC had conducted their
7 investigation and issued their initial findings?

8 A Presumably.

9 Q Well, they did that in January of 2008. Was
10 your visit --

11 A It would have had to have been after January
12 2008.

13 Q And did they contact you and say, you know, we
14 have this theory. We have this theory as to the mechanism of
15 transmission and want you to validate that theory?

16 A No.

17 Q Okay. What did they want you to do?

18 A They wanted me to provide -- to be an expert,
19 a source of expertise in this area in hepatitis C transmission
20 in this setting.

21 Q So did they contact you throughout their
22 investigation from 2008 forward? Did they contact you --

23 A No, actually, I didn't hear from -- I then
24 talked to the -- Mr. Staudaher, who explained, you know, that
25 sort of what the -- my guidelines should be in terms of other

1 people calling me to discuss the case. The only thing I knew
2 about it were the things that I directly read. Actually, they
3 didn't tell me anything. They did not approach me with any
4 particular -- any particulars, the police.

5 Q Okay. Well, I'm still unclear as to what you
6 were to do for them. They contact you and they tell you we
7 want you to be an expert in this area because --

8 A You are an expert.

9 Q -- you're renowned for that. What did they
10 want you to be an expert to do? Did they give you anything
11 written, instructions, or here's a theory?

12 A No. They wanted me, I think, as an outside
13 observer and whose expertise is specifically in this area, and
14 I'm very experienced, to provide either -- to provide
15 information or --

16 Q Okay. And we don't --

17 A -- on this outbreak.

18 Q And what information did you provide to them.

19 A I provide to them directly?

20 Q Yes.

21 A The articles.

22 Q Okay. Well, the article I have -- one of the
23 articles I have from you was downloaded three days ago. So, I
24 mean, when did you provide it to them. When I --

25 A Three days ago.

1 Q -- mean them, I mean --

2 A Those articles.

3 Q -- Metropolitan Police Department.

4 A Then there were -- did I send that -- you have
5 to understand that our -- actually, there could have been
6 several years that went by between my first contact with Mr.
7 Staudaher and my next contact. I knew that until I was told
8 differently that there was the possibility that I would be an
9 expert witness for this case.

10 Q Okay.

11 A But it, obviously, went on quite awhile and I
12 just went on about my business.

13 Q How many contacts did you have with either the
14 District Attorney's office or the Metropolitan Police
15 Department either telephonically, emails, or person to person?

16 A A handful.

17 Q A handful? Six? Five? Six.

18 A Want me to look? I can look on my phone and
19 see how many emails I have. There are not many.

20 Q Okay. So a few?

21 A Well, that's a handful to me.

22 Q Depends on which hand your using.

23 A I know. I know, but really it's -- there
24 weren't that many. In fact, there weren't that many. They
25 provided me with, you know, the final reports, which one of --

1 which are all public anyway. And --

2 Q When did you get those reports?

3 A Well, I already had them, but the District
4 Attorney's office provided them to me in the last few months.
5 I want to say maybe -- well, earlier this year. Okay. I'm
6 sorry, I just --

7 Q So earlier this year you get the trip report
8 from the CDC from the District Attorney's office.

9 A From their office. I already had everything.

10 Q And then you get from their office what else?

11 A The Southern Nevada County -- the district
12 report.

13 Q Okay.

14 A And -- and 18 exhibits or 25 exhibits, or
15 whatever all the exhibits were that had been filed at that
16 time.

17 Q Did you get the report, statement of
18 deficiencies from the BLC, the Bureau of Licensing and
19 Certification?

20 A I remember it being mentioned, I mean, in my
21 reading. But I don't -- if it was an exhibit, then I got it.
22 If it isn't -- wasn't, then I didn't.

23 Q Well, I'm asking you what your recollection --

24 A I know. Well --

25 Q -- of what you received.

1 A -- I don't remember seeing the report and -- I
2 don't remember seeing the report.

3 Q Okay. You need to let me finish my question
4 before --

5 A Sorry.

6 Q -- answer, okay? Because --

7 A Yes, I --

8 Q -- we're recording.

9 A -- apologize. I apologize.

10 Q You're doing it again. We're recording this,
11 okay. And the record has to be very clear. Okay. Was --
12 were you being compensated for this by the District Attorney's
13 office or Metro or citizens of Clark County?

14 A Since I no longer work for the government, I
15 do have -- I am going to be compensated, but I haven't been
16 compensated as yet. I haven't even submitted a voucher.

17 Q Okay. But you're getting compensated for your
18 testimony here today?

19 A Yes.

20 Q And for any work you did previously on the
21 case?

22 A For the number of hours that I did to review
23 the documents, yes.

24 Q And -- and what is your compensation that
25 you're receiving? How much is it?

1 A For today, I don't know. But for -- you can
2 see I'm a real business person. My hourly rate for reviewing
3 documents or writing reports is \$450 an hour.

4 Q And what is your fee for testifying in court?

5 A This is the first time I've done it as a
6 private citizen, so to speak, and so I have no idea.

7 Q Okay.

8 A Well, I shouldn't say I have no idea, but --

9 Q Well, what's the idea you have?

10 A Well, let me put it to you this way, okay.
11 Well, we have -- we didn't agree on anything. To be quite
12 honest, I still think of myself as a public service.

13 Q Well, let's surprise them right now and tell
14 them --

15 A Well, what I'm going to --

16 Q -- how much.

17 A -- let me tell you that I looked up what other
18 -- what physicians do who have to take off, you know, and it's
19 -- it's so far above what I would even consider that -- you
20 know, they charge 5,000, \$6,000 a day for testimony. And if
21 it's out of town it's more. We're not even --

22 Q Are you from out of town or do you live here
23 now?

24 A I'm from out of town.

25 Q Well, where -- where do you reside?

1 A I reside in Galveston, Texas.

2 Q So you were flown in here today for your
3 testimony?

4 A I flew in last night.

5 Q Well, it's safe to say you're not going to be
6 charging less than \$450 an hour for testifying here today;
7 right?

8 A Yes, I am, probably.

9 Q Oh, you are?

10 A Well, I would do it as a lump sum. I didn't
11 count the number of hours, you know, in the day. I'm not
12 going to charge them by hour since I left home. I just can't.

13 Q I might get --

14 A I'm just not --

15 Q -- into contract negotiations --

16 A -- that way.

17 Q -- after this career is over.

18 A I told you. It's not a business. It's just,
19 you know --

20 Q Okay.

21 A It's something that I do when I believe in
22 something.

23 Q All right. So let's get back to what you --
24 you were supposed to do here. You reviewed certain documents
25 from the CDC, from the Health District, and from someplace

1 else. I don't know where else, but some articles or
2 something?

3 A Well, I -- in the course of my career, I've
4 read or reviewed almost all of the articles that are currently
5 in the literature since I've written reviews and editorials
6 and --

7 Q And so now you have -- at some point you have
8 the Southern Nevada Health District Report and you have the
9 CDC trip report?

10 A And their publication in -- and their
11 publication in the journal.

12 Q And then from that, you read all of that, and
13 you came up with an opinion, or you validated their opinion,
14 one or the other. Which was it?

15 A I don't know. I -- I -- it was already -- I
16 guess I validated their opinion.

17 Q Okay. Now, did you review or look at anything
18 else other than what you've told us here today?

19 A You mean other than the literature, the
20 publications and the literature and the major reports from the
21 CDC and the Health District --

22 Q Right.

23 A -- and the exhibits that were on file, which,
24 you know, were line listings of specimens and patients and
25 things. I don't think so --

1 Q Okay.

2 A -- to the best of my recollection.

3 Q And your opinion was basically supporting the
4 CDC's opinion that the mechanism of transmission in this
5 particular case was the unsafe injection practices at the
6 clinic; is that correct?

7 A Yes, that's correct.

8 Q And what methodology did you employ to come up
9 with that opinion?

10 A I reviewed the methodology for both the
11 epidemiologic investigation, the -- as well as the laboratory,
12 as well as the virus sequencing performed in the laboratory,
13 and then for which I had the results to determine if I agreed
14 with the methods that were used and the conclusions that were
15 drawn from those methods.

16 Q Okay. Were you aware when the CDC conducted
17 their investigation that they were not sure as to which
18 patient was in which room at which time?

19 A I was -- I am aware from reading the reports
20 that it was -- that the records were very inaccurate.

21 Q Okay. How many --

22 A That's all I can --

23 Q How many procedure rooms were at Shadow Lane
24 on July 25, 2007?

25 A Two. I don't know.

1 Q Is that a guess?

2 A Yes, that's a guess.

3 Q How many procedure rooms were at Shadow Lane

4 on September 21, 2007?

5 A I know that they did 65 procedures.

6 Q And the question I asked you was how many --

7 A I'm sorry.

8 Q -- procedure rooms.

9 A I don't know.

10 Q Okay.

11 A Or don't recollect.

12 Q Okay. So my question was were you aware that

13 the CDC did not know which rooms the patients were in and at

14 what times when they conducted their investigations?

15 A No.

16 Q You were not aware of that?

17 A Well, no, not specifically at the time they

18 conducted their investigation, no.

19 Q Were you aware that they didn't know that

20 information when they issued their initial findings?

21 A No. What I was --

22 Q That's -- that's all I need to know. Were you

23 sent copy of Exhibit -- State's Exhibit 156 and 157 as part of

24 your examination?

25 A Yes.

1 Q So you looked at these?

2 A Yes.

3 Q And when did you receive these documents?

4 A In the last couple weeks, sometime in the last
5 couple of weeks.

6 Q Okay.

7 A Like three weeks ago, maybe, four weeks ago.

8 Q When did you reach your conclusion or concur
9 with the CDC's finding?

10 A After reading the reports. It had nothing to
11 do with this.

12 Q It had nothing to do with this. So you
13 reached your conclusions before you saw these two exhibits?

14 A That's right because I reached my conclusions
15 based on the epidemiological investigation.

16 Q Were you aware that the CDC did not interview
17 the RN that administered the heplock on September 21, 2007?

18 A I don't know.

19 Q Were you aware of the cleaning practices for
20 the endoscopes and the biopsy forceps for September 21, 2007?

21 A I read the methods that were used in -- in the
22 reports, they were quite detailed, for the scopes. The biopsy
23 forceps were apparently -- they talked about some reuse of
24 disposables, I guess, that -- a practice that had been
25 stopped. But regardless, there was the investigation. The

1 results of the investigation indicated that there was no
2 association between getting infected and those pieces of
3 equipment.

4 Q Okay. Tell me what you understood the
5 cleaning procedures to be for the endoscopes.

6 A It was a very long -- it was a very long and
7 detailed explanation that involves the cleaning of the scope,
8 the rinsing of the scope. Manual cleaning is extremely
9 important. You have to get all of the organic debris that
10 might be in there out before the disinfectant can work.
11 Because organic matter like blood and things can prevent the
12 disinfectant from getting to the actual scope or germs that
13 might be left there, something that a lot of people don't
14 appreciate. And then they had a -- they have a machine that
15 then reprocesses the -- these scopes for high level
16 disinfection.

17 Q What's the difference between disinfection and
18 sterilization?

19 A High level disinfection actually kills
20 everything but bacterial spores. Sterilization also kills
21 bacterial spores.

22 Q And how was the clinic cleaning bite blocks
23 and biopsy forceps on September 21, 2007?

24 A The biopsy forceps, I'm not sure. The
25 cleaning blocks -- I mean, I'm sorry, the bite blocks I'd have

1 to look at the report. I just -- again, while I was aware
2 when I was reading these reports, it's the epidemiological
3 methodology they use to look at exposures associated with
4 infections that I was -- that I'm focused on and whether or
5 not they considered sufficient -- you know, they considered
6 the issues of importance in that -- in the setting. That's
7 what I was looking at. I'm an epidemiologist. That's what my
8 expertise is in this disease area.

9 Q Well, Doctors Langley and Schaefer testified
10 that prior to coming to Las Vegas they had a theory or
11 hypothesis that the infection was transmitted through unsafe
12 injection practices.

13 MR. STAUDAHER: Objection. Mischaracterizes their
14 statements, Your Honor.

15 BY MR. SANTACROCE:

16 Q But they didn't rule out of other mechanisms.

17 THE COURT: And that's -- that's overruled. And, of
18 course, I've told the ladies and gentlemen of the jury if
19 anyone, you know, prefaces a question with a statement of what
20 the testimony was and that's not your recollection of what the
21 testimony was, it's your collective recollection that's
22 important, not something the lawyers may say or something that
23 I may say as to what the testimony was.

24 BY MR. SANTACROCE:

25 Q So they looked at other mechanisms of

1 transmission.

2 A That's correct.

3 Q Okay. One of those mechanisms was scopes;
4 correct?

5 A Yes.

6 Q And you -- you ruled out that theory because
7 they ruled it out; correct?

8 A I ruled out the theory by looking at the data
9 they generated to show that there was no association.

10 Q Okay. What data did they generate?

11 A There's -- they showed the frequency with
12 which, you know, the -- the use of the scopes, you know,
13 depending on whether you got an upper GI or a colonoscopy,
14 they looked at the frequency of the specific procedures and
15 those people who got infected versus those people who didn't.
16 That's -- that's how you --

17 Q I'm talking about the cleaning of the scopes.

18 A Hold on. You asked me how I drew that
19 conclusion.

20 Q Right.

21 A Okay. That, in addition -- that was most
22 important. But also I thought that regardless of a few
23 deficiencies cited as like the detergent used --

24 Q And you thought those deficiencies were minor?

25 A Actually, from the point of view of

1 blood-borne virus transmission, yes.

2 THE COURT: Mr. Santacroce, we're going to need to
3 take a break now --

4 MR. SANTACROCE: Okay.

5 THE COURT: -- so I'm going to interrupt you.

6 Ladies and gentlemen, we're going to take a brief
7 recess. During the brief recess you're reminded that you're
8 not to discuss the case or anything relating to the case with
9 each other or with anyone else. You're not to read, watch, or
10 listen to any reports of or commentaries on this case, any
11 person or subject matter relating to the case. Don't do any
12 independent research. And please do not form or express an
13 opinion on the trial.

14 Notepads in your chairs and follow the bailiff
15 through the rear door.

16 (Jury recessed at 2:37 p.m.)

17 THE COURT: What do we have to look forward to for
18 the rest of the day?

19 MS. WECKERLY: Well, we have Dr. Lewis and then we
20 have the --

21 THE COURT: And that's Ms. Grueskin's physician;
22 correct?

23 MS. WECKERLY: That's correct.

24 THE COURT: So we have to do him today, which I'm
25 good with.

1 MS. WECKERLY: Okay. And then we have an insurance
2 person, and then --

3 THE COURT: Well, Ms. Stanish says she has all the
4 records, so that should go smoothly.

5 MS. WECKERLY: She's good with this one.

6 THE COURT: Yeah, so that should go smoothly.

7 MS. WECKERLY: And then -- well, we have -- we have
8 -- I mean, one thing we could do is we have Bob as the
9 witness, but I have a doctor for tomorrow, so I can --

10 THE COURT: Is that Romie?

11 MS. WECKERLY: No, Jurani.

12 THE COURT: That's his name Romie Jurani.

13 MS. WECKERLY: I thought it was Patero.

14 THE COURT: Well, I think it's his nickname.

15 MS. WECKERLY: Oh, okay. Maybe.

16 (Off-record colloquy.)

17 THE COURT: In any event. Does that mean we're
18 done?

19 MS. WECKERLY: You mean for tomorrow, then?

20 THE COURT: Right.

21 MS. WECKERLY: Well, with Dr. Olson, and then part
22 two of the other --

23 THE COURT: Right. And then that's it?

24 MS. WECKERLY: That's it.

25 THE COURT: So you're not calling Dr. Jurani at all?

1 MS. WECKERLY: No, because he doesn't really --
2 THE COURT: Okay.
3 MS. WECKERLY: I mean, he doesn't say anything that
4 -- that I don't think we've covered.
5 THE COURT: Okay. All right.
6 MS. WECKERLY: And another GI tech. Just kidding.
7 (Court recessed at 2:39 p.m., until 2:55 p.m.)
8 (In the presence of the jury.)
9 THE COURT: All right. Court is now back in
10 session.
11 And, Mr. Santacroce, you may resume your
12 cross-examination.
13 MR. SANTACROCE: Thank you.
14 BY MR. SANTACROCE:
15 Q You were talking about what you described as
16 insignificant lapses in the cleaning of the scopes. Were you
17 aware that the BLC actually observed the cleaning of the
18 scopes, ma'am?
19 A I know that the cleaning of the scopes was
20 observed.
21 Q Do you know that the BLC was part of the
22 investigatory team, along with Southern Nevada Health District
23 and the CDC?
24 MR. STAUDAHNER: Objection --
25 THE WITNESS: Yes.

1 MR. STAUDAHER: -- Your Honor. That's not actually
2 correct. They weren't part of the investigatory team. They
3 investigated separately.

4 THE COURT: Well, okay. They -- they were involved
5 in investigating. Is that your understanding?

6 THE WITNESS: Yes.

7 THE COURT: Okay.

8 THE WITNESS: Well, they were present when groups
9 were represented.

10 THE COURT: Okay.

11 BY MR. SANTACROCE:

12 Q And you understand that they issued a summary
13 statement of deficiencies; correct?

14 A I saw the statement of such, yes.

15 Q Okay. Well, I'm going to show that to you now
16 as Exhibit 80 E-3. This is their statement for the Shadow
17 Lane clinic. And it notes that on January -- I'm not sure if
18 it's a 6 or an 8, 2008. The GI technician was asked to
19 describe the measured amount of EmPower with what amount of
20 water. The GI tech stated add two to three pumps, not sure of
21 the capacity of the basin, I do not have an answer to that.
22 Were you aware the GI tech didn't even know how much
23 sterilizing fluid to use, the ratio between the water and the
24 sterilizing fluid?

25 A No.

1 they should be scheduled in the practice?

2 A Not that I was aware of.

3 Q This was the sort of the format that you had?

4 A That's how he specifically wanted it, that's how

5 I specifically wrote it.

6 Q And when I asked you the question about
7 PacifiCare, were you under any -- during anytime that you were
8 there, did you become aware of sort of an order that
9 PacifiCare patients had to be done?

10 A Not until later.

11 Q When you talk about later, are we talking
12 about -- well, let's use as a benchmark the investigation.
13 You know -- and I'm talking about the CDC investigation.

14 A Mm-hmm.

15 Q Was it after they came or before they came?

16 A After.

17 Q So this was something that you implemented at
18 his direction but you didn't -- did you understand what --
19 what the implications were?

20 A No. I was very busy. And I don't mean to be
21 disrespectful.

22 Q I'm going to move forward now to a couple
23 things, and I just want to -- those -- those records that you
24 showed, those were things that you've seen before in the
25 clinic, those documents and memos and so forth?

1 A Yes, sir.

2 MR. STAUDAHER: And I want to move for their
3 admission at this point, but I know counsel's still looking
4 through them.

5 BY MR. STAUDAHER:

6 Q With regard to the 30-minute issue, did that
7 ever become a problem at some point? And I'm talking about
8 before the investigation at CDC, at any time was there any
9 issue with that that had arose, but before January of 2008?

10 A Actually, yes. In 2007, Dr. Carrol had been
11 sued by a patient, Rexford. And in that lawsuit I was
12 deposed, the CRNA was deposed, and Dr. Carrol, of course, was
13 deposed. So one of the things they were questioning was the
14 CRNA time. I don't remember which CRNA it was. So it kind of
15 happened simultaneously. The lawsuit was later part of 2007,
16 the testimony happened in 2008, and the CDC thing happened in
17 2007.

18 And then there was a moment where, I don't remember
19 which CRNA, Dr. Carrol came screaming up to my office, by this
20 time I was located upstairs, saying and showing me one of the
21 papers that one of the CRNAs -- I can't -- I don't remember
22 which one, prefilled out an anesthesia form. He was livid.
23 He was screaming. It was a mess. So he --

24 Q Before that happened, did you have any
25 indication that there was any problem like that beforehand?

1 A We did have one with the nurses, the RNs. Katie
2 and Jeff had brought up an issue of the RNs precharting
3 something in their chart. We did bring that to Dr. Desai,
4 Katie, Jeff and myself.

5 MR. WRIGHT: Foundation.

6 THE COURT: When did that happen? And again, you
7 know, we don't expect you to say, oh, that was, you know,
8 July 15th at 11:45. We get, you know --

9 THE WITNESS: I want to say 2007, 2000 -- 2007, early
10 part of 2007.

11 THE COURT: So Katie and Jeff came to you with their
12 concerns, and then the three of you went to Dr. Desai?

13 THE WITNESS: Yes.

14 THE COURT: Okay.

15 BY MR. STAUDAHER:

16 Q So what happens in that meeting?

17 A Dr. Desai was very angry, I mean, first of all
18 that we were questioning him and what took place and so forth.
19 So he proceeded to yell. Everything calmed down and the
20 precharting stopped.

21 Q So the concern was brought to Dr. Desai. Did he
22 seem surprised by what you were bringing him, or just angry?

23 MR. WRIGHT: Could I have foundation as to the
24 conversation --

25 THE COURT: Well, can get there.

1 MR. WRIGHT: -- what the precharting --

2 THE COURT: Overruled. I mean, some of this you can
3 follow up with on cross, and some of it Mr. Staudaher, you
4 know, may get to the specifics.

5 THE WITNESS: I don't know exactly what they were
6 precharting. I think, if I remember correctly, it could have
7 been vital signs or something like that.

8 BY MR. STAUDAHER:

9 Q So you go with Katie and Jeff to tell Dr. Desai
10 about this?

11 A Right. Because Katie brought it to my
12 attention. Jeff was there. It was always better to approach
13 him with three or more.

14 Q So when you say he was angry, was he angry
15 because he was outraged about what was going on, or was he
16 angry because --

17 A Because he thought it was a small --

18 MR. WRIGHT: Objection, Judge.

19 THE COURT: That's sustained. Only --

20 MR. WRIGHT: Just what was said.

21 THE COURT: I sustained the objection, Mr. Wright.
22 If I sustain it you don't have to --

23 THE WITNESS: Dr. Desai --

24 MR. WRIGHT: They caught me off guard.

25 THE COURT: Wait, wait, wait. When an objection is

1 sustained, that means you can't answer the question. What you
2 can say is if Dr. Desai said something, you know, I'm angry
3 because or, you know, you can tell us what he said. But don't
4 like speculate as to what he was thinking or what was going on
5 in his head unless he tells you. That's basically --

6 THE WITNESS: It's very obvious when Dr. Desai is
7 angry. The voices get loud. The voice tone got loud. We
8 were wasting his time.

9 THE COURT: Was that said to you?

10 THE WITNESS: Yes.

11 THE COURT: Okay.

12 BY MR. STAUDAHER:

13 Q So he was mad because you were wasting his time?

14 A [No audible response.]

15 Q Was he angry at all because of what you were
16 bringing him, the actual information you were bringing him?

17 A No.

18 Q Now, with regard to the 31-minute issue again,
19 or 30-plus minute issue, whatever it was, when you have
20 essentially Dr. Carrol coming up to your office, beside that
21 one instance with charting and so forth with Katie and Jeff,
22 had there ever been an issue to your knowledge about any kind
23 of 30-minute time period that was being billed?

24 A No.

25 Q Were you aware -- well, I think you had

1 testified before that Dr. Desai told you that that's what it
2 needed to be though, correct?

3 A From the start time to the end time.

4 Q And that that was this --

5 A It should be around -- he didn't give -- he
6 never gave specific like time frames.

7 Q But didn't you testify that he said it should be
8 greater than 30 minutes?

9 A It should be -- yes, the more than 30 minutes,
10 but he didn't say 30, 31, 35 or anything like that.

11 Q Just more than 30?

12 A Mm-hmm.

13 Q Now, when -- when that occurs -- that's the
14 policy you said was in place forever, since the CRNAs started
15 essentially?

16 A Mm-hmm.

17 Q Now, when this issue comes up when Carrol comes
18 up to your office and he's got this anesthesia record, had any
19 other doctor ever raised this to you before?

20 A No.

21 Q So when he brings it to you, what do you do?

22 A First I tried to calm him down, because he
23 was -- like I said, he was livid. I called up the CRNAs from
24 downstairs, had them come up, and they --

25 MR. WRIGHT: I would interpose an objection, and just

1 give us a time frame.

2 THE COURT: Was this the --

3 THE WITNESS: Within ten minutes --

4 THE COURT: Okay.

5 THE WITNESS: -- after he calmed down.

6 MR. WRIGHT: Just this meeting.

7 THE WITNESS: I mean, he's this short little Jewish
8 guy. He was extremely mad. I mean, he was livid because of
9 the Rexford case and couldn't believe all this with the CDC
10 thing. So got him calmed down to some extent, brought up the
11 CRNAs.

12 I can't -- I know it was -- I think it was Vince
13 Mione, Vinnie Sagendorf, and maybe one or two others, whoever
14 was on the floor downstairs. And he reiterated and I
15 reiterated to them that their time had to be absolutely
16 accurate. He also got on the phone with Dr. Mason --
17 BY MR. STAUDAHER:

18 Q Is he still angry during this whole time?

19 A Yes, he's still angry.

20 Q So he gets on the phone --

21 A But he's composed more. He's a little bit more
22 composed.

23 THE COURT: So Dr. Carrol gets on the phone with
24 Dr. --

25 THE WITNESS: Dr. Phone -- Dr. Carrol picks up the

1 phone on my desk, calls over to Dr. Mason and tells him what
2 he finds, and he wants him to make sure that that's not
3 happening at Desert Shadow Endoscopy.

4 MR. WRIGHT: Can we have a time frame for this? I
5 missed it.

6 THE WITNESS: The whole thing took about 35 minutes.

7 MR. WRIGHT: I mean when did the 35 minutes take
8 place?

9 THE WITNESS: Sometime in February.

10 MR. WRIGHT: Of 2008?

11 THE WITNESS: Of 2008.

12 MR. WRIGHT: Thank you.

13 THE WITNESS: So the CRNAs just, they listened, they
14 said okay and they went back downstairs. Dr. Carrol was still
15 upset. He went downstairs to Dr. Desai's office. I followed
16 him downstairs to Dr. Desai's office, which is in the corner
17 of Shadow Lane building. He starts yelling. Dr. Desai starts
18 yelling. Dr. Desai tells me get the hell out of the room and
19 close the door.

20 I got out of the room, but I did stand there because
21 I didn't want the staff outside the door. They continued
22 their conversation, or disagreement. Dr. Carrol left upset.

23 THE COURT: Could you hear the -- don't say what was
24 said, but could you hear them yelling through the door?

25 THE WITNESS: Yes, I could. I think everybody in

1 the -- the rooms were this way [indicating].

2 THE COURT: It was loud?

3 THE WITNESS: It was very loud.

4 THE COURT: Go on, Mr. Staudaher.

5 BY MR. STAUDAHER:

6 Q So after, after Carrol leaves, what do you do?

7 A After Carrol leaves, which was about ten
8 minutes, maybe not ten -- I don't know. It seemed like
9 forever. After Carrol left, I went back to go talk to Dr.
10 Desai and he dismissed me, and he was mad and didn't want to
11 talk to me really, said, Don't worry about this. And I -- of
12 course, I was upset to see them like that.

13 That's really how it was left. Dr. Carrol left.
14 Dr. Desai was in his office. He was upset.

15 Q So let me ask you this. I'm going to stop there
16 for a moment and go back upstairs with when Dr. Carrol
17 confronts you with this anesthesia record and tells you what
18 he's seen. Did that -- I mean, when you heard that, saw the
19 record, was that a record that you used in your billing
20 company?

21 A Yes.

22 Q When you saw and heard what he was saying, did
23 that affect you in any way?

24 A Absolutely. It's --

25 Q How so?

1 A Well, we processed what they wrote down, and so
2 obviously I'm thinking if they're pre-doing this, this stuff
3 that we're not processing is not accurate and correct.

4 Q So you knew --

5 A Yeah, and I'm upset.

6 Q Did you know what the implications of that were?

7 A Of Medicare and Medicaid fraud, yes.

8 Q So you --

9 A Insurance fraud, yes.

10 Q So you knew that that was going to an insurance
11 company though?

12 A Yes.

13 Q After this all takes place, you get dismissed
14 from the clinic, do you stay in the clinic that day?

15 A I think I left as well. I think I was in shock
16 and like I said, Dr. Carrol and Dr. Sharma -- I mean, Dr.
17 Carrol and Dr. Desai, they've had arguments, but never to that
18 extent. I was probably shaken up, because I knew what
19 implications it would be for me personally in my company. So
20 I'm confident that I did leave the facility that day.

21 Q Where'd you go?

22 A Either to a meeting or home. I can't remember.

23 Q When was the next time you spoke with or saw
24 Dr. Desai?

25 A I can't remember exactly when. Two to three

1 days later.

2 Q Was this in person or on the phone?

3 A In person.

4 Q Did he ever call you at any time during that
5 window period to talk to you?

6 A I don't remember.

7 Q So when you see him again, tell us how that
8 goes.

9 A I go down and I see him and I tell him, you
10 know, what my concerns were. I mean, I respected him and I --
11 it was a different relationship. I told him what my concerns
12 were, you know, and the whole thing with Dr. Carrol and so
13 forth. And he would say, Darling, it's taken care of, there's
14 no problem, the times are right to the start time, to the end
15 time, so forth.

16 Q When you told him your concerns, what did you
17 actually tell him? What were your concerns when you were in
18 this room?

19 A There was two meetings.

20 Q Okay. Let's talk about the first one. What
21 time period are we talking about?

22 A Two to three days afterwards.

23 Q Okay. So two meetings. Did they occur the same
24 day --

25 A No.

1 Q -- or were they separated?

2 A No, they didn't.

3 THE COURT: Had it been a weekend or something that

4 you didn't --

5 THE WITNESS: I think it was like a Thursday --

6 THE COURT: Okay. And that's why --

7 THE WITNESS: -- to be honest with you.

8 THE COURT: -- it was a couple of days to --

9 THE WITNESS: Right. I think it was like a Thursday

10 or something like that. I can't remember the exact date. But

11 I want to say it was a Thursday because it gave Dr. Carrol

12 time to calm down when he came back Monday, you know.

13 BY MR. STAUDAHER:

14 Q Okay. So let's talk about the first meeting.

15 Where --

16 A The first meeting that I had --

17 Q -- does it take place?

18 A -- with Dr. Desai when I was scared, or when I

19 thought all this stuff was going on?

20 Q Yes. Where did it take place?

21 A In his office. We often met in his office

22 downstairs.

23 Q And this is the two to three days later?

24 A Two to three days later.

25 THE COURT: So would that have been on like a Monday

1 after the weekend, or...

2 THE WITNESS: Monday or Tuesday.

3 THE COURT: Okay. So there's the -- kind of the
4 blow-out between Carrol and Desai, you go home, and then it's
5 a few days, maybe a weekend, and then you meet with Dr. Desai
6 early the next week?

7 THE WITNESS: Yes.

8 THE COURT: And that would have been in Dr. Desai's
9 office?

10 THE WITNESS: Mm-hmm.

11 THE COURT: Is that yes, for the record?

12 THE WITNESS: Yes. I'm sorry.

13 THE COURT: And it's just the two of you at this
14 first meeting?

15 THE WITNESS: Yes. I mean, I talked to him a lot by
16 myself.

17 THE COURT: No, just to make it clear.

18 THE WITNESS: Yes, it was.

19 THE COURT: All right. Go on, Mr. Staudaher.

20 BY MR. STAUDAHER:

21 Q So tell us what the concerns were that you
22 voiced to him at that time.

23 A I voiced to him, you know, the concerns of, you
24 know, the precharting and making sure the times -- and he
25 reassured me. He goes, Tonya -- he used to call me darling or

1 he'd call me other endearing names sometimes -- don't worry.
2 He goes, It's okay, they'll write the time down, they'll write
3 what needs to be done, we're fixing anything that needs to --
4 and that was it.

5 Q So at that point, I mean, you had mentioned you
6 were concerned about insurance fraud, things like that. Did
7 you voice that to him at the time?

8 A I did. I did voice it to him.

9 Q What was his response?

10 A That the times were accurate. And he went back
11 to the time they start interviewing and the time that the
12 patient was safe, because they were still in the care of the
13 CRNA, that the CRNA was responsible for that patient, if I had
14 a problem that CRNA would be the one reviving me. So I felt a
15 little bit more comfortable at that point.

16 Q That's what he's telling you though?

17 A That's what he was telling me.

18 Q So you said that there was a second meeting
19 later on.

20 A There was a second meeting which didn't --

21 Q Well, wait. Before we get there, your billing
22 company at this point, do you try to find out what's going on
23 with that with regard to the records that are coming over from
24 the Endoscopy Center to your company to be billed?

25 A Yeah. I mean, obviously as the owner of a

1 company, I went over to make sure my billers were putting
2 exactly what the CRNAs put their start time, end time and made
3 sure, and it did match. What had happened though, is one of
4 my data entry clerks and my billing manager contacted me after
5 this whole blow-out with Dr. Carrol, Dr. Desai, and the
6 anesthesia time went from eight minutes, ten minutes, 12
7 minutes, from 30, whatever, 20, 30, 31, 35 minutes.

8 Q So you say it went from eight to 30?

9 A No. It went from high number, 30, 35, down to
10 eight, ten, 12 number.

11 Q So less than 15 minutes?

12 A Yes.

13 Q Okay. Does that give you concern when you hear
14 that?

15 A Absolutely. I told Brian --

16 Q Before we go any further, the records that are
17 coming in, is this just an isolated one or two, or how many of
18 these are coming over in that way?

19 A I would say a significant amount that where a
20 new employee noticed the difference.

21 Q And called you?

22 A And called myself and the manage -- my billing
23 manager. And I told him bill whatever time is on the sheets.
24 The next -- the next day I went in early, because Dr. Desai
25 would do his prayer in the morning or whatever and I knew he

1 would be early. And I went in there and I showed -- and I
2 talked to him. And I told him that the times are
3 significantly different. I told him that he's putting my
4 family at jeopardy, my business at jeopardy and so forth.

5 Q How does he respond to this?

6 A That conversation he was very angry, and I don't
7 know if it was because of everything else that was going on
8 with the CDC. He started cussing. He started swearing. He
9 was just extremely upset.

10 Q Did he deny it at all, that that was a problem?

11 A No.

12 Q Did he acknowledge that what you were saying was
13 accurate?

14 MR. WRIGHT: Could I have foundation, what was said?

15 THE COURT: I think she already said, so overruled.

16 BY MR. STAUDAHER:

17 Q Was there anything else said?

18 THE COURT: I mean, I guess the question would be
19 what did Dr. Desai say.

20 THE WITNESS: What, you mean his cuss words?

21 THE COURT: No, no. It might be entertaining, but
22 no, that wasn't my question. When Mr. Staudaher said did he
23 acknowledge something, and I guess, you know, what did he say?

24 THE WITNESS: He didn't address my concerns because I
25 have never been that upset with him. I -- I actually cared

1 about him. So when this all came across, it was very
2 overwhelming because of the hepatitis C thing, then this.
3 So -- can I just take a minute?

4 THE COURT: Sure, of course.

5 (Pause in proceeding.)

6 THE WITNESS: I worked for him for a very long time,
7 and the whole idea is -- oh, anyways. Go ahead.

8 So the -- so I was very upset because I knew what the
9 problem was going to be, and he was very angry and I know that
10 it had to do with all the stresses that he was under.

11 BY MR. STAUDAHER:

12 Q So when you say you knew what the problem was
13 going to be, what are we talking about?

14 A Well, obviously if -- if we were getting
15 information from the CRNAs 30 minutes, 31, 35, 20, these high
16 numbers, and then within one week of Dr. Carrol's meeting the
17 anesthesia time went in less than half, there's a problem.

18 Q What is that problem?

19 A We weren't processing accurate times. They must
20 have been precharting. I don't know.

21 Q When you said that you were -- you confronted
22 Dr. Desai and you said that, if I have it correctly, you put
23 me at risk, you put my family at risk, my business at risk,
24 what is the risk that you're talking about?

25 A Well, exactly what -- I can't go into there. So

1 I mean, obviously he put --

2 Q Were you worried about your own liability in all
3 this?

4 A Well, yes, because I'm the billing company. I'm
5 the one who's relying on the information given to me by the
6 licensed professionals. If somebody said they had gall
7 bladder removal and I had a surgeon give me a gall bladder
8 removal, I would bill a gall bladder removal.

9 Q So you were assuming what was given to you was
10 accurate?

11 A Yes, absolutely.

12 Q Now, after -- after he yells at you and the
13 like, I mean, how does this end?

14 A We agreed not -- I told him I -- I couldn't do
15 his billing anymore.

16 Q So you're going to stop doing his billing?

17 A Yes.

18 Q Did you do that?

19 A Yes. He told me I had to finish up what I
20 started, at the end he would get it changed over, get it over
21 to Ida. And I was fine with that.

22 Q So what's the next thing that happens after
23 that?

24 A Well, the facilities were getting shut down.
25 The business licenses were getting yanked. There was a lot of

1 things going on with that. So the billers boxed all the
2 information up, and I couldn't tell you what happened after --
3 I know we stopped doing the billing.

4 I mean, I think that was like it was happening in
5 February. So maybe March is when we were finished and he paid
6 us the residual money that we worked for and finished that
7 out, and I just continued with my other doctors that we
8 performed services for. We laid the staff off.

9 Q So you did billing for other doctors?

10 A I did.

11 Q Was this ever an issue with any other doctor you
12 worked with?

13 A No.

14 Q Now, as far as your interaction with Dr. Desai
15 after that time period, when things are shutting down and
16 after this sort of blow-up meeting that you have with him, the
17 second one, did you have further communication with him about
18 anything?

19 A Yes, I had communication with him. I mean, I
20 helped him shut down -- I didn't quit working for him until
21 2009. I helped him shut down his facilities. I helped him
22 reset up an office for his billing department, and helped him
23 get the medical records and worked with the attorneys to get
24 medical records for patients.

25 MR. SANTACROCE: I'm going to ask for a cautionary

1 instruction at best, not to the jury, but to the witness.

2 THE COURT: Okay. Again, don't get into, you know,
3 conversations with the lawyers.

4 I'll see counsel up here. You meant for like the
5 civil loss?

6 MR. STAUDAHER: I'm not going to ask anything about
7 lawyers, Your Honor, so.

8 THE COURT: Okay.

9 THE WITNESS: I was just getting the medical records
10 ready.

11 THE COURT: Okay. So for if --

12 THE WITNESS: They were like medical requests we had.

13 THE COURT: From the civil lawsuits, when people --

14 THE WITNESS: There were seven staff members.

15 THE COURT: -- wanted their medical records?

16 THE WITNESS: Right.

17 THE COURT: Okay.

18 THE WITNESS: Or legal counsels, when they wanted
19 stuff too. I will get those --

20 MR. STAUDAHER: My question is --

21 THE COURT: Right. You would help -- somebody sent
22 the request for a patient, you know, John Doe's records, you
23 would help to get that together; is that what you were doing?

24 THE WITNESS: Or if the corporate attorneys or any
25 other attorneys wanted information --

1 THE COURT: Can I see counsel at the bench.

2 I'm sorry.

3 (Off-record bench conference.)

4 THE COURT: Ladies and gentlemen, we need --
5 apparently some of the jurors need a break. So we'll just
6 take a quick break, ladies and gentlemen.

7 And during the break, you're reminded that you're not
8 to discuss the case or anything relating to the case with each
9 other or with anyone else. You're not to read, watch, listen
10 to any reports of or commentaries on the case, person or
11 subject matter relating to the case, and please don't form or
12 express an opinion on the trial. Notepads in your chairs.
13 Follow the bailiff through the rear door.

14 And Ms. Rushing, if you'd like to take a break, you
15 can exit through that door, but don't leave yet. Do not
16 discuss your testimony with anyone else during our break.
17 Okay.

18 (Jurors recessed at 4:34 p.m.)

19 THE COURT: How much -- Mr. Staudaher, how much --

20 MR. STAUDAHER: I'm just going to -- I have one
21 question left and that's it.

22 THE COURT: Okay. They -- the jury told the bailiff
23 they needed a break. That's why we took the abrupt break.
24 There is a juror question up here. You guys can look at it.
25 It looks okay to me. I'm going to take a break.

1 (Court recessed at 4:35 p.m. until 4:41 p.m.)
2 (Outside the presence of the jury.)
3 THE COURT: Mr. Staudaher, you said you just have one
4 question?
5 MR. STAUDAHER: I actually don't have any.
6 THE COURT: Okay.
7 MR. STAUDAHER: I'm just going to move to admit those
8 documents [inaudible].
9 THE CLERK: Can you be specific? Eighty-one -- or I
10 mean, 179 to 208?
11 MR. STAUDAHER: Yes.
12 THE CLERK: Okay. And then you mentioned 81. Are
13 you --
14 MR. STAUDAHER: Eighty-one is already admitted.
15 THE CLERK: Oh. Well, that's not what I have.
16 MR. STAUDAHER: That's not what you have?
17 THE CLERK: No. She left me a list --
18 MR. STAUDAHER: Do you have a big red sticker?
19 THE CLERK: -- of --
20 MR. STAUDAHER: That was one of the --
21 THE CLERK: Well, okay.
22 MR. STAUDAHER: That was one of the earlier ones.
23 THE CLERK: So you have the top part that we need to
24 take off, right?
25 MR. STAUDAHER: Yes.

1 THE CLERK: And then we're going to get the red one?
2 MR. STAUDAHER: And that one is the copy [inaudible].
3 (Pause in proceedings)
4 THE COURT: We're waiting for Mr. Wright and
5 Ms. Stanish, and I think the jurors are about ready.
6 (Pause in proceeding.)
7 (Tonya Rushing resumes the witness stand.)
8 (Jurors reconvene at 4:48 p.m.)
9 THE COURT: Court is now back in session.
10 Mr. Staudaher, do you have any more questions for the
11 witness?
12 MR. STAUDAHER: No, Your Honor. The only issue that
13 I have is with the exhibits that I proffered or proposed, and
14 I'd move for their admission again. I know that counsel's now
15 looked at them and --
16 THE COURT: Any objection?
17 MR. WRIGHT: No.
18 THE COURT: All right. And Mr. Santacroce, any
19 objection?
20 MR. SANTACROCE: No.
21 THE COURT: That was exhibit what?
22 THE CLERK: 179 to 208.
23 THE COURT: All right. Those are all admitted.
24 (State's Exhibit 179 through 208 admitted.)
25 THE COURT: And Mr. Santacroce, are you ready to

1 proceed with your cross-examination?

2 MR. SANTACROCE: Yes, Your Honor. Thank you.

3 CROSS-EXAMINATION

4 BY MR. SANTACROCE:

5 Q Good afternoon, Ms. Rushing. I'm going to ask
6 you some questions about your direct testimony today, okay?

7 A Mm-hmm.

8 Q The first thing -- one of the first things you
9 were asked today was whether or not the State had given you
10 immunity from prosecution, and I'm talking about the State.
11 Did -- and I believe you answered no. Was that your answer?

12 A They gave me a proffer in the very beginning,
13 and I have had no immunity or anything else given.

14 Q As you testified today, do you have state
15 immunity from prosecution?

16 A No, sir.

17 Q Do you remember giving testimony in front of the
18 grand jury?

19 A Yes, sir, I do.

20 Q I'm going to show you page 55 of that
21 transcript. I'd ask you to read this portion, please, to
22 yourself.

23 A From here?

24 Q You can read as much as you want, but I'm just
25 directing your attention to here.

1 A Okay.

2 Q Have you read that?

3 A Yes.

4 Q Do you remember Mr. Staudaher asking you --

5 MR. STAUDAHER: Your Honor, I'm going to object to
6 the display of the transcript. He can certainly ask the
7 question --

8 THE COURT: That's sustained. You're on the
9 overhead.

10 MR. SANTACROCE: Oh, okay. I'm sorry.

11 BY MR. SANTACROCE:

12 Q And Mr. Staudaher asked you, "And that out of
13 the abundance of caution, although you were not a State target
14 in this particular case and you have made proffers that you
15 have in the past, out of the abundance of caution we are
16 telling you today from the State's perspective that you in
17 fact are not going to be subject to prosecution by anything
18 you say during this proceeding today, correct?" And you
19 answered correct.

20 Was it your understanding at the time that you gave
21 testimony before the grand jury that you had immunity from the
22 State for prosecution?

23 A It was my understanding that I had a proffer,
24 that what that meant to me was that I could talk and describe
25 and answer the questions, but there was no guarantee of them

1 not using anything or any -- either the State or the other
2 one, against me.

3 Q Have you been charged by the State for insurance
4 fraud?

5 A No, sir.

6 Q Have you been charged by the State for theft?

7 A No, sir.

8 Q Have you been charged by the State for obtaining
9 money under false pretenses?

10 A No, sir.

11 Q You testified that, I believe, back in 2003, you
12 started doing billing for the Endoscopy Center; is that
13 correct?

14 A In 2003 was when Rebecca Duty and myself were
15 introduced by Dr. Desai, and Rebecca's company subcontracted
16 the work to my company, so our company let her company do the
17 billing.

18 Q Prior to that time you had worked for Larry
19 Preston, correct?

20 A Correct.

21 Q And Larry Preston had a medical billing company,
22 correct?

23 A Medical billing and consulting.

24 Q And what did you do for Mr. Preston?

25 A Practice management.

1 Q And Mr. Preston's company did the billing for
2 Dr. Desai at that time, correct, prior to 2003?

3 A I think it was Lizmar and Larry's company.

4 Q And the first nurse anesthetist was Ms.
5 LoBiondo, correct?

6 A Correct.

7 Q And when did she come to be employed, do you
8 know?

9 A I can't recall the date. I would assume 2000.

10 Q 2000?

11 A I would assume there or very close to.

12 Q And when did her billing become your
13 responsibility?

14 A You mean Healthcare Business Solutions?

15 Q Is that your company?

16 A That was my company.

17 Q Healthcare Business Solutions?

18 A Mm-hmm.

19 Q Were you a sole proprietor?

20 A I was an LLC.

21 Q And who were the managing partners of that LLC?

22 A Well, I owned it 100 percent, and then I -- like
23 I said, I didn't do the billing, the physical billing until
24 Rebecca quit in 2006. So Rebecca's company was subcontracted
25 to do all the data entry, all the claim processing and

1 everything else, because she had experience with billing.

2 Q So tell me how that works. You have a company,
3 Healthcare Solutions. She has Paragon.

4 A Right.

5 Q And how does the flow --

6 A There was a contract --

7 Q You need to let me finish the question.

8 A Oh, sorry.

9 Q How does the flow from the CRNA billing get to
10 Paragon?

11 A She had a runner.

12 Q No, I don't mean physically. I mean what is the
13 business procedure. How does it go through Healthcare
14 Solutions to Paragon?

15 A Paragon had a subcontract contract with
16 Healthcare Business Solutions, which --

17 Q You?

18 A Yes, which Rebecca owned a 10 percent ownership
19 in.

20 Q Okay. Let me stop you there. So you had a
21 contract with the Endoscopy Center?

22 A Rebecca and I did.

23 Q Well, Healthcare Solutions --

24 A Healthcare Business Solutions, which was owned
25 by Rebecca Duty and myself, and Rebecca Duty signed the

1 initial contract for health -- on behalf of Healthcare
2 Business Solutions to do billing. Healthcare Business
3 Solutions then had another contract between her company,
4 because it was her employees and stuff like that, to go ahead
5 and process the billing, because she's already been doing that
6 for a few years.

7 Q And that occurred in what years?

8 A Initially right off the bat, off the contract.

9 Q Okay. So after you left Larry Preston's
10 company --

11 A No. Yes, 2003. I'm sorry. You're right.

12 Q So you left Larry's company --

13 A And I went to work for Dr. Desai.

14 Q Went Dr. Desai. Then there came a time shortly
15 thereafter where you formed Healthcare Solutions, and you went
16 into business with Rebecca Duty?

17 A Correct.

18 Q And how did you and Rebecca share the profits at
19 that time?

20 A Rebecca owned 10 percent, and she would invoice
21 Healthcare Business Solutions for the staffing, supplies or
22 whatever else they used in the billing for their billing
23 staff. And then they would do -- I think we would just do
24 disbursements or whatever.

25 Q I want to focus primarily and solely upon the

1 CRNA billing, okay?

2 A Mm-hmm.

3 Q So there came a time in 2006, when Rebecca left
4 and you did the sole billing for the CRNAs?

5 A Correct.

6 Q When I say you, I mean your company.

7 A Correct.

8 Q Of which you're a 100 percent owner?

9 A Correct.

10 Q And what third party payors did you have at that
11 time for the CRNA billers?

12 A The CRNAs were credentialed and contracted
13 through Gastroenterology Center of Nevada. So whatever
14 contract they were on, Blue Cross Blue Shield, Culinary
15 [phonetic] or whatever it was.

16 Q Okay. Well, I want you to give me a list of
17 those, okay?

18 A Okay.

19 Q Go ahead.

20 A The CRNAs were credentialed through Gastro on
21 all the Gastro contracts; Culinary, Medicare, Medicaid --

22 Q You need to slow down. I can't write that fast.

23 A Sorry.

24 Q Culinary. Who else?

25 A Culinary, Medicare, Medicaid, Blue Cross Blue

1 Shield, PacifiCare --
2 Q Hold on.
3 A Sorry.
4 Q Blue Cross Blue Shield. Who else?
5 A Culinary, Medicare, Medicaid, Blue Cross Blue
6 Shield, PacifiCare. HPN, which would be all Sierra products.
7 There's a ton of them. Tri-Care, Tri-West. Gastroenterology
8 Center was contracted with every payer. I can't even begin to
9 tell you what payers. They were not excluded from any payer.
10 Q I'm talking solely about the CRNAs.
11 A The CRNAs were on the Gastro contracts.
12 Q So let's talk about these ones here. Okay.
13 A Mm-hmm.
14 Q For a anesthesia process or procedure, how much
15 did Culinary pay?
16 A I can't remember what they paid from back then.
17 Q How much did Medicare pay?
18 A I'm -- I don't remember. I know it was like
19 probably \$500.
20 Q How much did Medicaid pay?
21 A I don't remember.
22 Q How much did Blue Cross pay?
23 A I can't remember from 2006. I don't know what
24 the payers paid. I'm guessing.
25 Q Okay. You're telling me you don't know any of

1 what these people paid?

2 A Not now.

3 Q Blue Shield?

4 A Not now.

5 Q PacifiCare, HPN, Tri-Care, Tri-West?

6 A I mean, it would depend on how many units were
7 billed and what the contract said. They could vary.

8 Q Well, you testified that they billed 31 minutes
9 or more than 30 minutes.

10 A Right. But some of them were flat rate too.

11 Q Okay. Who's flat rate?

12 A I know the cash pays were flat rate \$150.

13 Q Who were they?

14 A Anybody who was uninsured.

15 Q Okay. I'm talking about third party payers.

16 A I couldn't give you an accurate answer. I mean,
17 it's been six years, five years.

18 Q Well, how much percentage -- and I'm assuming
19 you received a percentage of all billings collected, correct?

20 A Receipts, yes.

21 Q And how much did you receive?

22 A Nine percent.

23 Q Did that ever go up?

24 A It did.

25 Q How --

1 A To 10 percent.

2 Q So in what years were you earning 10 percent?

3 A I think the last year.

4 Q What were you earning in 2007?

5 A It would have been the 9 percent.

6 Q And so you --

7 A I'm guessing at what time frame that was.

8 Q Your company received 9 percent of all the CRNA

9 billings; is that an accurate statement?

10 A Yes, of receipts.

11 Q So if the billings were increased, you would

12 stand to earn more money, correct?

13 A Correct.

14 Q Okay. And conversely, if they went down you

15 would earn less money?

16 A Correct.

17 Q How much money did your company earn from the

18 CRNA billings in 2007?

19 A I would have to look at a document or something

20 to tell you the truth, or a tax return.

21 Q Did your company file a tax return in that year?

22 A Yes, we did.

23 Q How many procedures a day did the clinic do in

24 2007, your best guesstimate?

25 A Forty-five, 45 to 50 a day.

1 Q So up to 50 a day. And what would you say the
2 average third party payer would pay? You've identified
3 Medicare 500 bucks. Would they all be around the same?
4 A I would say probably.
5 Q So 500 times 50 is how much, do you know? I
6 come up with -- and I'm not good at math, so do you have a
7 number?
8 A No.
9 Q 25,000?
10 A Mm-hmm. Probably --
11 Q Is that right?
12 A Probably around there.
13 Q And there was two procedure rooms, correct?
14 A Well, there was --
15 Q Or is there a total of 50 patients?
16 A No. There would be also the Burnham location
17 too.
18 Q So you would get money from Burnham?
19 A All the CRNAs.
20 Q Okay. So let's just talk about Shadow. The 50
21 patients, was that for both rooms or for one room?
22 A For Shadow, that was the whole facility.
23 Q Okay. So from the CRNAs you made 25,000 -- or
24 billed \$25,000 per day; is that correct?
25 A It sounds correct.

1 Q And if you multiply that times five -- I mean,
2 they worked five days a week, right?

3 A Sometimes six.

4 Q Okay.

5 A They pulled Saturdays every once in a while.

6 Q So if we bill times five, is that -- can that be
7 possibly right; is that \$125,000 per week?

8 A I don't remember ever getting a check for that
9 amount.

10 Q Well, you wouldn't though, because you would
11 have billed that and you would have gotten -- well, you would
12 have got 10 percent of that, correct, 9 percent?

13 A Nine percent or 10 percent.

14 Q So you would have received about \$12,500 per
15 week from the CRNA billings; is that correct?

16 A It sounds correct. Without seeing the numbers,
17 I couldn't tell you.

18 Q Okay. You testified that Dr. Desai set up a
19 CRNA fund, correct?

20 A Not fund. An account.

21 Q And he had sole control over that account?

22 A Yes. He would use it at his discretion.

23 Q So when you made the billings in this amount of
24 money per week -- and did you bill per week to the third party
25 payors?

1 A Billed every night. Every time the claim was
2 in, it would go out every night.

3 Q And then would you get a check from the -- would
4 your company, Healthcare Solutions, get a check from these
5 third party payors?

6 A No, sir. They paid directly to Gastroenterology
7 Center of Nevada.

8 Q And which account would they go into?

9 A Gastroenterology Center of Nevada, I believe, or
10 the CRNA. I can't remember which one.

11 Q And your commission came from which account?

12 A Gastroenterology Center of Nevada.

13 Q So Dr. Desai would pay you out of that account
14 for your percentage of the CRNA billings, correct?

15 A Yes. The CRNAs were employed from
16 Gastroenterology Center of Nevada.

17 Q I'm talking about how you got paid.

18 A Yes. Gastroenterology.

19 Q And how often would you get a check? Would you
20 get it weekly, monthly?

21 A Monthly.

22 Q Monthly?

23 A Mm-hmm. At the end of the month they would run
24 the reports.

25 Q And that check would come out of the CRNA

1 account, or the Gastro account?

2 A As I stated, I can't remember which. I'm

3 sure -- more so sure that it came out of the Gastro account.

4 Q Okay. You were the manager of the Shadow Lane

5 clinic, correct?

6 A Correct.

7 Q And you were the COO?

8 A Correct.

9 Q Chief operating officer?

10 A Correct.

11 Q Are you aware that the CRNAs never got one

12 dollar out of that CRNA account?

13 A They would be paid out of Gastroenterology

14 Center.

15 Q So the answer would be yes, you're aware that

16 they didn't?

17 A They were employed, so yes, that would make

18 sense to me.

19 Q And you're aware that they got a salary,

20 correct?

21 A They got a salary and then they got a bonus.

22 Q And there's testimonies that at some point those

23 bonuses stopped; is that your understanding?

24 A They did for everybody, yes.

25 Q So the CRNAs were on a salary?

1 A Yes, sir.

2 Q So unlike your company, Healthcare Solutions,
3 the CRNAs, it didn't matter if they did one patient or 50
4 patients a day?

5 A Correct.

6 Q Now, you testified that you took, or the CRNAs
7 would, I guess -- let me just strike that.

8 How did you get the anesthesia records to bill for
9 the CRNAs?

10 A At the end of the day there was a bin, and the
11 CRNAs would have filled out their charge ticket, like I said,
12 with all the patient information and so forth. The front desk
13 person at the Endoscopy unit would attach the insurance
14 information and everything else, put it back in the bin in an
15 envelope, and the runner would come by and pick up the
16 envelope from that facility.

17 Q Who would attach the documentation?

18 A The front desk person would attach to the charge
19 ticket the patient's copy of the patient's insurance card, a
20 copy of the patient's driver's license, and I think the
21 financial policy of gas -- of Endoscopy Center.

22 Q So the CRNAs would drop off the anesthesia
23 records in the bin, correct?

24 A Right. After they were done filling them out.

25 Q And that was the end of their responsibility as

1 far as billing was concerned?

2 A Right. Because they put their start time and
3 end time, that's all they needed to do.

4 Q Did you ever view any of those anesthesia
5 records when they were in the bin for the three, four, five
6 years that you were doing this?

7 A I'm sure I did.

8 Q Did you ever view any of the EOB cards?

9 A I am sure I did.

10 Q And it's your testimony here today that the
11 first time that you are aware of the CRNAs billing 31 minutes
12 was when Dr. Carroll came to you after the Rexford case?

13 A When the precharted record was done, that is the
14 first time I've heard of that.

15 Q And if Anne LoBiondo told you that when she
16 testified that when she started working you told her to bill
17 31 minutes, she'd be wrong?

18 A Yes. I had -- I can't oversee CRNAs.

19 Q Well, according to the organizational chart, you
20 are overseeing CRNAs. Isn't that you here?

21 A Right. And they have a direct line to the
22 physicians and the physician staff up to Dr. Desai. As I
23 stated earlier, they would coordinate with Mr. Lakeman for
24 their schedule and their covering. I would dissonate that
25 schedule and that covering.

1 Q So the only thing Mr. Lakeman did as far as --
2 was scheduling the CRNAs?

3 A Right. He would coordinate. If they would take
4 off vacation days or whatever, they would communicate it to
5 him.

6 Q And how long did he do that?

7 A I would say probably about a year and a half,
8 two years.

9 Q And he had nothing to do with ordering supplies
10 or anything of that nature, correct?

11 A No, sir. There was only one incident that I can
12 remember that he had an argument with Katie --

13 Q Okay. I don't want you to tell me about that,
14 because that's hearsay from Katie.

15 A No. I was there.

16 THE COURT: Well, it's -- that doesn't matter.

17 BY MR. SANTACROCE:

18 Q So other than that one instance, whatever it
19 was, he didn't have any control over -- he didn't order
20 propofol, he didn't order syringes, he didn't order Chux, he
21 didn't order --

22 A No. He didn't order --

23 Q -- K-Y Jelly?

24 A No. No, sir. He did not.

25 Q Okay.

1 A He wanted a specific drug.

2 Q All he did was schedule the CRNAs as to what
3 their work schedule was for about a year?

4 A Coordinate it, yes.

5 Q Yeah, coordinate it. And you said that he had a
6 direct line to staff physicians. He also has a direct line to
7 the COO, you.

8 A Mm-hmm.

9 Q Okay. Is that fair estimate of the chain of
10 command here?

11 A Yes. He would turn in those sheets and he would
12 turn in his vacation requests and so forth.

13 Q And who would approve them, you?

14 A No. Dr. Desai would approve or the doctors.

15 Q So Dr. Desai would approve every single week of
16 what CRNAs were scheduled; is that what you're telling us?

17 A Absolutely.

18 Q Okay. And he would oversee all of the other
19 things that you mentioned and still be able to do 50
20 procedures a day?

21 A Like I said, he was quite remarkable. Yes.

22 Q He was quite remarkable.

23 In your direct testimony you talked about a meeting
24 that you had with the CRNAs; is that correct?

25 A I'd have to remember it. If you could bring it

1 and let me remember it.

2 Q I believe it was in February of 2008, when Dr.
3 Carrol came to your office about the precharting. Was that
4 '08 or '07?

5 A It was '08, like in February of '08.

6 Q And you testified that you called the CRNAs into
7 the office.

8 A Right. Dr. Carrol, he's a partner, came up, had
9 the --

10 Q I don't need all that explanation.

11 A Yes.

12 Q You called the CRNAs up, correct?

13 A Under the direction of Dr. Carrol, I would
14 definitely call the CRNAs up, yes.

15 Q And you testified that you called -- you can
16 specifically remember calling Vinnie Mione and Vinnie
17 Sagendorf up, correct?

18 A Couldn't remember the others, yes.

19 Q Didn't Vinnie Mione and Vinnie Sagendorf work at
20 Burnham?

21 A They could rotate.

22 Q Do you remember if this meeting took place at
23 Shadow or Burnham?

24 A Shadow.

25 Q You also in your grand jury testified that you

1 called up Vince, Linda, Linda Hubbard and Keith Mathahs. Do
2 you remember that?

3 A I -- if I -- I guess.

4 Q Well, let me show you the transcript.

5 MR. STAUDAHER: Page, Counsel?

6 MR. SANTACROCE: I'm sorry. Eighty-five.

7 THE WITNESS: Eighty-five? Okay. Yes, and I also
8 state here if I can't remember the other Vinnie was there or
9 not, so obviously I might not have gotten all the names right.
10 Whoever was on the floor at Shadow Lane was called up to the
11 office.

12 BY MR. SANTACROCE:

13 Q Well, one thing is for sure is that Mr. Lakeman
14 wasn't called up, correct?

15 A I didn't remember Mr. Lakeman being called up.
16 I don't know if he was there or not.

17 Q Well, he left your -- the employment in October
18 of 2007, and you're telling me this occurred in February 2008?

19 A Then he wouldn't have been called up.

20 Q So the meeting that you had in Dr. Carrol's
21 office with you and the CRNAs did not include Mr. Lakeman; is
22 that a fair statement?

23 A That would be a fair statement.

24 Q Now, you talked about a time when your company
25 started to grow and you took on other doctors, physicians,

1 correct?

2 A Yes, sir.

3 Q When was that?

4 A I want to say 2005, approximately. I can't give
5 you the exact date. I don't have the books in front of me.

6 Q And what other physicians did you take on?

7 A We took on Dr. Michael Gunter.

8 Q What is his area of practice?

9 A Internal medicine.

10 Q Okay.

11 A Dr. Bhatnagar, who is a surgeon.

12 Q I guess I don't want to go through the names.
13 Tell me if there were any other CRNA billings in any of those.

14 A No, sir, there was not.

15 Q So the Gastro was the only CRNA billings you
16 did?

17 A Yes, sir.

18 Q And you talked about when you found out about
19 the 31 minutes you confronted Dr. Desai; is that correct, or
20 you went to Dr. Desai?

21 A Yes, sir.

22 Q And you expressed your concern to him and he
23 said, Darling, honey, whatever he said, don't worry about it
24 because the procedures start from the preop area to discharge?

25 A Correct.

1 Q Were you aware that that's how Larry Preston was
2 billing the CRNA time as well?

3 A No.

4 MR. STAUDAHER: Objection. Speculation.

5 MR. SANTACROCE: He testified to that.

6 MR. STAUDAHER: It's not what he testified to.

7 MR. SANTACROCE: Well, that's my recollection.

8 THE COURT: All right. Well, she --

9 BY MR. SANTACROCE:

10 Q Okay. So your answer's you were not aware of
11 that?

12 A No, I was not aware.

13 Q Okay. Let me put it -- let me state it this
14 way. Were you aware that Larry Preston believed that the
15 anesthetist's time started when he first made contact with the
16 patient until the patient was discharged?

17 MR. STAUDAHER: Objection, Your Honor.

18 THE COURT: Sustained.

19 THE WITNESS: Can I answer, or no?

20 THE COURT: No, no, don't. Don't answer.

21 MR. SANTACROCE: No, you can't.

22 BY MR. SANTACROCE:

23 Q You never did any CRNA billing when you worked
24 for Larry Preston?

25 A Never.

1 Q Did you see any of the CRNA billings when you
2 worked for Larry Preston?

3 A Never. I was always in Dr. Desai's office.

4 Q You were shown that memo about the insurance
5 companies, and specifically about PacifiCare.

6 MR. SANTACROCE: I think it's 179.

7 MR. STAUDAHER: It's, I believe, 79 or 81.

8 MR. SANTACROCE: Let me see 180, please. I'm sorry.
9 It's actually 185.

10 BY MR. SANTACROCE:

11 Q You were asked about why PacifiCare was spaced
12 this way.

13 A Yes, sir.

14 Q And what was your answer?

15 A At that time the memo was written, I just wrote
16 it and followed orders.

17 Q Is that your whole take on this thing, that you
18 just were following orders?

19 A On that specific memo that you just showed me,
20 yes.

21 Q What sorts of things at the clinic did you have
22 direct control and authority over?

23 A Like I said, I answered to the partners and I
24 answered to Dr. Desai.

25 Q When you answered to the partners, the partners

1 are Dr. Carrol, Dr. Carrera, Dr. Desai?

2 A Mason, Dr. Herrero, Dr. Faris. There was a ton
3 of them.

4 Q And what sorts of things -- were there regular
5 meetings with all of those folks?

6 A Only when Dr. Desai had called them. I mean, he
7 was the one who called the partner meetings. He was very
8 specific on his agendas of what he called them for. He didn't
9 allow us to socialize or have outside conversations like that.

10 Q Well, were you in attendance in those meetings?

11 A On some occasions, and some occasion I was not.

12 Q And so what sorts of things that were in your
13 control did you bring to those partner meetings?

14 A I did not bring much to the partner meeting
15 other than attend. Dr. Desai would have me bring down Medical
16 Manager reports, which showed the productivities of the
17 physicians. He would have us discuss opening new facilities.
18 He just -- he would discuss when a new doctor, like a doctor
19 who had already done three years' time and was getting ready
20 to become partner.

21 Q Well, I guess I'm not quite understanding this.
22 You told us over and over how busy you were at the clinic,
23 correct?

24 A Mm-hmm.

25 Q I want to know what you were doing that kept you

1 so busy.

2 A I would go see referring physicians, drop off
3 referring physicians, referring physician pads, make sure that
4 people were happy. I would do for errands for him, as well as
5 something else if somebody else needed it. I would write
6 letters if he needed letters written. I would build
7 facilities. When I got there, there was only two, three
8 locations. And we revamped the whole Shadow Lane office.

9 So I'd work with the contractors, buy furniture, help
10 him redo like the phone system. Because when we first started
11 we had a very adequate bad phone system in each office. So
12 then he had to put a central phone system, so I'd work with
13 those. I would work with check-in to make sure that they were
14 getting all the patient demographics and all that stuff in, in
15 checking the patients in.

16 We developed patient satisfaction surveys. I mean,
17 whatever he needed. I mean, if it was, you know, set up a
18 dinner with him and somebody, or a doctor with somebody, or
19 attend a meeting, or decorate his office, decorate the offices
20 that they had there. I mean --

21 Q And what -- how much time did you spend
22 overseeing Healthcare Solutions then?

23 A I would go there either an hour in the morning
24 or I would go there three hours at night, two hours at night.
25 Sometimes I couldn't make it there depending if we had a

1 function.

2 Q And when you oversaw the activities at
3 Healthcare Solution, did you review any of the billing
4 records, the CRNA billing records?

5 A No. Because Healthcare Business Solutions
6 didn't do just billing. We also did credentialing, startups,
7 that type of thing for physicians. So that took -- that's
8 where I concentrated on. I had billing managers. I had
9 billers that went to school for billing, and then Ida would
10 address if there was any concerns.

11 Q And those billing managers, who are they?

12 A Ida Hansen was one of them. Kim Taylor
13 [phonetic] was one of them. Tammy Davidson [phonetic] was one
14 of them. Sheila Seefus [phonetic] was one of them. I mean,
15 there was a few of them.

16 Q And those were all employees of Healthcare
17 Solutions?

18 A Yes, sir.

19 Q And during that time period of 2006, when you
20 started that until you closed down, or until the Gastro closed
21 down --

22 A I didn't close down when Gastro closed down.

23 Q No, no. I'm sorry. That's not what I was
24 inferring. Let me restate that. From the time you started
25 Healthcare Solutions in 2006, until the billing practices from

1 CRNAs changed at some time in 2008, not one of those billers
2 came to you and said, hey, all of these guys, these CRNA guys
3 and girls are billing 31 minutes? That didn't raise a red
4 flag to anybody?

5 A No. I mean, they did the same thing. They did
6 a colonoscopy and an EGD in the facilities. It's not like
7 they did different things. They were always the same.

8 Q So that never triggered a red flag to you?

9 A No. And from my understanding, it was the same
10 at Lizmar. I mean, I don't think any of our practices
11 changed, and I don't think the CRNAs' practices changed.

12 Q Who's Ryan Cerda?

13 A Ryan Cerda was an entry level data entry person
14 that we hired at Healthcare Business Solutions.

15 Q Did Ryan Cerda ever come to you voicing concern
16 about the CRNA billings?

17 A After the conversation with Dr. Carrol and they
18 dropped, like I said, to eight, ten, whatever minutes, I can't
19 remember if he came to me directly. I think he may have, or
20 he came to Tammy, and then they brought it to my attention.
21 Then I went and brought it to Dr. Desai.

22 Q You realize then or at some point that you had
23 some liability because you were the one that was pushing the
24 buttons, sending this information to the third party payors?

25 A I realized that I am responsible for all my

1 staff, and yes, I realized that I had some liability.

2 MR. SANTACROCE: I have nothing further. Thank you,
3 ma'am.

4 THE COURT: Thank you, Mr. Santacroce. Can I see
5 counsel at the bench.

6 (Off-record bench conference.)

7 THE COURT: Ladies and gentlemen, we're going to go
8 ahead and take our evening recess. We'll be in recess for the
9 evening. 9:30 tomorrow morning.

10 During the evening recess, you are reminded that
11 you're not to discuss this case or anything relating to the
12 case with each other or with anyone else. You're not to read,
13 watch, listen to any reports of or commentaries on this case,
14 any person or subject matter relating to the case. Don't do
15 any independent research by way of the Internet or any other
16 medium, and please do not form or express an opinion on the
17 trial.

18 Notepads in your chairs. Follow the officer through
19 the rear door, and we'll see everyone back here at 9:30.

20 And Ms. Rushing, once again, I must remind you that
21 during the break you're not to discuss your testimony with
22 anyone, all right?

23 THE WITNESS: Mm-hmm.

24 THE COURT: Thank you, and you're excused.

25 (Jurors recessed at 5:25 p.m.)

1 THE COURT: Somebody had a dental appointment on the
2 jury. That's why we're starting at 9:30, so.

3 MR. STAUDAHER: No, that's fine. I just --

4 MR. SANTACROCE: I want to bring something up. Are
5 we --

6 THE COURT: Okay. Is this back door --

7 MR. SANTACROCE: Are we on the record?

8 THE COURT: Yeah, we can be on the record.

9 Oh, Ms. Rushing, you're excused.

10 TONYA RUSHING: Yeah. I'm waiting for...

11 THE COURT: Okay.

12 MR. SANTACROCE: I just want to bring up to the
13 Court's attention that every time Mr. Wright makes an
14 objection, this juror in the back row on the left where that
15 shawl is makes an audible gasp, and it's getting very
16 frustrating to me. And I want to bring her in here and ask
17 her if she's already made a decision in this case as to the
18 guilt or innocence of Mr. Lakeman and Dr. Desai.

19 No one else is making those audible grunts, groans,
20 moans and gestures every time, and it only happens when
21 Mr. Wright makes his objections that she makes those gasps and
22 moans. So I'm very concerned about it and it's my request
23 that we be allowed to ask her if she has formulated an opinion
24 as to the guilt or innocence of these two people.

25 THE COURT: Well, I don't know that that's

1 appropriate, because there's already been how many weeks of
2 evidence. So of course she's forming preliminary opinions
3 and, you know --

4 MR. SANTACROCE: I'm not asking about preliminary
5 assessments of the evidence.

6 THE COURT: Do you see what I'm saying? I mean,
7 it's -- they're not allowed -- you know, they don't have to --
8 I mean, we tell them -- I mean realistically, of course they
9 start forming opinions. And, you know, with all due respect
10 to Mr. Wright, maybe she doesn't like Mr. Wright. I mean,
11 that's not reason --

12 MR. WRIGHT: Well, I want to examine her about that.

13 THE COURT: Well, no. I mean, you know, as long as
14 she didn't start out not liking you, if you have earned her
15 dislike over the course of the trial, and that sounds
16 facetious, but by that I mean, you know, if she for whatever
17 reason, you know, just doesn't, you know, just doesn't like
18 you, you know, I don't know that that's grounds for anything
19 as long as she didn't start out not liking you.

20 But if she doesn't like you because she thinks you
21 take too long or make too many objections or something like
22 that, I mean, we tell them at the beginning don't hold it
23 against the lawyer. But as long as --

24 MR. SANTACROCE: It might be just my perception. I
25 might be completely off base here. I don't know if anyone

1 else has observed or heard it. But I'm just bringing it up
2 because I'm very concerned. We tell the jurors, don't make a
3 decision as to guilt or innocence until all of the case is
4 presented. The defense hasn't presented anything, and I'm
5 just concerned because of these, you know, these gestures and
6 gasps and moans. And I might be off base, but I want to raise
7 it.

8 MS. WECKERLY: My perception of some of the jurors is
9 when it seems like the testimony or -- even on direct, the
10 direct or the cross is repetitive, then there's, you know,
11 some sort of reaction. And I mean, we're all sort of -- you
12 know, we do that at our peril. And I don't think it's proper
13 at all to inquire into her mental processes. I mean, yawning
14 or making a -- you know, she hasn't done anything improper and
15 so -- or none of her conduct.

16 MR. SANTACROCE: Am I crazy?

17 MS. WECKERLY: I mean, she's allowed to react.

18 MR. SANTACROCE: Am I the only one hearing it?

19 THE COURT: No. I think she may be doing that, but
20 even let's just assume that she is gasping and moaning and
21 sighing and, I mean, part of that could be boredom.

22 MR. SANTACROCE: Well, I'm not --

23 THE COURT: And, you know, like I said, I mean, part
24 of it may be she just doesn't like Mr. Wright or she thinks
25 his cross-examination takes too long.

1 MS. WECKERLY: She's done that when we're up too.

2 THE COURT: And you know what I mean. Frankly,
3 Mr. Wright and Ms. Stanish take longer in cross. You know,
4 you're more pithy, you get right in there, you know, tend to
5 have a joke or two. And so I'm not -- you know, I don't sense
6 that with them. Ms. Weckerly is shorter on direct than
7 Mr. Staudaher.

8 So basically, you know, I think it's more Staudaher
9 on redirect and Wright -- Mr. Wright, and I think it has to do
10 with the length of their questioning and going over the same
11 material. And just because someone becomes exasperated or
12 bored doesn't mean that they're not fit to be a juror.

13 MR. SANTACROCE: Okay.

14 THE COURT: I mean, that's my assessment. And so,
15 you know, I just -- as I said, as long as, you know, that was
16 an opinion formed during the course of the trial, you know, we
17 can't, you know, say, oh, well, all the jurors have to like
18 the lawyers equally, or they have to think that the lawyers
19 are doing a good job, or that the lawyers aren't, you know,
20 being redundant. That's not the standard.

21 As long as they start out and don't have a
22 preconception about the lawyers, you know, then -- you know,
23 people are people and they're going to form opinions and
24 they're going to like some lawyers better than other lawyers.
25 It's just the reality of the situation. And, you know, like I

1 said, as long as that's based on something that's happened in
2 the courtroom --

3 MR. SANTACROCE: Well, she might be doing that to
4 everybody. I don't know. I'm just telling you my perception.
5 If someone else has a different perception, fine. I accept
6 the Court's analysis of it.

7 THE COURT: I don't -- I don't think it's a different
8 perception. The issue is, okay, if that's true what do we do
9 about it.

10 MS. STANISH: Your Honor.

11 THE COURT: Yes.

12 MS. STANISH: Just for the record, a few times
13 already I have tried to make a record of this very same juror
14 who moans and groans when we, the defense, are put in an
15 objection -- or I'm sorry, put in a position to object
16 repeatedly about what elementary rule of evidence foundation.
17 And then we all have to scurry up to visit Your Honor, where
18 you engage in an Evidentiary 101, and explain to the --
19 Mr. Staudaher how to properly lay a foundation.

20 And it's happened numerous times throughout this
21 trial. And that's what I had -- my concern was and we've
22 stated this, I believe, on the record, certainly up at the
23 bench when visiting Your Honor on this issue, that we felt it
24 was going to be held against the defense attorneys that we
25 were delaying the trial because we were making these

1 objections to prevent this ongoing issue with lack of
2 foundation, which Your Honor even addressed today and lectured
3 about foundation at the bench.

4 THE COURT: Well, I mean, here's the thing, you know.
5 I mean, I think Mr. Staudaher did better today laying a
6 foundation now that he under -- now that I think it's clear
7 what the defense wants and the Court, which, you know, a
8 couple times said when did this meeting happen, who was at the
9 meeting, a couple of things like that.

10 I'm happy, as you know, a standard instruction is to
11 tell the jury that it's -- you know, I don't remember exactly
12 verbatim, but it's the duty of a lawyer to object to evidence
13 that the lawyer thinks may not be admissible. Please do not
14 be prejudiced against the lawyer or client if the lawyer makes
15 objections on behalf of the party he or she represents,
16 et cetera.

17 I'm happy to remind them of that objection -- of that
18 instruction if you want me to do that. I mean, I don't see,
19 you know, a big deal about doing that. If that's something
20 that's requested, I'll do it. But again, you know, to
21 reiterate, just because a juror finds it tedious and may make,
22 you know, sighs or gasps or expressions of frustration or
23 boredom or whatever to me isn't grounds for removal or any
24 kind of discipline or anything like that.

25 So I don't know what the point is to ask her the

1 questions if there is nothing we can do about it. And in
2 fact, if we drag her in and ask her the questions like, well,
3 it really appears that you're gasping when Mr. Wright asks a
4 question, then to me now what have we done? We've really
5 alienated her, because she's going to know, oh, they're
6 dragging me in here because somebody complained about me
7 sighing or gasping or whatever.

8 And so because the remedy is -- in my view isn't
9 removal, what's the point of asking the question? All to me
10 we'd do is create the possibility that now she's tainted, or
11 now she becomes alienated against somebody if in fact before
12 she wasn't. It's like I said, she's going to wonder, well,
13 who -- you know, who complained.

14 I mean, I can, you know, finger Kenny for it and say
15 he complained that you were sighing, you know. But still, I
16 just don't know what would be --

17 MR. SANTACROCE: I didn't mean to -- I don't want to
18 make a big deal about this.

19 THE COURT: -- accomplished.

20 MR. WRIGHT: I like that one.

21 MR. SANTACROCE: I'm not going to make a big deal
22 about it.

23 THE COURT: Well, there's other behind the scenes
24 issues going on there.

25 MR. SANTACROCE: There's bigger fish to fry and I'm

1 not here to make a big deal about that, but I wanted to raise
2 it because it was a concern to me, quite frankly annoying to
3 me, and I didn't know if it was just something that I was
4 misperceiving or not.

5 THE COURT: And I'm hearing, which I heard today, you
6 know, Dr. Desai's family members making noises and gasps and,
7 you know, so I'm more aware of that. And I know Kenny, you
8 know, it's the bailiff's job to maintain --

9 MR. SANTACROCE: Well, we can advise them right now.
10 Don't make gasps and noises, okay.

11 THE COURT: Yeah. It's the bailiff's job to monitor
12 and maintain control of the courtroom. He did inform me that
13 he went over and told them to do it because I said, I just
14 heard then, they made like, I can't remember the noise, but it
15 was in response to a foundation question or something against
16 Mr. Staudaher.

17 I don't remember exactly what happened, but I
18 sustained the objection, or I said we need to do it this way
19 or something, and then we heard something. And apparently
20 it's been going on. So, you know, that can also be, you
21 know -- I think they're making noises and I think probably the
22 gal in Seat 14 is making noises.

23 MR. SANTACROCE: Okay. Well, we fixed this
24 [indicating]. We fixed this problem.

25 THE COURT: So, you know, yeah, because --

1 MR. SANTACROCE: That one we can't fix.

2 MS. WECKERLY: Yeah. You can't say anything to her.

3 THE COURT: I just don't -- yeah, because whatever,
4 you know, again, as long as she wasn't biased against anybody
5 to start, then, you know, so what. You know, she thinks
6 Mr. -- I'm just speculating, you know, she thinks Mr. Wright
7 is boring. Well, that's not grounds for removal or, you
8 know --

9 MR. WRIGHT: I'm not so sure about that. No. I
10 don't want her holding -- if she does not -- if she decides --

11 THE COURT: Yeah, but -- no, no. As --

12 MR. WRIGHT: If she decides my behavior is offensive
13 and inappropriate and takes it out on my client, I'm concerned
14 about it.

15 THE COURT: Well, but you're making a big --

16 MR. WRIGHT: And I don't care if she makes the
17 judgment here in the courtroom.

18 THE COURT: No, no. You're making a big leap from
19 her -- if that's even it -- from her thinking you take too
20 long on cross to somehow holding it against your client. And
21 again, there's an instruction. I'm happy to give it. I'm
22 happy to add to the instruction, you know, and I think it's
23 already part of it, you don't hold it against the party he or
24 she represents, number one.

25 And again, you know, frequently in closings, that's

1 one of the first things lawyers often say, you know, I hope I
2 haven't done anything to offend you or to annoy you, and
3 sometimes I may be tedious and sometimes, you know, I'm
4 redundant, but please, you know, don't hold it against my
5 client, you're free to say that.

6 And that's, as we all know, said all the time, you
7 know, don't do any -- don't take anything I may have done as a
8 lawyer, you know, I'm doing the best I can, I've made
9 mistakes, what have you, you know, you're free to do that if
10 you think it's an issue. But like I said, just because she
11 might --

12 I mean, okay. Let's be real here. It is long. It
13 is boring. It is tedious. It is uncomfortable. It is
14 incredibly repetitive. And so if she's thinking all of those
15 things, to me that is a normal reaction, not something that
16 causes inquiry for some kind of misconduct or something like
17 that.

18 MR. SANTACROCE: Well, as long as she's not directing
19 it toward the defendants because of what we the lawyers are
20 doing. That's my only concern.

21 THE COURT: Well, and I can remind --

22 MR. SANTACROCE: She can hate me all she wants.

23 THE COURT: And I'm happy to remind her of that as I
24 said, if we stipulate to adding to the stock instruction. I'm
25 happy to, you know, ad lib a little bit and say, look, this

1 has been a long process, we've all been tired, we've all been
2 hungry, you know, you may think the questioning went on too
3 long or there were too many objections.

4 I just want to remind everyone that you can't hold it
5 against the party the lawyer represents, whether that be the
6 State or whether or not that be the defendants, because you
7 don't like something a lawyer may have done or you don't like,
8 you know, that lawyer. I'm happy to do that if you ask me to
9 do it. I'm happy to do that.

10 MR. SANTACROCE: I ask you to do it.

11 THE COURT: All right. Well, let's make sure
12 Mr. Wright and Ms. Stanish are on board --

13 MR. WRIGHT: Yep.

14 THE COURT: -- and the State. And as long as I
15 direct it towards both sides, that -- you know, they may
16 not -- you know, I don't know. They may not like Ms.
17 Weckerly.

18 MR. SANTACROCE: Oh, I don't believe that.

19 MS. STANISH: Oh, no way.

20 MS. WECKERLY: I think that's true in the sense, you
21 know, we've heard like, oh, why do they keep asking the same
22 things over and over. And of course we'd like to say, look,
23 you know, we have this really big burden, we want to make sure
24 you get this straight. I mean --

25 THE COURT: Right. Well, the other thing I can tell

1 them, if it's fine with everyone -- again, these are
2 suggestions. I'm only going to do it if we all agree to it,
3 is something like look, the questioning becomes repetitive,
4 unfortunately the lawyers -- and this is another thing often
5 lawyers, as you know, say. Unfortunately we can't all say,
6 hey, does everybody understand, by a show of hands do you
7 understand, so they have to ask the questions to make sure
8 you're understanding hearing the evidence.

9 Something like that, I'm happy to give it if we all
10 think that that would be better. And, you know, again, a lot
11 of times this stuff is addressed in closing. But I can tell
12 them, you know, look, we don't have the benefit of saying does
13 everyone understand the testimony, did everyone get that. We
14 have to, you know...

15 MR. SANTACROCE: Well, I think, given the length of
16 the trial and at this juncture of the trial it might be
17 appropriate.

18 THE COURT: Like I said, as long as it focuses on
19 both sides and is fair to both sides, I'm inclined to do that.

20 MS. WECKERLY: Sure. Sure.

21 MS. STANISH: Well, and too, and especially since it
22 sounds like we're going two weeks beyond what the jury was
23 told, it might be a good time to at some point soon talk to
24 the jury about scheduling and give some instructions.

25 THE COURT: Well, the jury has all asked for letters,

1 and I just --

2 MR. WRIGHT: What's that mean, letters?

3 THE COURT: Well, we give letters. You know, we told
4 them in the jury selection if you need a letter for your
5 employer. What happens is one or two will ask for a letter,
6 and then everybody wants a letter. And now they've asked for
7 new -- one or two asked -- not to me personally, but to Kenny.
8 And then one or two want letters to their employers and then
9 they all want letters to their employers.

10 And originally we wrote the letter and we said three
11 to four weeks, and I couldn't bear to sign the letter frankly.
12 And so I said, Sharry, don't do it today, we're going to see
13 where we're going to be. So Ms. Weckerly, realistically you
14 think the 27th -- or I'm sorry, the 24th?

15 MS. WECKERLY: But I mean, I don't mean -- I mean
16 like maybe we would have evidence on that day, but be done
17 around that day.

18 THE COURT: Right. And so then for the defense,
19 maybe July 1st, which would give you --

20 MR. WRIGHT: 2000 --

21 THE COURT: No. Which would give you -- so that's
22 basically another three weeks. I mean, if you had four days
23 the last week of June, and Monday, July 1st, we could do
24 closings the 2nd and the 3rd possibly, and then the 4th, of
25 course, is a national holiday. And we also have a juror

1 leaving for vacation for ten days -- or no, more than ten
2 days, which he told us about during jury selection. But of
3 course we all said, oh, no, it's never going to go that long,
4 don't worry about it.

5 MR. SANTACROCE: Oh, no. I didn't say that.

6 MS. STANISH: Well, we didn't say that.

7 MR. SANTACROCE: There's only one person that said
8 that.

9 THE COURT: Well, no. You said about eight weeks and
10 we're well over that, we'll be over that. So in any event, I
11 mean, do we think we can finish Wednesday the 3rd -- well,
12 then he can't deliberate. But as long as we make it to there
13 with more than 12, we can call in an alternate.

14 MS. WECKERLY: Is the defense case really --

15 MR. SANTACROCE: Who is the juror that has the --

16 MS. WECKERLY: -- going to take three weeks?

17 THE COURT: It's the guy, Juror No. 6 -- 7. I'm
18 sorry.

19 MR. SANTACROCE: Who is that?

20 THE COURT: It's the guy that works for the school
21 district.

22 MR. SANTACROCE: Oh, this guy on the end over here
23 [indicating]?

24 THE COURT: Yeah.

25 MS. WECKERLY: So three weeks from now?

1 THE COURT: Right.

2 MS. WECKERLY: Okay. But I mean, the defense case --
3 yeah, I guess that's right.

4 THE COURT: Right. Tomorrow's the 15 -- I'm sorry.
5 I'm looking at the wrong -- tomorrow is the 12th.

6 MS. WECKERLY: Yeah. I miscalculated, I think.

7 THE COURT: So I mean, it kind of depends on how much
8 time we need for the defense case, and basically we can stay
9 late one day. Dr. Desai doesn't have to be here. We can
10 settle jury instructions. And, you know, maybe this is
11 something you folks can start doing over the weekend or
12 whatever. But State -- sorry. State, do you have your
13 proposed jury instructions done?

14 MS. WECKERLY: Not done. Started, but not done.

15 THE COURT: Okay. Well, you're the youngest one in
16 the group, so.

17 MS. WECKERLY: I can -- I can try to have a proposed
18 packet on Monday. Is that --

19 THE COURT: Okay. And get it to the defense.

20 MS. WECKERLY: Yeah.

21 THE COURT: And basically the way I like to do it is
22 pretty standard. Anything that's proposed as either an
23 alternate to a special or an addition to a special, separate
24 those, the additions and the alternates to the specials, and
25 that's all I want from the defense. Obviously not all of the

1 other stocks and everything like that.

2 Then the way I do it is I make the lawyers meet,
3 because sometimes you can make agreements on small changes and
4 things like that. Anything you can't agree on then we settle
5 on the record, and then I decide whether you're going to get
6 the instruction or not. I want from both sides, you know,
7 obviously the stocks don't need to be -- you know, anything
8 that's unusual.

9 I want an annotated and an unannotated copy.
10 Anything that's typical, just give me an unannotated. Same
11 for the defense, annotated and unannotated. If for some
12 reason you don't get that done that way, it's not a big deal
13 as long as we get a disk or, you know, something like that.
14 Worse comes to worst, we make Sharry retype them. I shouldn't
15 tell you that, but...

16 MS. STANISH: Word or Word Perfect for you?

17 THE COURT: We can do either, right? I think we're a
18 Word system, hideous Word system. But I think it will
19 convert. I think we have the ability to convert. If not,
20 it's not, you know, like a huge, huge deal, so.

21 All right. Then we'll see you all back at 9:30.

22 (Court recessed for the evening at 5:46 p.m.)
23
24
25

CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

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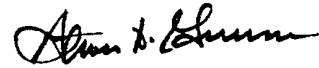

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TRAN



CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA,)

Plaintiff,)

vs.)

DIPAK KANTILAL DESAI, RONALD)
E. LAKEMAN,)

Defendants.)
_____)

CASE NO. C265107-1,2
CASE NO. C283381-1,2
DEPT NO. XXI

**TRANSCRIPT OF
PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 37

MONDAY, JUNE 17, 2013

APPEARANCES:

FOR THE STATE:

MICHAEL V. STAUDAHER, ESQ.
PAMELA WECKERLY, ESQ.
Chief Deputy District Attorneys

FOR DEFENDANT DESAI:

RICHARD A. WRIGHT, ESQ.
MARGARET M. STANISH, ESQ.

FOR DEFENDANT LAKEMAN:

FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

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I N D E X

WITNESSES FOR THE STATE:

BRIAN LABUS

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1 LAS VEGAS, NEVADA, MONDAY, JUNE 17, 2013, 9:13 A.M.

2 * * * * *

3 (Outside the presence of the jury.)

4 THE MARSHAL: Judge Valerie Adair presiding. Thank
5 you. Everybody may be seated.

6 THE COURT: Our last juror just arrived, so -- but
7 then I just heard you had something out of the presence?

8 MR. WRIGHT: Yeah. Introduction of the report.

9 THE COURT: Okay. Shut the door. All right. Yes?

10 MR. WRIGHT: The Health District report.

11 THE COURT: I'm sorry?

12 MR. WRIGHT: Admissibility of the --

13 THE COURT: Right. We have to have a ruling on that
14 because Mr. Labus is -- I've consulted the cases, and while
15 Health District-type reports are admissible in some cases, you
16 know, reading everything, this is not a routine cataloging of
17 information. That's one of the things talked about in the
18 case of United States versus Barry.

19 One of the things we look at is whether or not the
20 report is prepared, it's likely there's going to be litigation
21 or a criminal proceeding. I think this was a very unique
22 case, and I think that this report is much more akin to an
23 investigative police-type report than it is to an
24 epidemiological report or a public record, which is, you know,
25 as cited by the United States Supreme Court, the routine

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1 cataloging of information. And so for that reason I don't
2 think that the report is admissible in this case.

3 Now, the next issue are the hepatitis-infected
4 people, the 109 or so people. Are you -- and I haven't fully
5 decided that issue -- will that be something that you're going
6 to be getting to in the -- this morning, Ms. Weckerly?

7 MS. WECKERLY: Your Honor, I wasn't planning to
8 actually go into that --

9 THE COURT: Okay. Here's --

10 MS. WECKERLY: -- on direct.

11 THE COURT: -- that's -- okay. You and I are on the
12 same page, then.

13 MS. WECKERLY: Okay.

14 THE COURT: Here's my sort of preliminary ruling, if
15 you will. The State is precluded from going into it on direct
16 examination. If, however, on cross-examination the defense
17 opens the door by, kind of like what I said with the CDC
18 investigators by, you know, pointing to, oh, it's only these
19 seven people or it's only these eight or nine or however many
20 it was, people, then I think the door can be opened for
21 questioning. You know, there were other people who could not
22 be determined to have been infected by another source, nor
23 could they, you know, scientifically or genetically be linked
24 to the center. So I think it could be opened.

25 Is that what you're going to say, Ms. Weckerly?

1 MS. WECKERLY: I was going to say that. There's just
2 a couple of things -- just so it -- on the actual infection
3 days that we have charged, there were ten people on each day
4 that were lost to follow-up.

5 THE COURT: Okay.

6 MS. WECKERLY: I was planning on eliciting that on
7 direct examination.

8 THE COURT: And I think that's fine, that doesn't
9 implicate the confrontation clause --

10 MS. WECKERLY: Right.

11 THE COURT: -- because they were lost to follow-up.

12 MS. WECKERLY: Right. We don't know their outcome,
13 right.

14 THE COURT: Right.

15 MS. WECKERLY: I think if there's questions, though,
16 about, you know, the exclusion, you know, maybe it was Lynette
17 Campbell and the saline flush or maybe it was scopes, I think
18 certainly the fact that there were numerous other infections
19 that are at least related or linked, I mean, that -- Mr. Labus
20 uses -- he categorizes it by whether or not there's a risk
21 factor, but there were 105 people that didn't have a risk
22 factor, and I think that lends itself to it not being scopes
23 and it not being a particular employee.

24 THE COURT: It still could be scopes, though, because
25 didn't you say of the people who are on the case, not all had

1 colonoscopies? So you've got that same argument whether it's
2 the 100 and -- is that basically what you're saying? Because
3 if they all had the same thing, whether it's 100 people or
4 10,000 people, if the -- let's just say the scopes were the
5 means of transmission, they could still be infecting that many
6 people.

7 Do you see what I'm saying? If they're not
8 sterilizing the scopes or the forceps --

9 MS. WECKERLY: Yeah.

10 THE COURT: -- or whatever --

11 MS. WECKERLY: I mean, I think that it's not
12 conclusive, but I think it certainly --

13 THE COURT: Well, I'm not sure it is -- I mean, I
14 think it could be suggestive if you looked at, okay, well,
15 Lynette Campbell wasn't working these other days, or I think
16 you pointed out already previously in the trial, you know, you
17 can't say it's the colonoscopy instruments when some people
18 had endoscopies.

19 MS. WECKERLY: Right.

20 THE COURT: I mean, I think that kind of --

21 MS. WECKERLY: Right.

22 THE COURT: -- thing, but just a number alone doesn't
23 tell me anything. Do you see what I'm saying?

24 MS. WECKERLY: Yes.

25 THE COURT: And so I think, yes, different procedures

1 than that would -- or some people had polyps removed so that
2 could implicate the forceps, but some people didn't have
3 polyps removed so that couldn't implicate the forceps.

4 MS. WECKERLY: Yeah.

5 THE COURT: Or some people had endoscopies so -- with
6 nothing removed at all, no tissue sampling, so that wouldn't
7 be the same. Do you see what I'm saying? A comparison like
8 that, I think, is meaningful because you're comparing the use
9 of different instruments.

10 Numbers alone, I don't find particularly meaningful
11 in a vacuum because, like I said, let's just say it's the
12 forceps and you're treating 60,000 people and you tell me,
13 well, it was 100 people. Well, it still could be dirty
14 forceps if all of those people were having polyps removed or
15 biopsies done or something like that. Do you see what I mean?

16 MS. WECKERLY: I do. There was -- there was, though,
17 at least one case at the other center --

18 THE COURT: Okay.

19 MS. WECKERLY: -- and, I mean, that would -- I doubt
20 --

21 THE COURT: Well --

22 MS. WECKERLY: -- there's the same scope there or
23 whatever. I guess there could be the same cleaning issues or
24 whatever, but in -- I -- whatever the ruling is, I'll
25 certainly --

1 THE COURT: I mean --
2 MS. WECKERLY: -- abide by it.
3 THE COURT: -- like I said, I can see them opening
4 the door.
5 MS. WECKERLY: Okay.
6 THE COURT: If you feel that they have opened the
7 door in some way, then obviously the remedy is to approach the
8 bench --
9 MS. WECKERLY: Sure.
10 THE COURT: -- and we may have to -- I may -- we may
11 have to do some questioning of Mr. Labus out of the presence
12 of the jury to establish, you know, what he knows and how he
13 knows it and possibly argument to say -- to link up whether or
14 not, in fact, it is contrary to what has been suggested by a
15 question on cross. Do you see what I mean?
16 MS. WECKERLY: There is one table from the report
17 that -- I understand the ruling on the report itself, but it
18 goes through what was eliminated as a source of transmission
19 on the 21st that I will seek to admit because it's just
20 narrowed to that infection date.
21 THE COURT: Any objection to the table --
22 MR. WRIGHT: Yes.
23 THE COURT: -- being separately marked as an exhibit?
24 MR. WRIGHT: Yes, I object to it.
25 MR. SANTACROCE: Can I see it?

1 MS. WECKERLY: Sure.

2 THE COURT: Basis?

3 MR. WRIGHT: The basis is -- and it's a bigger basis
4 than just the table, and so -- I understand the report is not
5 admissible, and the State is not going to elicit -- I just
6 want to make sure I understand --

7 THE COURT: Elicit on --

8 MR. WRIGHT: -- the rules, right?

9 THE COURT: -- direct examination the infection.
10 That's what Ms. Weckerly said, she does not --

11 MR. WRIGHT: Right.

12 THE COURT: -- have the intent to elicit on direct
13 examination the 100-plus other infected patients. But she
14 does intend to elicit that how many people were -- couldn't be
15 contacted, we just don't know.

16 MS. WECKERLY: Ten on each day -- on each infection
17 day didn't respond. So they were lost. There's no follow-up
18 on them.

19 THE COURT: I'm fine with that because I don't think
20 that implicates the confrontation clause because --

21 MR. WRIGHT: Well, the --

22 THE COURT: -- it is what it is. They were contacted
23 and we just don't know.

24 MR. WRIGHT: They were subpoenaed?

25 MS. WECKERLY: Well, we didn't --

1 THE COURT: They didn't. That was what the whole
2 issue was.

3 MS. WECKERLY: We don't know who they are.

4 THE COURT: That was the whole issue with the Health
5 District --

6 MR. WRIGHT: Certainly, we know who they --

7 THE COURT: -- Mr. Coffing, who I see is sitting here
8 --

9 MR. WRIGHT: Certainly.

10 THE COURT: -- opposed the release of that
11 information. I ruled in the Health District's favor. That
12 was one of the issues, as I recollect.

13 MR. WRIGHT: There's only 120 patients. We know the
14 names of every one of them. This isn't rocket science. Of
15 course they know who it is, and they can subpoena them. And
16 because they opted not to, I'm supposed to -- if I examine the
17 expert on the information he used to reach his conclusions,
18 I'm opening the door to waiving my confrontation rights?

19 THE COURT: I don't think that's what anyone is
20 suggesting here. I think -- what I'm ruling, anyway, is kind
21 of what happened with the CDC people, where you sought to
22 suggest that, oh, well, you are basing it on this limited
23 number or something like that, and I said -- I don't remember
24 exactly what the question was -- I don't remember exactly what
25 the answer was, but I said, Look, you can't create a false

1 impression without opening the door to then the State, you
2 know, addressing that false impression. That's what I said.
3 I think it's the same with Mr. Labus.

4 So, you know, if you open the door, then the State
5 may be able to get into that. Again, limited to this: By
6 their own self-reporting we did not identify other risk
7 factors, but they could not be scientifically or genetically
8 linked to the center. I mean, that's it. That's what I
9 understand that the evidence would be.

10 So they can't say that -- in argument -- that
11 they're linked because they never were linked. They can't say
12 definitively they didn't have other risk factors. By their
13 own self-reporting they didn't identify other risk factors. I
14 mean, I think that's what it would open the door to.

15 Again, you know, I think my ruling is consistent
16 here, that, you know, you can't create a false impression, and
17 if you do, then that may open the door to what really occurred
18 with the testing and interviewing of all of the infected
19 people.

20 MR. WRIGHT: Okay. So if I open the door, then I get
21 the identity --

22 THE COURT: Well --

23 MR. WRIGHT: -- of all of those people and I get the
24 information I need? The State has created this riddle, Judge,
25 and I want to -- I'm not making myself clear. They opted

1 to --

2 THE COURT: No, I think you --

3 MR. WRIGHT: -- put an --

4 THE COURT: -- are making yourself clear.

5 MR. WRIGHT: -- no, they opted to put an expert on
6 the stand who has looked at materials and reached his
7 conclusions. And part -- part of his thought process had to
8 have been, oh, I think it's this or that because we sent out
9 letters and we got this many back, and that corroborates it to
10 me this or that happened. And so that's off limits. I can't
11 go to the area that he relies upon because I'm not going to
12 get it, if -- because of the law that says that's --

13 THE COURT: Well, what if you asked him of his
14 thought process and his thought process was, well, there were
15 100-and-something other infected patients? I'm not going to
16 tell him, Well, you can't testify about your true thought
17 process.

18 It's exactly the same situation that was created
19 with the CDC. I'm not going to tell him, well, if Mr. Wright
20 asks you what your thought process was or why you focused on
21 this to the exclusion of something else and that involved 109
22 other patients, then I'm not going to tell him that he can't
23 answer that question truthfully.

24 I mean, I guess we are in a bit of a --

25 MR. WRIGHT: That's good. So I'm -- I'm waiving --

1 THE COURT: -- conundrum here, but --

2 MR. WRIGHT: -- I'm waiving my confrontation rights

3 --

4 THE COURT: No, you're not --

5 MR. WRIGHT: --- he --

6 THE COURT: -- waiving your confrontation rights.

7 MR. WRIGHT: -- certainly I am.

8 THE COURT: You have your full confrontation rights.

9 MR. WRIGHT: Of those 106 patients? Get something
10 straight, I dispute that they even have hepatitis. I dispute
11 that they got it at the clinic. I admit nothing. He's
12 relying upon hearsay to make the determination, No. 1, that
13 they are infected. No. 2, that they're clinic-associated
14 because they have no risk factors. And No. 3, he won't
15 disclose who they are. That's the evidence. He won't tell us
16 who they are.

17 They're putting an expert on the stand who knows
18 something, has it down -- I can't look at what he's looked at,
19 and the State opted to use him as the expert. In any ordinary
20 case like this, you get an expert, you have him read all the
21 transcripts of the evidence that came in, or you have him sit
22 here the whole day so that they have heard the same thing
23 everyone has heard, and then they get up there and opine.

24 But Mr. Labus has, by law -- by your ruling -- the
25 right to have information that he has relied upon, that he

1 cannot share with me. And so how do I have the right to
2 confront him on that issue?

3 MS. WECKERLY: As to --

4 THE COURT: Ms. Weckerly?

5 MS. WECKERLY: -- as to the charge days, everybody
6 has access to -- to all of that information, and I don't --
7 the fact that they sent out letters and didn't get a response
8 from 10 people on each day -- there isn't -- there's nothing
9 there. There's nothing to confront because they didn't get
10 information back from --

11 THE COURT: He's not talking about that. I am
12 assuming --

13 MS. WECKERLY: But as --

14 THE COURT: -- you're talking about the 100-and-some
15 --

16 MR. WRIGHT: Correct.

17 MS. WECKERLY: Okay. The other 100 -- the other 105,
18 he can -- I mean, he's certainly, when I've read his
19 depositions, he's very qualified when he talks about that
20 because he says, This is their self-reporting, I can't link
21 them conclusively to the clinic; they may, you know, there's
22 instances where people falsely report. I don't think he
23 relies on those opinions to form his opinion or conclusion
24 about how the transmission occurred on our actual days, but he
25 does rely on the transmission to, I guess, to make the

1 decision as to how far -- how far back to send out
2 safe-injection practices.

3 So he -- he saw unsafe-injection practices back in
4 2005 --

5 THE COURT: But -- and that doesn't really matter --

6 MS. WECKERLY: -- but -- but I'm not asking --

7 THE COURT: -- what --

8 MS. WECKERLY: -- him about that, so --

9 THE COURT: -- whether he sent out 30,000 letters --

10 MS. WECKERLY: Right.

11 THE COURT: -- or 90,000 letters or 60,000 letters or
12 whatever. I mean, to me that has nothing to do with, you
13 know, whether your defendants, in this case, you know, are
14 guilty or not guilty --

15 MS. WECKERLY: Right.

16 THE COURT: -- how many letters he wound up sending.

17 MS. WECKERLY: Right. But I don't think that he
18 relies on that aspect of the Health District action to reach
19 the conclusion as to the source of transmission. But if he's
20 going to be asked about, you know, why did you send all those
21 out, or boy, you only got seven people out of sending out 47
22 letters, you know, that's not true. So I think that's where
23 the --

24 THE COURT: I --

25 MS. WECKERLY: -- the false impression is.

1 THE COURT: -- and that's -- that's exactly what I
2 was -- was saying too. Everything else you can -- I mean, I
3 don't see a problem with fully confronting him on the bases of
4 his conclusions, and how, you know, he determined it had to
5 have been the propofol and the CRNAs, and --

6 MR. WRIGHT: Because they elect to choose him as the
7 witness who has information that he cannot share with me.
8 They -- they didn't have to use him, and so because of that if
9 I cross-examine him fully with my confrontation rights I'm
10 waiving -- I'm opening the door and then in can come evidence
11 that is hearsay, and that I don't have a right of
12 confrontation to --

13 THE COURT: Well, let's be clear here --

14 MR. WRIGHT: -- all because the State didn't do it.

15 THE COURT: Let's be clear here. First of all, they
16 didn't go out and choose Mr. Labus as their expert. Mr. Labus
17 was the employee of the Health District that went out and did
18 the investigation which far preceded any involvement by the
19 District Attorney's Office. Just -- so to me I think it's
20 unfair to somehow suggest that Mr. Labus is in the same exact
21 position of a retained expert and they could have chosen
22 anyone is inaccurate.

23 I mean, they're -- they're calling Mr. Labus because
24 Mr. Labus was on the front lines of this thing. He was on the
25 ground there doing this investigation, and the District

1 Attorney's Office had no part in that choice.

2 Ms. Weckerly?

3 MS. WECKERLY: Well, I mean, that's true. He's a
4 percipient witness too. He has conversations with people that
5 we intend to bring in because their statements in court, you
6 know, these are prior inconsistent statements. He's a regular
7 witness and he also has expertise, and based on his
8 observations on the day they were there, his collaborative,
9 you know, I guess discussions with the CDC representatives, he
10 reaches a conclusion about how the transmission occurred. And
11 when he rules out the other sources it's based on information
12 he observed or got from the records from those two infection
13 days.

14 Now, why the notification was as broad as it was is
15 a different decision, so, I mean --

16 THE COURT: I don't think that's really what Mr.
17 Wright is focusing on, the --

18 MR. WRIGHT: Right.

19 THE COURT: -- notification.

20 MR. WRIGHT: I'm not. I just have the -- and I have
21 a problem with the -- for the two dates in issue, July and
22 September. The -- they're -- they are going to elicit that 10
23 patients on each day we don't know whether they have
24 hepatitis, is that what I understand?

25 MS. WECKERLY: Right. Yeah, there's no follow up on

1 -- they didn't --

2 MR. WRIGHT: Okay. But --

3 MS. WECKERLY: -- respond.

4 MR. WRIGHT: -- okay.

5 THE COURT: I think what you can't argue -- I mean, I
6 think the evidence will be they didn't respond, that's it.

7 MR. WRIGHT: To what? The subpoenas?

8 THE COURT: To the letters.

9 MR. WRIGHT: The compulsory process? What -- why
10 wasn't the case investigated? So I -- I open the door if I go
11 into these 10? I want to know who they are. I want to know
12 who didn't respond, and that's what I'm going to ask him.

13 THE COURT: I don't think you open the door to
14 anything --

15 MR. WRIGHT: Okay. Well, then --

16 THE COURT: -- there.

17 MR. WRIGHT: -- I'm going to ask him for those 10 on
18 each day --

19 THE COURT: And then he can say, well, it was our
20 belief that -- or we were -- or we were told we didn't have
21 to -- or whatever the case may be. I mean, those were the
22 part of the ones that, as I recollect, were litigated. The
23 State subpoenaed the information, as you recall, the Health
24 District filed -- I think they filed that they objected to the
25 service of a subpoena, I believe, so they filed it, I think,

1 as a motion to quash, if I recall, and they argued that
2 pursuant -- as you -- as you'll remember, pursuant to state
3 statute. They didn't have to disclose that information.

4 The Court ruled in the Health District's favor, that
5 they didn't have to disclose that information. And so -- now,
6 could the --

7 MR. WRIGHT: So that --

8 THE COURT: -- state have done more?

9 MR. WRIGHT: Yeah, could --

10 THE COURT: Yes.

11 MR. WRIGHT: -- is that hard to figure out with 126
12 patients? They sit on their hands and do nothing to
13 investigate the case.

14 MS. WECKERLY: But, I mean, even if -- even if we got
15 the people, we still don't know how the Health District
16 classified them. I mean, that's -- you know, yes, we could,
17 but we wouldn't know what the internal classification of the
18 Health District --

19 THE COURT: Right. But you would -- I mean,
20 hypothetically, had you done the -- I mean, to be fair, had
21 you done the investigation and had you found the people and
22 had you contacted them and had some of them been willing to
23 speak with your investigator, at least some of them may or may
24 not have been tested and some of them may have disclosed the
25 results of those tests.

1 MS. WECKERLY: Right. I mean, that's how we got --

2 THE COURT: That's what Mr. Wright --

3 MS. WECKERLY: -- looked --

4 THE COURT: -- is talking about. So then you would
5 know, okay, these ten -- of the ten you found five and five
6 were infected with hepatitis -- or two of the five were and
7 the other three weren't, or whatever the case may be. Is that
8 basically what you're saying?

9 MR. WRIGHT: Correct. And I am viewing it that there
10 are six total -- well, one -- one viral -- not connected, I
11 mean, the one for the two days -- or two.

12 MS. WECKERLY: Two.

13 MR. WRIGHT: But I'm viewing that that the state of
14 the evidence is there were seven for the two days combined,
15 seven out of 126 or whatever the number is. And if the State
16 is going to argue that there's seven, or there may be 27 --

17 THE COURT: Yeah, I don't think that would be --

18 MR. WRIGHT: -- that -- that --

19 THE COURT: -- fair. They can't argue that. That
20 would be --

21 MS. WECKERLY: No, we're going to argue that --

22 THE COURT: -- totally --

23 MR. WRIGHT: Well, then why are they --

24 THE COURT: -- unfair.

25 MR. WRIGHT: -- bringing it out at all?

1 MS. WECKERLY: We're -- we're going to argue there's
2 nine because we're -- we count --
3 THE COURT: Yeah, the --
4 MS. WECKERLY: -- Lakota Quannah and --
5 THE COURT: -- Lakota Quannah --
6 MR. WRIGHT: Oh, that -- that's --
7 THE COURT: -- that's fine.
8 MR. WRIGHT: -- what I meant.
9 THE COURT: You can argue that there's nine. I mean
10 --
11 MR. WRIGHT: But they're --
12 THE COURT: -- I don't --
13 MR. WRIGHT: -- they're going to argue there's --
14 MR. COFFING: Hold on, one --
15 THE COURT: -- think you can say --
16 MR. COFFING: -- at a time.
17 MR. WRIGHT: -- 29.
18 MR. COFFING: One at a time.
19 THE COURT: -- well, we didn't hear from these
20 people, so they, you know, it -- the inference is that they
21 were infected. I mean, it's just as likely they didn't
22 respond to the Health District because they weren't infected,
23 and they thought --
24 MR. WRIGHT: Well --
25 THE COURT: -- I'm not infected, why -- why am I

1 going to bother with this whole thing?

2 MR. WRIGHT: Right. But the --

3 THE COURT: I mean, I think that's just --

4 MR. WRIGHT: -- what --

5 THE COURT: -- as reasonable an inference --

6 MR. WRIGHT: -- why -- why is it --

7 THE COURT: -- as to why.

8 MR. WRIGHT: -- coming out, other than to draw the

9 inference that there may be others?

10 THE COURT: I think they can bring it out to explain

11 the blanks on the sheet that -- that we don't know, that

12 the -- is that -- I mean, if that's what they're doing --

13 MS. WECKERLY: That's -- right, we don't --

14 THE COURT: -- on the schedule --

15 MS. WECKERLY: -- know.

16 THE COURT: -- is to say, look, these were people,

17 the Health District, that we don't know.

18 MR. WRIGHT: The Health District does, but we don't?

19 THE COURT: Yeah. I mean --

20 MR. WRIGHT: And so in a --

21 THE COURT: -- the truth is the truth --

22 MR. WRIGHT: -- criminal case we're not --

23 THE COURT: -- Mr. --

24 MR. WRIGHT: -- allowed to know. I --

25 THE COURT: Mr. Wright, there are -- I've said this

1 over and over again. You know, you didn't weigh in on the
2 issue with the Health District and the State. I'm not saying
3 you had to, but here's the deal, and I've said this over and
4 over again: There are two, you know, just -- this is a, you
5 know, the Health District preventing the spread of disease and
6 studying how disease is, you know, spread and things like
7 that, that's a very strong State-ish interest, and I ruled
8 that that State interest is equal to the State interest in
9 going forward in criminal proceedings.

10 And so in this case I ruled they didn't have to
11 disclose --

12 MR. WRIGHT: Okay.

13 THE COURT: -- that name because you --

14 MR. WRIGHT: I -- I'd --

15 THE COURT: -- have to protect the open flow of
16 information with the Health District because their function is
17 to, you know, identify communicable diseases and to try to, I
18 guess, ascertain how those are spread and to prevent the
19 further spread. And so, you know, they have a strong and
20 compelling, in my view, legitimate interest --

21 MR. WRIGHT: Okay. As --

22 THE COURT: -- in keeping the -- that information
23 confidential.

24 MR. WRIGHT: And stronger than my client's right to a
25 fair trial and his compulsory process rights and his rights of

1 confrontation? I make the demand right now for a Court order.
2 You say the State's balance doesn't tip; I want it -- under
3 compulsory process, my right to confront witnesses and the
4 evidence that is available. I want the information that won't
5 be turned over to the State by the Health District.

6 MS. WECKERLY: Well, yeah, I don't have it, so...

7 MR. WRIGHT: No, I'm -- I'm subpoenaing it, I'm
8 demanding it, he's testifying, I am requesting that the
9 witness produce it.

10 THE COURT: Mr. Coffing, I'm assuming you're here for
11 the Health District?

12 MR. COFFING: Your Honor, I was here to just be with
13 the witness, Your Honor. I wasn't --

14 THE COURT: Right. I mean, here's --

15 MR. COFFING: -- anticipating --

16 THE COURT: -- the thing. You want to subpoena the
17 information, I guess, subpoena the information. As I recall,
18 the --

19 MR. WRIGHT: No, I'm requesting --

20 THE COURT: -- statute, it was pretty much no
21 exceptions. You know, to me the remedy if, you know, you
22 can't get a fair trial with the information is a separate
23 remedy than forcing the Health District to turn over the
24 information. Now, everyone keeps saying that, well, you could
25 have figured out the information other ways. So if that's the

1 case, then I don't see how the interest of the Health District
2 somehow is minimized when there are alternate routes to find
3 that information.

4 MR. WRIGHT: I don't have to do any of that.

5 THE COURT: Well, all I'm saying is, first of all,
6 the State cannot create a false inference to their benefit by
7 virtue of the fact ten people didn't respond. They can
8 explain what the missing people mean on the chart, but they
9 can in no way argue, well, maybe these people would have had
10 hepatitis, we just don't know. That would be improper
11 argument in my view, and you can't do it. So does that
12 alleviate some of your concerns?

13 MR. WRIGHT: No. I still want the information.
14 I'm -- I don't want to -- I don't want to -- I don't want this
15 on an idea that, okay, if you want it, go subpoena it. The
16 witness is here, and so I am going to request that he produce
17 it. And so I -- I just want a ruling so that --

18 THE COURT: Do you have the 126 names?

19 MR. STAUDAHER: They're -- they're on the chart.

20 MS. WECKERLY: They're on the charts, but we --

21 THE COURT: On the day?

22 MS. WECKERLY: -- you know, we redacted them. But I
23 don't --

24 MR. STAUDAHER: Counsel --

25 MS. WECKERLY: -- I don't --

1 MR. STAUDAHER: -- Counsel had the --
2 MS. WECKERLY: -- know who --
3 MR. STAUDAHER: -- originals, so they've --
4 MS. WECKERLY: -- didn't follow up.
5 MR. STAUDAHER: -- got all that.
6 MS. WECKERLY: I don't know that. I know who the
7 people are, but I don't know who was lost to follow up because
8 that would only be known to the Health District.
9 MR. WRIGHT: Oh, so you're -- you're talking about
10 -- I mean, there are -- there are 20 people who didn't respond
11 for the two --
12 MS. WECKERLY: Right.
13 MR. WRIGHT: -- days, correct?
14 MS. WECKERLY: Correct.
15 MR. WRIGHT: The identity of those 20?
16 MS. WECKERLY: I don't know that. Only the Health
17 District knows that.
18 THE COURT: Then how do you know --
19 MR. WRIGHT: We have patient lists.
20 THE COURT: -- okay, well, wait. I'm missing
21 something here because if you have -- let's make this easy for
22 us, 100 people, okay? And let's say of the 100 people 8 -- 8
23 that day were infected, okay? So now you've got 92 people.
24 And of those 92 people, are you saying -- and then, of the 92
25 people, I understand you knew X, you know, A, B, and C, and D,

1 weren't infected; is that true?

2 MR. STAUDAHER: No.

3 MS. WECKERLY: No.

4 MR. STAUDAHER: What we have is 126 -- the -- and
5 Counsel had the original, the unredacted information, so both
6 sides have had all the names of the patients that -- those two
7 days, who had procedures done on those two days. Of those 126
8 people, or whatever, we -- we -- there are apparently a total
9 of 20, 10 for each day, that were lost to follow up by the
10 Health District. So of the --

11 THE COURT: Right. But you know who was not lost to
12 follow up.

13 MR. STAUDAHER: No.

14 MS. WECKERLY: No.

15 MR. STAUDAHER: If we knew who was not lost to follow
16 up, we would know --

17 THE COURT: Then you would know who --

18 MR. STAUDAHER: -- was --

19 THE COURT: -- right.

20 MS. WECKERLY: Right.

21 MR. STAUDAHER: -- and that was all -- that was the
22 information that we were requesting. That was what the Court
23 ruled we could not get. So we don't know which ones the
24 Health District contacted and didn't contact --

25 THE COURT: So all you know is, okay, of the other,

1 say 90 people that weren't lost to follow up --

2 MR. STAUDAHER: We don't know who those people are --
3 which ones were not lost.

4 THE COURT: -- right. That -- that none of them
5 tested positive for hepatitis, and that 10 people you don't
6 know and nine people did test positive; that's what you know?

7 MS. WECKERLY: Right.

8 THE COURT: And you know the identity of the people
9 who do -- did test positive?

10 MR. STAUDAHER: That we have linked --

11 THE COURT: Right.

12 MR. STAUDAHER: -- and --

13 THE COURT: Right. And --

14 MS. WECKERLY: Of the ones that followed up --

15 THE COURT: -- that's all you know?

16 MS. WECKERLY: -- we know who they are. We know that
17 the -- we know the ones that are positive.

18 THE COURT: Right. Which are the ones -- you know
19 that. So the other people, you know that they weren't
20 positive, but you don't know their identities.

21 MR. STAUDAHER: No, we don't know that they weren't
22 positive. We don't --

23 THE COURT: I'm not talking about --

24 MR. STAUDAHER: -- know if they were ever tested --

25 THE COURT: -- the people who didn't follow up, I'm

1 talking about --

2 MR. STAUDAHER: Oh.

3 THE COURT: -- the people who did follow up.

4 MR. STAUDAHER: It's our understanding that those
5 people were tested --

6 THE COURT: And they're negative?

7 MR. STAUDAHER: -- at some point and they were
8 negative, yes.

9 THE COURT: Okay. And what Mr. Wright is saying is
10 okay, you know there were 126 patients on that day. You can
11 eliminate the people we already know their identities because
12 they're in this case and they tested positive. Of those other
13 people, what you could do is try to subpoena and contact all
14 of those, and then find out from those who contacted you back,
15 Did you follow up with the Health District or not follow up
16 with the Health District?

17 Is that essentially what you're saying, Mr. Wright?

18 MR. WRIGHT: Yes. And it -- it affects on the chart
19 when we have skipped -- the whole skipping and room to room,
20 and presumptions that this -- this person that followed didn't
21 get hep C, now it's going to be left -- well, we -- we don't
22 know if they did or didn't.

23 THE COURT: How is this different from --

24 MR. WRIGHT: And --

25 THE COURT: -- any other case where the defense's

1 argument is, Look at how poorly investigated this case was.
2 Let's just take a run-of-the-mill robbery case and, you know,
3 somebody says, oh, you know, it was an African-American person
4 that was 5 feet, and then they stop an African-American person
5 on the street and he's 5'7 and they arrest him, and then they
6 shut the whole thing down and they don't bother with
7 fingerprints or DNA or anything else that they could have done
8 that would have potentially exonerated the person that they
9 picked.

10 And that's what the defense argues, and I know,
11 though, you don't tend to handle those kinds of cases, but
12 trust me on this, that's probably the majority of what we see.
13 You know, how is this any different when the argument is,
14 look, the State didn't do a good job? They didn't do a
15 thorough investigation. They could have done more. You know,
16 where -- where are these other things that they could have
17 done?

18 MR. WRIGHT: The --

19 THE COURT: Tell me how this is different.

20 MR. WRIGHT: The difference is the State of Nevada
21 has the information. They -- the State of Nevada has it.
22 You're saying the District Attorney doesn't. The State has
23 evidence that may be exculpatory. That may help the -- and I
24 can't have it. And you're putting this privacy right of the
25 Health District --

1 THE COURT: Well, first of all, let's be --

2 MR. WRIGHT: -- above --

3 THE COURT: -- clear here, Mr. Wright. You weren't
4 heard on -- you were all here, as I recall, but none of the
5 defense wanted to be heard on the issue with the Health
6 District. So what the Court considered was what the State had
7 presented and what the Health District had presented.

8 And basically, the issue that was litigated at that
9 time was, well, the State said, well, we, you know, feel like
10 we need to find these things and blah, blah, blah, and, you
11 know, the Health District, as I recall, said there's other
12 ways for them to get it.

13 And our interests in protecting full and complete
14 disclosure to fulfill the duties of the Health District, you
15 know, are tantamount to -- to their, you know, interests in
16 finding this information. The statute, I thought, was pretty
17 clear -- the State statute -- and so that was the issue before
18 the Court at that time.

19 The Defense, you know, was here, they, you know,
20 didn't -- didn't choose to weigh in at that point. And so I
21 don't think in some way it's fair to penalize the District
22 Attorneys who are here because they did seek out that
23 information --

24 MR. WRIGHT: Well, they --

25 THE COURT: -- from the Health District. I'm not

1 saying you were obligated to do it.

2 MR. WRIGHT: Of course, I'm not --

3 THE COURT: All I'm --

4 MR. WRIGHT: -- I'm not obligated --

5 THE COURT: -- no, and I'm not -- and well, just
6 before -- I'm not suggesting that you were, but let me just
7 say that the consideration that, you know, what was -- what
8 was considered by the Court was the arguments from the State,
9 the DA's office, and the Health District at that time, you
10 know, not, you know, some of the arguments that you're making
11 today. So that's all I'm saying.

12 In any event --

13 MR. WRIGHT: Because today I'm saying it under
14 compulsory -- compulsory process, and the right of
15 confrontation, I want the evidence that the State of Nevada
16 has and will not give me.

17 And I don't buy their higher investigative privilege
18 that trumps my client's right to the evidence. There -- these
19 cases come up all the time. The State, if they don't want to
20 turn it over, has the option. They do this in secrecy cases,
21 top secret, don't want to turn over CIA information. The
22 remedy is the case gets dismissed.

23 You don't just say, oh, sorry, you got to go to
24 trial without it. That's what I am requesting and want, and
25 the State has it. And the Health District, they're

1 willy-nilly on their obligations. They'll promise
2 confidentiality. I mean, it's right in their -- in Labus's
3 note, they tell someone this is an off-the-record statement,
4 and then turn right around and hand it to the police.

5 So I don't buy this investigative --

6 THE COURT: Well, just --

7 MR. WRIGHT: -- privilege and the public interest.

8 THE COURT: -- just to be clear, it's not an
9 investigative privilege under the --

10 MR. WRIGHT: Public health privilege.

11 THE COURT: -- statute -- it's a patient privilege.
12 It's to get people to disclose these diseases to the Health
13 District, as I -- as I recall it, so that they're not afraid
14 that their identities will be made known, in this case,
15 publicly.

16 And so, that's what it's for, so that people feel
17 like they can go to the Health District if they've contracted
18 a disease and they don't have to worry about their name being
19 disclosed down the road.

20 And the -- the State interest is pretty obvious. We
21 need people who are willing to go and disclose these things
22 for the Health District so that the Health District can
23 determine outbreaks and put an end to them. And the idea
24 being, if people know, well, hey, if I go to the Health
25 District, then some criminal defense attorney may get my name

1 and, you know, the reporter sitting in the back row now is
2 going to know who I am and that I've got hepatitis, or, you
3 know, maybe I went even, you know -- you know, some people may
4 not want it -- want it known they went to the gastro center
5 because maybe they have, you know, Crohn's disease or cancer
6 or some other disease that they don't want known publicly.
7 They don't want their employers to know about it.

8 And so these are all interests. What if one of
9 those people tested positive for AIDS, HIV, totally unrelated
10 to this case? That's something that's clearly protected. And
11 so there are abundant reasons why that's an important statute
12 that had nothing to do with the proceeding.

13 But, you know, right now as I'm sitting here I can
14 think, well, gosh, if people know, wow, if I go in and I
15 disclose these things and I'm tested and I have a disease that
16 I don't want people know -- knowing about because it's
17 stigmatized, and it could even be a problem with my employer,
18 you know, what if you're -- then that's going to put a --
19 put a stop to the flow of information to the Health District.

20 And I think this right here what we're -- what we're
21 seeing is exactly what they're concerned about. And so, you
22 know, I -- I stand by the ruling in that regard.

23 So here's what I would suggest going forward. Let's
24 get started. We'll go through the direct of Mr. Labus. If
25 you have a question regarding cross, if that will open the

1 door, then certainly approach the bench. If we need to take a
2 break or something like that, we'll excuse the jury and take a
3 break.

4 With respect to this issue with the nondisclosure.
5 This was an issue that's been known for a long time, and so to
6 me, to spring it on, you know, on the Court and ask for an
7 order compelling the Health District to turn over these
8 records in, you know, contravention of the previous order
9 or -- I'm not going to do that.

10 So, you know, you certainly have the right to raise
11 this issue at a later date, and you can do that, you know, to
12 brief it fully and say that your client's rights were
13 denied --

14 MR. WRIGHT: Okay.

15 THE COURT: -- because of the failure of the Health
16 District upon the Court's order to disclose the information,
17 and then the failure of the District Attorney's Office to take
18 alternate steps to try to learn or ascertain the information.
19 You certainly can do that, as, you know --

20 MR. WRIGHT: Okay. So is it --

21 THE COURT: -- post-trial remedy, but at this point
22 in time I don't think it's fair to make the motion while the
23 jury is all waiting around to start, when this is an issue
24 that's been known, not for days, not for weeks, but for
25 months. I made that ruling months ago.

1 So, Mr. Santacroce?

2 MR. SANTACROCE: Yes, I just needed to make my
3 record, Your Honor. I want to join Mr. Wright's motion
4 objection regarding these 104 patients. In addition, I want
5 to object to State's Proposed 228, which is the chart. This
6 chart lists a bunch of things that the Health District
7 apparently considered and ruled out, and it says, results
8 ruled out.

9 They go through the IV placements. They go through
10 the scopes. They go through the biopsy equipment. And they
11 say, we've ruled these out for various reasons. And now, the
12 Court's telling me if I go into, for example, Lynette Campbell
13 and the IV placements which they ruled out, then I'm opening
14 the door to these 104 patients? I mean, how -- if you're
15 going to allow this in, and the jury is going to take it back
16 to the jury room --

17 THE COURT: I didn't say I was -- okay. Go on.

18 MR. SANTACROCE: -- no, I'm just saying I object to
19 it coming in, unless I can cross-examine on each one of these
20 things that were ruled out without opening the door to the
21 bigger issue. So that's the dilemma I have, and that's why
22 I'm objecting to allowing this to come in.

23 THE COURT: All right.

24 MR. SANTACROCE: Or at least give me some direction
25 as to what I can go into without opening the door.

1 THE COURT: One of the problems the Court's having
2 right now is I don't know what Mr. Labus's answers would be to
3 those questions. And I don't know if Ms. Weckerly knows what
4 Mr. Labus's answers would be to those questions. I mean, I
5 think it's fair, you know, Mr. Santacroce's theory is that
6 it's more likely that the -- that it was transmitted through
7 contaminated saline than it was through, you know, the
8 propofol, which makes sense in -- you know, I think he's --
9 he's got a good theory he's working with because you got to
10 put the virus in numerous bottles of propofol as opposed to a
11 single bottle of saline.

12 So, you know, it's -- that's where he is, and he has
13 a right to flesh that theory out, certainly. So, you know, if
14 Mr. Santacroce gets into, you know, why was Lynette Campbell
15 and the saline solution excluded, you know, do you know what
16 Mr. Labus is going to say because I certainly don't?

17 MS. WECKERLY: I mean, I think he's going to say
18 it's, you know, it's based on their observations at the clinic
19 and their review of the charts. I don't think he -- I mean, I
20 don't think he's going to make reference to the other 105
21 cases. But he's going to base it on what they observed at
22 their investigation.

23 THE COURT: Okay. So pretty --

24 MS. WECKERLY: And all of these conclusions are based
25 on their observations or chart reviews from the --

1 THE COURT: -- just from those two days.
2 MS. WECKERLY: -- two infection days.
3 THE COURT: As long as that's it, then I don't see
4 that opening the door. You can fully cross-examine.
5 MR. SANTACROCE: Okay.
6 THE COURT: You know, Ms. Weckerly, I guess what --
7 MS. WECKERLY: Well, I can get him and ask him.
8 THE COURT: -- well, you can ask him or, you know,
9 just tell him, look, if some answer is going to call for going
10 into the -- why don't you just, you know, ask him. If that's
11 all he based everything on, then I don't see the door being
12 opened, and we're -- okay?
13 MS. WECKERLY: Okay.
14 THE COURT: So if anyone needs -- yes, Mr. Wright?
15 MR. WRIGHT: Right. I just want it clear. I don't
16 want to ask him in front of the jury. I mean, the state of
17 the record is I have requested the production of the patients
18 that -- the 105, identity of them, and the 20 for the two
19 dates in question.
20 THE COURT: Right.
21 MR. WRIGHT: And the -- the privilege precludes the
22 production; is that correct?
23 THE COURT: I mean, I don't know --
24 MR. WRIGHT: I mean, I just want the record --
25 THE COURT: -- I don't know why it --

1 MR. WRIGHT: -- straight.

2 THE COURT: -- would be different from you requesting
3 it than it was from the State requesting it.

4 MR. WRIGHT: Because I have compulsory process --

5 THE COURT: Well, that wasn't --

6 MR. WRIGHT: -- and right of confrontation --

7 THE COURT: -- okay --

8 MR. WRIGHT: -- and they don't. And I -- and you act
9 like I knew this the entire time. I'm telling you, until we
10 were at a sidebar up there talking about the 105, I did not
11 know they didn't know who those 105 were. We were up there --

12 THE COURT: Well, the 105, and the 10 are different
13 --

14 MR. STAUDAHER: Yes, they're completely different.

15 MR. WRIGHT: Correct.

16 MS. WECKERLY: They're different.

17 THE COURT: -- different issues.

18 MR. WRIGHT: Correct. I understand they're different
19 issues, but I -- I'm telling you, I didn't know they hadn't
20 conducted -- because that's when I was up there squawking
21 about --

22 THE COURT: Okay.

23 MR. WRIGHT: -- why didn't they do a criminal
24 investigation. Why did they just take -- handed to them this,
25 and then they turned it into a criminal case? And then I

1 learned, up there for the first time, that they didn't do
2 anything. That they just --

3 MR. STAUDAHER: No, that's --

4 MR. WRIGHT: -- well --

5 MR. STAUDAHER: -- that's another time, now --

6 MR. WRIGHT: -- that's a misstatement. I'm -- I
7 don't meant hey didn't -- they accepted the report of the
8 Southern Nevada Health District, and accepted what would be
9 turned over to them, and did nothing further to try to get
10 more information than what was in there. And so, I didn't
11 know all of that from preparation towards the case.

12 So all I'm saying is now my compulsory process right
13 under the Constitution, I just want it clear that they -- that
14 the privilege, and I -- you articulated it well, and I
15 understand the reasons and the basis for it, and I don't --
16 and I'm not arguing about your judgment on the call, I'm just
17 saying I want the record clear that it not only trumps the
18 State's demand for it, but it trumps my demand for it for Dr.
19 Desai.

20 THE COURT: All right. Off -- that issue was not
21 considered at the time I made the ruling.

22 MR. WRIGHT: Right.

23 THE COURT: All right. So having said that, you
24 know, I read this months ago. My belief, from memory, would
25 be that there were no exceptions to that. Now, you know, if

1 you would like -- again, I think it's a little bit unfair to
2 ask for a ruling, you know, right now. My recollection of
3 reading everything and studying it and -- was that there are
4 no exceptions. And again, I'm, you know, I think it's to
5 protect people from, you know, being hauled into court in
6 unrelated matters, and having their private health information
7 disclosed.

8 And so, you know, I think that the -- the ruling
9 would be the same. And I'll certainly say, this morning I'm
10 not going to order Mr. Labus or the Health District to turn
11 over the information to you.

12 MR. WRIGHT: Okay. And I wasn't -- I wasn't
13 suggesting there was a statutory exception in there for the --

14 THE COURT: No. No, I know you --

15 MR. WRIGHT: -- okay. I'm saying --

16 THE COURT: -- you're not -- I'm saying, I didn't
17 consider it -- the statutory rule and weighing that, doing any
18 kind of weighing analysis with Dr. Desai's Constitutional
19 rights. And I think you're right, you know, generally if he
20 can't get a fair trial and there's no way to turn over the
21 information or get the information, then the remedy is
22 dismissal. I don't see that as being the case here. I don't
23 see that he's being denied his right to a fair trial because
24 of the absence of the information.

25 MR. WRIGHT: Okay. But I'm not talking due process

1 for a trial. I'm talking compulsory process aside from right
2 of confrontation in me cross-examining him. My independent
3 right. I can't even remember the cases on compulsory process,
4 but it's -- there's one Supreme Court case, Oklahoma versus
5 somebody, and there was a statute that precluded turning over
6 certain information, and it was found that compulsory process
7 trumped --

8 THE COURT: And I'm happy to read that case, and I
9 would have read it had anyone given me a heads-up that we
10 would be arguing this this morning, which is why I'm saying, I
11 don't think it's fair of you, really, to spring this this
12 morning on the State. Ms. Weckerly, did you read that case in
13 anticipation for --

14 MS. WECKERLY: Not on --

15 MR. WRIGHT: I didn't either.

16 THE COURT: -- today's argument? I certainly didn't.

17 MS. WECKERLY: Not on compulsory process.

18 THE COURT: So, you know, I'm happy to read it at the
19 lunch break, if someone wants to get me a cite for that case,
20 and consider it; but again, that wasn't what was considered
21 last time, you know, no exceptions to the statute.

22 I'll reiterate it, the State interests and the
23 public health interests in the statute, I think, are obvious.
24 And as we sit here fighting over these people, and, you know,
25 media being present, I think the reason for the statute,

1 really, has hit home. And it's quite obvious to the Court.

2 And so, you know, if these people were hauled into
3 court, I think it would have a chilling effect on future
4 people going to the Health District if they think, gee, I
5 don't, you know, want to be -- I don't want my name being out
6 there in the -- in the public eye. I'm happy to read the
7 case.

8 MR. WRIGHT: Okay.

9 THE COURT: Like I said, you know, this is just
10 sprung on me this morning. I didn't read the case. You know,
11 I haven't been reading up on compulsory process and -- and
12 statutes that preclude, you know, dissemination of
13 information. So --

14 MR. WRIGHT: I haven't read up on it either, Your
15 Honor. It just seems so fundamental to me that a witness
16 can't get on the stand that knows more than I do, and then the
17 State has the information and can't share it with me. I mean,
18 I don't even need cases for that -- to say that proposition
19 doesn't work.

20 But I understand -- understand the ruling --

21 THE COURT: Well, he is a percipient witness to this,
22 and frankly --

23 MR. WRIGHT: I have no problem with his percipient
24 witness -- I want to be clear on that -- I didn't say he
25 couldn't testify. I mean, whatever his percipient thing is, I

1 got it. I know the issue.

2 THE COURT: Here's the problem, though, the whole --
3 I mean, part -- what I'm -- I've heard from the Defense is,
4 you know, this was sort of the whole -- I mean, my words not
5 yours -- this whole sort of rush to judgment and, you know,
6 that they didn't consider everything. Brian Labus was, you
7 know, and the CDC -- the gals from the CDC, it was them. So I
8 don't know how this case could be put on without Brian Labus
9 or someone from the Health District to explain, well, Why did
10 we get to this theory?

11 Because that's what I'm hearing in the opening
12 statement, it was a rush to judgment, it wasn't a thorough
13 investigation. Then you get the plaintiff's bar involved and
14 it's really, oh, go after the propofol and -- to the exclusion
15 of these other cheaper things, like the saline -- the multiuse
16 saline. And so I don't know how the case could go forward
17 without bringing all of that out.

18 So let's take a couple-of-minute break, and then I
19 want to get started with the jury.

20 MR. STAUDAHER: Your Honor, I'm not going to argue
21 anything. I just want to put something on the record, if I
22 may, and it will just take one second.

23 I know that the Court -- and I'm not quibbling with
24 the order regarding the admission or not of the actual report
25 of the Health District, but I do want to put in that the State

1 did submit four cases for the Court's review: United States
2 v. Berry, 683 F 3d --

3 THE COURT: And I think that was the one --

4 MR. STAUDAHER: -- 1015 --

5 THE COURT: -- I was quoting from this morning.

6 MR. STAUDAHER: -- a 2012 case, that was a criminal
7 matter. And then also, Ellis v. International Playtex, 745 F
8 2d 292. Drayton v. Pilgrim's Pride, which was 472 F 2d 638.
9 And also, the Beechcraft -- or Aircraft Corporation v. Beech
10 Aerospace Services v. Rainey, which was 488 US 153, a U.S.
11 Supreme Court decision.

12 I didn't indicate -- have any indication that the
13 Defense had ever submitted any cases --

14 THE COURT: They did not.

15 MR. STAUDAHER: -- and I don't know what else the
16 Court reviewed, but I did want to have on the record that that
17 was submitted, and --

18 THE COURT: And I did consider all of them, and --

19 MR. STAUDAHER: -- at least --

20 THE COURT: -- and the case I was quoting from this
21 morning was U.S. v. Berry, which was the sole criminal case,
22 and that was the one where the documents that the Court upheld
23 were routine administrative documents, that there was no
24 anticipation of a criminal proceeding.

25 Other cases have talked about litigation, and, you

1 know, I don't know the exact timing of all of these events,
2 but, you know, I think it was pretty clear early on, certainly
3 by what was going on in the media, that there could be
4 criminal charges, certainly that there would be civil
5 litigation involved in all of this.

6 And so I think the record is complete there. Can we
7 get started with the jury?

8 MR. STAUDAHER: Yes, Your Honor.

9 THE COURT: Okay.

10 (Pause in the proceedings.)

11 THE COURT: Go ahead and bring in the jury, Kenny.
12 Thanks.

13 Do you have the full name of that Oklahoma case?

14 MR. WRIGHT: No, but I'll get it.

15 THE COURT: Doesn't give me a lot -- doesn't give my
16 poor law clerk a lot to work with there.

17 MS. STANISH: Oklahoma and compulsory process --

18 MR. WRIGHT: Right.

19 MS. STANISH: -- U.S. Supreme Court, you'll find it.

20 MR. WRIGHT: Compulsory process.

21 MS. STANISH: Westlaw search will work with that.

22 MR. WRIGHT: It seems like to me it was a statute
23 that preclude -- if you can believe this --

24 THE COURT: Well, I mean, if it's --

25 MR. WRIGHT: -- a statute precluded the defendant

1 from calling a charged accomplice as a witness or something.
2 It was a statute that precluded testimony.

3 THE COURT: What was the, like, basis for the
4 statute? Like, the public policy behind the statute?

5 MR. WRIGHT: I don't even -- it wasn't very good. It
6 wasn't as big as the --

7 THE COURT: Unlike this public --

8 MR. WRIGHT: -- interest here.

9 THE COURT: -- policy behind the statute, which is,
10 you know, pretty compelling.

11 MR. WRIGHT: Correct.

12 THE MARSHAL: Ladies and gentlemen, please rise for
13 the presence of the jury.

14 (Jury entering at 10:11 a.m.)

15 THE MARSHAL: Thanks, everybody. You may be seated.

16 THE COURT: All right. Court is now back in session.
17 The record should reflect the presence of the State through
18 the Deputy District Attorneys, the defendants and their
19 counsel, the officers of the court, and the ladies and
20 gentlemen of the jury.

21 And the State may call its next witness.

22 MS. WECKERLY: Brian Labus.

23 THE COURT: Mr. Labus, just right up here, please,
24 sir, next to me, up those couple of stairs. And then remain
25 standing, facing this lady right there, who will administer

1 the oath to you.

2 BRIAN LABUS, STATE'S WITNESS, SWORN

3 THE CLERK: Thank you. Please be seated. And please
4 state and spell your name.

5 THE WITNESS: Brian Labus, B-R-I-A-N, L-A, B as in
6 boy, U-S, as in Sam.

7 THE COURT: All right. Thank you.

8 Ms. Weckerly?

9 DIRECT EXAMINATION

10 BY MS. WECKERLY:

11 Q Sir, how are you employed?

12 A I'm the senior epidemiologist for the Southern
13 Nevada Health District.

14 Q And how long have you been the senior
15 epidemiologist for the Health District?

16 A I've been the senior epi for about 11 years;
17 I've been employed there for 12.

18 Q Okay. And what's your educational background
19 that allowed you to work in that capacity?

20 A I have a bachelor's degree in biology from
21 Purdue and I have a master's of public health and infectious
22 diseases from UC Berkeley.

23 Q Prior to having the position you have as the
24 senior epidemiologist, did you hold other positions within the
25 Health District?

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1 A Yes, I was an epidemiologist.

2 Q An epidemiologist. Were you assigned to
3 investigate the hepatitis outbreak at the Endoscopy Center of
4 Southern Nevada in 2007?

5 A Yes, I was.

6 Q Can you explain to the members of the jury how
7 it was that the -- the outbreak itself came to your attention?

8 A Hepatitis C, when acute cases occur, is
9 reportable to the health authority, and by law we're
10 responsible for investigating those.

11 Q And what -- what is -- how does the Health
12 District and the CDC define an acute case of hepatitis C?

13 A An acute case of hepatitis C is defined by a
14 number of lab tests that show the person has hepatitis C, as
15 well as some current liver problems, so an elevated liver
16 enzyme which shows damage to the liver, or bilirubin, which is
17 why you turn yellow and get the symptoms from hepatitis. You
18 have to have a discrete onset of symptoms. So the combination
19 of the lab test and the symptoms are what defines it as an
20 acute case of hepatitis C.

21 Q And is there a time period where cases are
22 defined as acute, like, from the time of exposure, like, what
23 would be the outer range of what could be considered acute?

24 A If a person is infected, they'll develop acute
25 disease within six months.

1 Q And the other cases, I assume, are called
2 chronic?

3 A That winds up being a little bit of a tricky
4 term. Chronic usually refers to a long-term infection with
5 hepatitis C. So you have a new infection. A small percentage
6 of those people get symptoms, they get sick with the disease.
7 The rest have a subclinical disease. So the virus is in them,
8 it's doing damage, but they don't have any outward symptoms.
9 Some people clear the infection, but most go on to have a
10 long-term infection, which is the chronic hepatitis C.

11 Q And are chronic cases reported to the Health
12 District?

13 A All lab reports are reported to us, but chronic
14 hepatitis C is not legally reportable to us.

15 Q Okay. And typically how many acute cases would
16 be reported to the Health District in a normal year?

17 A Usually between two and four cases in Clark
18 County.

19 Q Okay. In Clark County? Now, when you -- when
20 was it that you first learned of this outbreak?

21 A I learned about it on January 2, 2008.

22 Q And when you -- did you learn about it, like,
23 because you were assigned to investigate it, or how was it
24 that it came to your attention?

25 A We had the two cases reported, one was in late

1 November, one was in December. They were investigated by our
2 investigation staff at the office. And when they identified
3 the common link between the cases it was passed up the chain,
4 and that's when I became aware of it.

5 Q Okay. So initially you were just aware of two
6 cases that were possibly associated with the clinic?

7 A That's correct.

8 Q And based on that, what steps did you take in
9 order to kind of get a plan together to start investigating?

10 A This was sort of uncommon for us. We don't
11 normally see hepatitis C tied to a medical facility; and when
12 the two cases were identified, they had procedures on
13 different dates. So we had two cases, sort of associated with
14 the same place, and sort of in the same time range, but not on
15 the same date. So we contacted the CDC to talk to them about
16 where should we go with this investigation? What would be the
17 appropriate next steps?

18 Q So initially, one of the cases you had reported
19 was -- went from July 25?

20 A That's correct.

21 Q And then you had another one from September the
22 21st?

23 A That's correct.

24 Q And then based on that they -- they had an
25 association with the clinic, but not much else of a

1 connection; is that fair, initially?

2 A Yes. Colonoscopies are a common procedure, and
3 so the fact that both people had them, it was uncommon, but it
4 really -- didn't really make it certain that it was any one
5 particular clinic. It could have just been a coincidence.

6 Q Okay. And what was -- what was behind the
7 decision to contact the CDC?

8 A The fact that we had some connection between
9 these two cases, but not a really strong connection, and we
10 wanted to talk to the experts on hepatitis and
11 healthcare-acquired infections to see if this warranted a full
12 investigation.

13 Q And when -- had you -- have you in previous
14 investigations contacted the CDC for, I guess it's advice
15 or -- or their thoughts on an investigation or an outbreak?

16 A Yes.

17 Q And is that something that's frequently done by
18 the Health District?

19 A Yes, and there's a process in place to do that.
20 There's kind of informal request and formal request, but
21 they're kind of the -- the experts on those diseases. So when
22 we don't know what to do -- if the State doesn't know, then we
23 go up to the CDC.

24 Q Now, do the -- does the CDC always send an
25 investigative team out, or sometime do they just offer advice

1 or -- or maybe information, and then the investigation is just
2 done with local officials?

3 A Most of the time it's more of an informal
4 discussion with CDC where we're just asking for their
5 expertise and they kind of give us their thoughts just as
6 scientists. We occasionally will request a formal
7 investigation from the CDC. There is a document that's
8 requested by our state epidemiologist that goes to the CDC,
9 and there's an official process for having them send somebody
10 out.

11 Part of it is deciding, is it worth sending somebody
12 out? Is it something where they need to come into the field?
13 Or is it something they can do just by assisting from Atlanta?

14 Q Okay. In this particular case two people were
15 sent out from the CDC, correct?

16 A Yes, that's correct.

17 Q And that's Dr. Melissa Schaefer and Dr. Gayle
18 Fischer, now, Langley?

19 A Yes, that's correct.

20 Q Okay. When was it that those two doctors came
21 out?

22 A They arrived on January 9.

23 Q And prior to them coming on January 9, what --
24 what did you do in terms of the investigation?

25 A Well, on the 2nd we were discussing things with

1 CDC, and we identified a third case. And the third case with
2 acute disease also had a procedure on September 21. So now we
3 had two cases that were on the same day, a third case on a
4 different day. Clearly there was something going on with that
5 clinic because that's more than we'd expect in a typical year,
6 basically.

7 Q Sure.

8 A So we began just to -- to get whatever documents
9 we had on -- on the clinic; we talked to the Bureau of
10 Licensure and Certification because they are the group
11 responsible for regulating that facility. So the first
12 question was, are they responsible; we contacted them, they
13 said that they were responsible, and then we coordinated our
14 response with them.

15 We both decided to wait until CDC arrived to launch
16 our field investigation.

17 Q Okay. And then the CDC obviously gets there?

18 A Yes.

19 Q And do you -- are you the one that actually
20 makes the call over to the clinic on the 9th to inform them
21 that you're coming over?

22 A Yes.

23 Q And how -- how much in advance of your arrival
24 at the clinic did you make that phone call?

25 A It was about 30 minutes.

1 Q Okay. And when -- when you all went over on the
2 9th, do you recall if it was in the morning, afternoon?

3 A It was in the afternoon.

4 Q And it was yourself, Dr. Schaefer, and Fischer,
5 and who else?

6 A And we had two people from the Bureau of
7 Licensure and Certification.

8 Q Was the -- was the investigation of the Bureau
9 of Licensure coordinated with your investigation at all, or
10 was it a separate one, or how would you describe it?

11 A I would say it's a parallel investigation. They
12 had their own investigative process. There were things that
13 they had to look into when they were out there. They were
14 doing basically a complaint response, essentially, and they
15 had certain things they had to do that -- that we didn't and
16 vice versa.

17 So CDC was there to assist us, and the BLC was doing
18 a parallel investigation at the same time.

19 Q Okay. So it's fair to say you worked pretty
20 closely with the CDC and less so with the -- the Bureau of
21 Licensure?

22 A We were all in the same room, but a lot of it --
23 they were looking at some other things that we weren't
24 particularly interested in, and they looked at a lot of the
25 paperwork; do -- do the employees all have licenses, do they

1 have up-to-date TB tests, a lot of just the normal things they
2 do as part of the -- the regulation of the clinic. Things
3 that didn't matter to us as part of the outbreak, really.

4 Q Okay. And so it's pretty close by, right -- the
5 -- where the Health District was at that time versus the
6 location of the clinic?

7 A Yes, the clinic was right across from the Health
8 District; my office was another block up the street.

9 Q Okay. So you -- did you just walk over there --

10 A Yes.

11 Q -- on the 9th, all of you?

12 A Yes.

13 Q And who do you meet up with when you get to the
14 clinic on the afternoon of the 9th?

15 A We met with Tonya Rushing. We met with Dr.
16 Carrol. And then they had a few other people join us. Jeff
17 Krueger was in and out, and Katie Maley.

18 Q And who was it of your group that explained to
19 the clinic staff why you were there?

20 A I did.

21 Q And what did you tell them?

22 A Basically what I've told you. We identified
23 three cases of hepatitis C, we had this common connection,
24 they were acute cases, we, you know, we don't know what's
25 causing it, but we're here to do an investigation, figure out

1 why this occurred, and what steps, if any, are needed to
2 prevent additional cases in the future.

3 Q Did you make any requests of the clinic in terms
4 of your next steps in the investigation?

5 A Yes, we started to ask for documents and those
6 sort of things. They took us down and gave us a quick kind of
7 walk through the clinic just to give us an overview, and we
8 started talking about what kind of documents they had so that
9 the next day we could start to get the -- the paperwork we
10 needed to go through.

11 Q And what was the -- the paperwork that you were
12 looking for?

13 A We wanted the -- the logs that had a list of
14 every person that was seen on those days, and then we wanted
15 the charts from all the people that had procedures on those
16 days, as well as the -- I believe the three or four days prior
17 to the -- their procedures as well.

18 Q Okay. You didn't get -- you didn't review those
19 charts on the first day you were there, though; is that fair?

20 A No, we were at the clinic maybe an hour, hour
21 and a half. We had a meeting with them, they gave us the
22 overview, and that was -- we got there at the end of the day,
23 4:00 or so, so it was already late in the day. We planned to
24 come back the next morning at 8:00 and start our -- our
25 document review at that time.

1 Q Did you observe any procedures at all that first
2 day on the 9th, or was it just sort of a walk-through?

3 A We didn't really observe procedures. We could
4 see what was going on; I think it was the last patient of the
5 day, or they were just finishing up. So there really wasn't
6 much to see at that point. It wasn't a -- an observation of
7 their procedures, more just kind of a looking around and
8 getting a feel for how the clinic worked.

9 Q Okay. Obviously you go back on the 9th?

10 A The 9th was the Wednesday, we went --

11 Q I mean, the 10th, sorry.

12 A Yes, that's correct.

13 Q And did you go in the morning at this -- at that
14 point?

15 A Yes, we did.

16 Q And is it the same group of people that you
17 described, the BLC, the two doctors from the CDC, and
18 yourself?

19 A Yes, as well as a couple additional
20 investigators from my office. We had a lot of documents to go
21 through, so I -- we had different people at different times
22 assisting us go through and abstract the information.

23 Q Okay. And what were the -- what did you first
24 do when you -- when you got there on that second day?

25 A We were requesting documents on that day, and so

1 they started to bring us those documents. They showed us to a
2 conference room and let us get set up in there so we could
3 start to review things. Then we started going through all the
4 -- the paperwork that they had, the patient logs, the charts;
5 we started requesting things, like their policies and
6 procedures. BLC was doing the same thing at the same time, so
7 we made a lot of requests of them for paperwork, basically.

8 Q Between yourself and other representatives from
9 the Health District and the CDC, did you all develop sort of
10 information you were looking to extract from each patient file
11 on those days, or how did you go about categorizing that
12 information?

13 A The CDC came up with a questionnaire that we
14 could use to extract the information on the document, so
15 collect the patient names, demographic information, then all
16 the -- the details of the procedure: What time did it start?
17 What time did it end? Which people were involved. Basically
18 so we got consistent information out of the charts and could
19 put a big table together of everything we collected.

20 Q And was that to do sort of a comparison to see
21 if you could see any, I guess, commonalities?

22 A Right. We were looking for whatever common
23 links we could identify between the cases.

24 Q Now, at the time you were there and extracting
25 information from the charts, did you have at that time, in

1 your head, an idea of how you thought the hepatitis C could
2 have been transmitted in this case that early on?

3 A We had a number of possibilities going in, just
4 knowing what had happened in previous outbreaks, but we didn't
5 know what happened in this particular clinic.

6 Q And when you say you had a number of ideas, are
7 part of those or were part of those ideas based on just the
8 nature of the disease itself?

9 A No, they were based more on the nature of
10 previous outbreaks that had happened over the last 10 or 15
11 years that CDC investigated and had been published in the
12 literature. So we knew what sort of things others had found
13 doing these types of investigations, so those were kind of the
14 main things that we expected to look at in our investigation.

15 Q Okay. And those were -- I mean, I think you
16 just said it, those were things you were going to look at, but
17 not to the exclusion of other options or other possibilities;
18 is that fair?

19 A That's correct.

20 Q So as -- as you're reviewing the charts on the
21 second day, did you or any members of your team or the CDC
22 start to observe procedures at all?

23 A At the end of the day we went in and we did a
24 meeting with the staff, and explained why we were there. We
25 saw part of one procedure, and I believe they walked us

1 through the scope-cleaning process that day and showed us how
2 they did things.

3 Q The procedure that you just mentioned, was that
4 one that you personally observed?

5 A Yes, I was in the room.

6 Q And who -- who was the CRNA, I guess, on that
7 procedure; if you recall?

8 A That day it was Linda Hubbard.

9 Q And at the time you observed that procedure, was
10 there anything that you took notice of in terms of how she
11 handled the procedure or administered the sedation?

12 A I noticed that she was only wearing one glove,
13 instead of two. Other than that, it was just the very end of
14 the procedure, I believe. She had already given the
15 injection, so there wasn't really that much to observe. We
16 were just there for part of that procedure, not the entire
17 one. So it was just a little bit of that on that particular
18 procedure.

19 Q And I think you also said that you observed the
20 scope cleaning on that day?

21 A Yes.

22 Q And was that something you personally observed?

23 A Yes.

24 Q And can you describe what you saw of that
25 procedure, or of that aspect of the practice?

1 A They walked us through step by step from when a
2 scope came into the room, through the manual cleaning process,
3 through the automated reprocessing of the scopes, just kind of
4 step by step how they did everything.

5 Q From your observations of that, did you -- did
6 you see any deficiencies or anything that you were concerned
7 about in terms of the scope cleaning?

8 A The one that we noticed was that they used the
9 detergent solution for two scopes. It was labeled for use on
10 a single scope or set of instruments. But that was the only
11 one that jumped out as not following the manufacturer's
12 instructions.

13 Q And the -- the fact that you'd seen that
14 deficiency, how did that play into your assessment as to
15 whether that was the -- the reason why hepatitis C was
16 transmitted at this clinic?

17 A I guess it was a cause for concern, and so we
18 asked the CDC -- their experts on scope cleaning what they
19 thought of it.

20 Q Okay. And was that discounted at some point or
21 at that point?

22 A At some point after discussion, the people at
23 the CDC felt that there was a cleaning process in place --

24 MR. SANTACROCE: I'm going to object as to hearsay.

25 MS. WECKERLY: Well, it's already been testified to

1 by them, but --

2 MR. SANTACROCE: Well, it's still hearsay.

3 THE COURT: Well, that doesn't mean it's not hearsay.

4 MS. WECKERLY: Okay.

5 BY MS. WECKERLY:

6 Q Well, based on -- based on your investigation
7 collectively at some point, did you discount that?

8 A Yes.

9 Q Now, was that -- you sort of saw the end of --
10 or a little bit of one procedure that day, and then you
11 observed the scope cleaning, and did anything else happen that
12 day aside from additional possible chart review?

13 A No, it was mostly chart review. Every day we
14 were meeting with the clinic multiple times to let them know
15 what we found. I believe on the first day we identified one
16 or two more additional cases. We had the -- the list of
17 recent cases that we've been notified of, and we were able to
18 cross-reference those with the clinic patient list. So we did
19 identify -- I'm not sure which day it was, but we -- I know we
20 identified one on that day, and I don't know exactly when the
21 rest of them were.

22 Q So it's -- as you're there investigating, you
23 learn of at least one or two more cases from the September
24 21st date?

25 A Yes, that's correct.

1 Q And so at that point you're kind of at a bigger
2 number even than when you started?

3 A Yes, that's correct.

4 Q You go back the next day? I guess that would be
5 the 11th; is that right?

6 A Yes, Friday the 11th.

7 Q Okay. And what -- what do you do on that day?

8 A We spent the morning observing procedures. So
9 we had a number of us in the rooms observing procedures, while
10 other people were still back abstracting information from the
11 records.

12 THE COURT: How many people, total, went in with you
13 from the Health --- at that time?

14 THE WITNESS: On that day we had myself, the two
15 people from CDC, one or two BLC investigators were there, we
16 also had two or three other people from the Health District
17 doing the record abstraction at that point.

18 THE COURT: All right. Go on, Ms. Weckerly. Sorry.
19 BY MS. WECKERLY:

20 Q You personally observed procedures on that day,
21 that Friday?

22 A Yes, I did.

23 Q Who did you observe doing procedures?

24 A I observed -- Linda Hubbard was the CRNA and Dr.
25 Carrol was doing the procedures that morning.

1 Q And how did you -- what was the observation of
2 Linda Hubbard's practice with regard to administering
3 propofol?

4 A She would inject the patient with the propofol,
5 and when the procedure was done, any remaining propofol that
6 was in the vial stayed on the table she had set up for all her
7 equipment, and after several patients she took several
8 syringes and filled them from the existing vials of propofol.

9 Q Okay. So she would fill, like, one syringe from
10 a couple different vials?

11 A Yes. She had multiple vials out there, and she
12 basically just removed all the propofol from those four or
13 five vials that were sitting there into multiple syringes.

14 Q Did that get your attention or cause you
15 concern?

16 A Yes.

17 Q Why is that?

18 A Propofol is labeled for single-patient use. It
19 was being treated as a multidose medication at that point, and
20 so that's one of the concerns with injection-safety issues,
21 the use of essentially multidose vials -- or single-dose vials
22 incorrectly as multidose vials.

23 Q On the day that -- that you were there, do you
24 remember the size of the vials that were being used?

25 A I believe the ones that we saw were all 20cc

1 vials.

2 Q Did you observe the preop area of the clinic at
3 all on Friday or any of the other days?

4 A Yes, that was kind of the main area, so you had
5 to walk through that to go to anywhere else.

6 Q From your observations of the preop area, did
7 you see any deficiencies in terms of saline flushes or
8 administering heplocks, anything that caused you concern?

9 A There was a separate room where they did the IV
10 setup, and so that wasn't in the main preop area, that was a
11 separate room, and I didn't do observations of that particular
12 room.

13 Q Okay. The CDC investigators with you, did one
14 of them observe that area?

15 A Yes.

16 Q Now, when you were at the clinic, did you have
17 any conversations with any of the employees who were there?

18 A Yes.

19 Q Was one of them -- a conversation you had with
20 Vince Mione?

21 A Yes.

22 Q Did he tell you anything about syringes?

23 MR. SANTACROCE: I'm going to object to hearsay.

24 MS. WECKERLY: It's a prior inconsistent statement.

25 THE COURT: All right. Go ahead.

1 BY MS. WECKERLY:

2 Q You can answer. What did he tell you?

3 MR. WRIGHT: I join the objection.

4 THE COURT: I'll see counsel up here for a minute.

5 (Off-record bench conference.)

6 BY MS. WECKERLY:

7 Q Sir, I was asking you about the conversation you
8 had with Mr. Mione. Before you tell me what was said, can you
9 -- do you remember what day it was that you had the
10 conversation with him?

11 A Yes, it was Friday right before lunch, and we
12 were observing procedures.

13 Q So obviously it was at the -- obviously it was
14 at the clinic. Was anyone else present besides yourself and
15 Mr. Mione?

16 A Yes, Melissa Schaefer and I were standing there
17 talking to him.

18 Q And was it in a procedure room, or just kind of
19 in the hallway, or how would you describe the area?

20 A It was just outside the door of the procedure
21 room, so it was kind of in the -- the more common area.

22 Q And the comments that he made to you, were they
23 prompted by a question that you asked, or was it just
24 something that he said in the course of another conversation?

25 A No, we were asking a few questions.

1 Q Okay. Do you remember what you -- what you
2 asked him?

3 A Melissa was asking the questions, so I didn't
4 ask him. I remember the general tenor of the conversation,
5 but not the specific questions.

6 Q Do you remember if he said anything about
7 syringes?

8 A Yes.

9 Q What did he say?

10 A He said that they were instructed to reuse
11 syringes, but that he didn't do it.

12 Q Okay. And he didn't indicate who instructed
13 him; is that fair?

14 A That's correct.

15 Q When you -- when you were told that information,
16 did it cause you concern about a source or a means of
17 transmission?

18 A Yes, it did.

19 Q And why -- why would that be?

20 A With the reuse of the propofol vials that we've
21 seen, plus the reuse of syringes to access those vials, there
22 would be the potential for a disease transmission between
23 patients.

24 Q Okay. How long were -- were you and your
25 investigators and the CDC at the clinic in days? How many

1 days were you there?

2 A Five or six days.

3 Q And during those five or six days, were all
4 the -- the charts reviewed from July the 25th and September
5 the 21st?

6 A Yes, they were.

7 Q And based on your -- your interviews that you
8 personally did, as well as the CDC interviews and your review
9 of the charts and your own observations, did you eventually
10 personally reach a conclusion about how you believe the
11 hepatitis outbreak occurred in this particular case?

12 A Yes.

13 Q And -- I mean, did I leave any -- well, let me
14 ask you this: What was that conclusion?

15 A That the reuse of propofol vials for multiple
16 patients and the reuse of syringes to access those vials for
17 an individual patient provided the greatest risk of
18 transmission of blood-borne pathogens between patients.

19 Q And you, I think, talked about earlier that you
20 -- or you considered other possible means of transmission; is
21 that fair?

22 A Yes.

23 MS. WECKERLY: May I approach?

24 THE COURT: Mm-hmm.

25 BY MS. WECKERLY:

1 Q Sir, I'm showing you what's been marked as
2 State's Proposed Exhibit 228. Is this a chart that you
3 prepared in association with this investigation?
4 A Yes, it is.
5 Q In order to prepare this chart, did you rely on
6 your -- the investigation you conducted with the CDC?
7 A Yes.
8 Q And your observations at the clinic on the days
9 you were there?
10 A Yes.
11 Q Any -- like, the records or anything else that
12 you may have relied on?
13 A The clinic propofol records as well, and the --
14 some of the purchasing records the clinic had as well.
15 Q Okay. And the patient files, is that --
16 A Yes.
17 Q Okay.
18 MS. WECKERLY: State moves to admit 228.
19 MR. WRIGHT: Objection.
20 MR. SANTACROCE: Objection.
21 THE COURT: Yeah, let me see it.
22 MR. WRIGHT: May we approach --
23 THE COURT: Sure.
24 MR. WRIGHT: -- after you look at it?
25 (Off-record bench conference.)

1 BY MS. WECKERLY:

2 Q Now, let's talk about State's Proposed 228. Was
3 this a chart that -- that you personally prepared?

4 A Yes, it is.

5 Q And in terms of -- without reading what the
6 content is, with regard to the top of the chart and the
7 conclusion that you drew, on the first box there, was that
8 based on personal observations or the collective investigation
9 or -- can you let us know what that was based on?

10 A It was based on laboratory results that I
11 reviewed, and -- I guess both of them would be lab results
12 that I reviewed.

13 THE COURT: Can you speak up? I didn't hear that
14 last --

15 THE WITNESS: Both were laboratory results that I
16 reviewed.

17 THE COURT: Okay. Laboratory results from where?
18 The Health District, or the ---

19 THE WITNESS: It was a combination. The first one
20 was done -- the lab results -- the specimens were collected by
21 the Health District. The second one, the specimens were
22 collected by the Health District or their commercial labs and
23 tested at the CDC.

24 THE COURT: Okay. And then when you say "reviewed,"
25 is that you sitting there and looking at the -- at the results

1 yourself?

2 THE WITNESS: Yes.

3 THE COURT: Okay.

4 BY MS. WECKERLY:

5 Q And then the --

6 THE COURT: And just, sir, so you know, just sort of
7 generally, so I don't have to keep interrupting, if it's not
8 something that you did, let's say, you know, it's somebody
9 else at the Health District who did that, just, you know, say
10 who that person was as opposed to "we" did that because that
11 doesn't really mean anything to us, you know?

12 THE WITNESS: Okay.

13 THE COURT: Okay.

14 BY MS. WECKERLY:

15 Q And the -- the second conclusion, can you tell
16 us what that was based on, or -- or how you formulated that
17 opinion?

18 A I analyzed the data that was collected by the
19 team, extracted from the charts, and did the calculations to
20 see if that was a risk.

21 Q Okay. So that was your own calculation and your
22 own analysis of the data, but the data might have been
23 gathered by others, is --

24 A That's correct.

25 Q In addition to yourself, though, probably too?

1 A Yes, that's correct.

2 Q Okay. And then the -- sorry, the third box?

3 A Same thing. The data was collected by the
4 group; I did the analysis myself.

5 Q Okay. So that's your own conclusion?

6 A Yes.

7 THE COURT: I have a question, I'm sorry. How was
8 the data recorded by the group, meaning, did they just have
9 their notes and you all sat and discussed it, or did they all,
10 then, prepare their own written report of what the -- their
11 data was; or how was that, I guess, conveyed to you? Was it
12 conveyed through conversation or a meeting or what?

13 THE WITNESS: We had standard forms that we used to
14 --

15 THE COURT: Okay.

16 THE WITNESS: -- extract the data from the chart.
17 Once it was on the forms, the data was entered to a -- into an
18 Excel spreadsheet, and that -- I went back and recollected
19 some of the data and updated and corrected things, so at the
20 end we had one Excel spreadsheet that we could use to do the
21 data analysis.

22 THE COURT: Okay. And that was a compilation of all
23 of the chart -- the charts?

24 THE WITNESS: Yes, that's correct.

25 THE COURT: All right.

1 BY MS. WECKERLY:

2 Q Okay. And the fourth box?

3 A The fourth box, the same thing. It was a data
4 analysis that I performed on data collected by the group.

5 Q Okay. And the next one?

6 A Same thing. It was a data analysis that I did
7 on data collected by the group.

8 Q Okay. The -- is this the sixth box are we on
9 here?

10 A Yes.

11 Q Okay.

12 A That was a review of the data collected by the
13 group that I performed.

14 Q Okay. And that particular data was collected
15 from patient charts; is that fair?

16 A It would have been the procedure charts from --

17 Q The procedure charts.

18 A -- the endoscopy center. There were two sets of
19 charts. The patient charts were the -- kind of the medical
20 chart of all the -- all the things that patient had; then
21 there was a chart specific to the procedure that was in the
22 endoscopy center, not the gastroenterology center.

23 Q Okay. The next one?

24 A Again, that was an analysis I did of the group
25 data.

1 Q Okay. This is the third box up from the bottom.

2 A That was also an analysis I did of the data
3 collected by the group.

4 Q And the second-to-the-last one?

5 A The first part was an observation by the CDC --
6 actually, the whole thing was the -- the observations by the
7 CDC.

8 Q Okay. And the last one?

9 A Let's see. The first one was my observation --
10 it was a CDC observation, my observation, my conversation --

11 Q Okay.

12 A -- and then my review of the data collected by
13 the group.

14 Q Okay.

15 MS. WECKERLY: With that, Your Honor, the State moves
16 to admit 228.

17 THE COURT: All right. That is admitted.

18 (State's Exhibit 228 admitted.)

19 BY MS. WECKERLY:

20 Q Can you see that on your screen up there, sir?

21 A My -- I don't think my screen is on.

22 Q Oh. Thank you.

23 A It's on now. Yes.

24 Q Can you see it now? Okay.

25 A Yes, I can.

1 Q Looking at the top of what's been admitted as
2 State's 228, it looks like the chart goes through possible
3 modes of transmission from September the 21st of 2007 --

4 A Yes --

5 Q -- correct?

6 A -- that's correct.

7 Q Okay. Now, the first one is -- the first column
8 appears to be possible modes of transmission, the middle
9 column appears to be your conclusion regarding it, and the
10 third column on the right appears to be the -- the rationale
11 or your thought process for the conclusion that you drew?

12 A Yes, that's correct.

13 Q Okay. So let's talk about a possible
14 transmission source of staff to patient. What were your
15 conclusions regarding that as a possible source of
16 transmission?

17 A We ruled it out because none of the staff
18 members were positive for hep C. We reviewed the records we
19 had in the database to see if any of the former staff, those
20 were names that we couldn't test, were in there as previously
21 being positive for hepatitis C. And so that was -- initially
22 we ruled it out, and then we had the genetic testing later and
23 could identify the source patient, and that definitely ruled
24 out the staff as a source of hepatitis C.

25 Q Okay. And you -- not to pick on you, you said

1 we ruled it "out," but did you personally rule it out?

2 A I guess I'm speaking as the leader on behalf of
3 the team, but I ruled it out personally --

4 Q Okay.

5 A -- yes.

6 Q So if -- I just want you to be clear if these
7 are your actual conclusions as we go through the --

8 A It's a little difficult because we work as a
9 team all the time, but yes --

10 Q -- yeah.

11 A -- I was the leader of that team; these are my
12 conclusions.

13 Q Okay. Thank you. And the next possible -- next
14 possibility was, I guess, like, a physician transmitting the
15 hepatitis C, that was considered?

16 A Yes.

17 Q And ruled out. Why was that?

18 A We identified multiple physicians that treated
19 the patients that were infected. We did -- I did a
20 statistical analysis and evaluated if any one of those
21 physicians put the patient at higher risk of being infected,
22 and none was found.

23 Q Okay. And what -- when you say you did a
24 statistical analysis, saying -- I guess, looking at whether
25 one physician put someone more at risk of -- risk of

1 contracting the disease, what do you mean by that? Because I
2 know Margaret is going to want to know the math here.

3 A Okay. This is a calculation called relative
4 risk.

5 Q Okay.

6 A And so you look at the -- the risk of disease in
7 the exposed people, and you compare that to the risk of
8 disease in the nonexposed people. So you'd say, the risk of
9 being infected for Physician A, versus the risk of being
10 infected -- or not being infected from everybody else. It's a
11 comparison of the different risks there. So it's -- you do a
12 calculation, then, where it's -- the infection rate in one
13 divided by the infection rate in the other, and you can get a
14 statistical significance on it if you set the -- the P, the
15 probability that it happened by chance at 0.05, the -- kind of
16 the accepted standard, it has to be less than 0.05 to be
17 considered statistically significant.

18 Q Now, is that -- is that something that
19 epidemiologists do all the -- all the time to kind of assess
20 risks or possible factors that caused transmission, or -- or
21 how do -- I mean, how does that fit in the --

22 A We use that all the time. When you see on the
23 news that -- whatever the newest thing that's going to kill
24 you is 10 times more likely to kill you than whatever, those
25 are the kind of calculations they're talking about. So it's

1 the risk of disease, giving it exposure, compared to the risk
2 of disease not having that exposure.

3 Q Okay. And in my head I -- I would say that that
4 -- does the genetic link that we learned later from the CDC
5 affect that at all as well, or --

6 A Well, in this case we're talking about a
7 physician -- something that was specific to a physician's
8 procedure. So not --

9 Q I see.

10 A -- not the physician -- their blood going to the
11 patient, that would fall under staff to patient. So is it
12 some particular practice of one doctor --

13 Q Okay.

14 A -- that made it more likely to transmit hep C
15 because of something that doctor did.

16 Q All right. Thank you. The next was provider,
17 meaning, the CRNA?

18 A And this was the same sort of evaluation. We
19 ruled out any one particular CRNA. The patients that had a
20 CRNA were at no greater risk for any of the CRNAs compared to
21 the other CRNAs.

22 Q Okay. Technician?

23 A The same is true for that. There was no one
24 technician that created a greater risk for the patient than
25 others.

1 Q Okay. And what about biopsy equipment?

2 A Not all infected patients had a biopsy, so that
3 would make it very difficult to transmit it by biopsy
4 equipment, though there's always the potential for
5 cross-contamination. So we -- we did look at the
6 statistics -- or I did look at the statistics as well, and
7 there was no increased risk of disease based on having a
8 biopsy or not.

9 Q Okay. And when you look at those type of
10 statistics, is there a point in the statistics where it
11 becomes, like, statistically significant, or -- or how do
12 you -- how do you measure that?

13 A Yeah, there's a probability value that you can
14 calculate, and so it's -- they call it a P value and it's
15 between 0 and 1. So it's the probability that something
16 happened by chance alone.

17 Q Okay.

18 A If it's a -- if it's unlikely to have happened
19 just by chance alone, the P value is smaller and smaller and
20 smaller. Anything over 0.05, so 5 percent, is considered not
21 significant.

22 Q Okay. And that was the statistical outcome of
23 the biopsy equipment, essentially?

24 A Yes.

25 Q How about the endoscope?

1 A This one the -- there were a number of different
2 scopes that were used. Because of the large number of scopes,
3 there weren't enough to really do any meaningful calculations,
4 but the patients all had scopes that appeared to be different
5 from the source patient. We had some problems with the
6 records and some duplicates and things like that. So it's
7 difficult to say for certain, but it didn't appear that there
8 was one scope used on all the infected patients.

9 Q Okay. How about procedure type?

10 A There was no increased risk based on an upper or
11 lower endoscopy. The same statistical calculations I
12 performed.

13 Q And reuse of -- sorry. Reuse of bite blocks?

14 A This is basically the same as a procedure type.
15 The bite blocks are used only in one of those two procedures.
16 There was no risk from the -- the upper endoscopy procedure,
17 so there can't be the same risk from the bite blocks.

18 Q Okay. That one seems like you could do without
19 math, but I don't know. No?

20 A It's the same thing. We still do the
21 calculations just to make sure.

22 Q Okay. And IV placement?

23 A In this case, it was the observations on how the
24 IVs were set up by the -- the clinic staff.

25 Q Okay. And sedation-injection practices?

1 A So in this case this is the one we did not rule
2 out. We observed the staff reusing propofol vials. The
3 clinic records clearly indicated that they used fewer vials
4 each day than they would have needed for one per patient. So
5 there was vial reuse. And then there was also the observation
6 that the syringe was used to re-access the vial by the CDC.

7 Q And that was the observation made of Ms. Langley
8 by -- of Keith Mathahs? Is that the observation you're
9 referring to?

10 A Yes.

11 Q Okay.

12 A As well as the conversations with Vincent Mione
13 that said he was told to reuse the syringes but didn't. So it
14 was the idea that that was going on at the clinic at some
15 point.

16 Q Okay. Now, you talked about the -- the propofol
17 records, I -- you made an allusion to that or you made
18 reference to the propofol records versus the number of
19 patients. Was that something that you personally looked into?

20 A Yes, it is.

21 Q And -- and what were your -- what was your
22 assessment or what were your findings regarding that?

23 A For each day that we looked at we looked at the
24 number of vials that were checked out, the number of vials
25 that were returned, so we could determine how many vials were

1 used on a typical day in the clinic. For each day that we
2 looked at there were roughly 60 patients a day, and there were
3 fewer than 60 vials being used. It varied day-by-day
4 depending what was going on, and the size of the vials as
5 well.

6 But from that it was clear that they weren't using
7 the same number of vials, at least, as patients.

8 Q So there had to be some propofol reuse on
9 multiple patients?

10 A Yes.

11 Q Now, when you -- you and the CDC were there,
12 were you able to determine which patients were in which one of
13 the procedure rooms?

14 A No, we were not.

15 Q And was that ever something that -- that you, I
16 guess, incorporated in your conclusions as you sit here today,
17 or how does that fit in with your conclusions?

18 A Several months later something came to our
19 attention that allowed us to try and split it up. The board
20 of medical examiners told us about in their investigation they
21 had a comment from one of the staff members that there was
22 a -- a date error on the bottom of some of the charts, and
23 that could be used to split it out.

24 So we went back and looked at the date-error issue,
25 and found that that date error did exist at the time of the

1 procedure. I was able to contact the provider of one of the
2 patients on September 21 and get a copy of the chart that was
3 faxed over right after their procedure.

4 The date error was obvious at that time. So we know
5 that it happened at that point in time when the procedure was
6 performed, not later. And from that some charts had the date
7 error, some didn't, and that came from a computer system. So
8 we were able to -- if that showed that one room had the error
9 and the other didn't, it allowed us to split up the two rooms.

10 Q Now, the -- the fact of that date error, did
11 that at all affect your conclusions at all?

12 A No, it did not.

13 Q And were you able to reach your -- were you able
14 to reach a conclusion regardless of -- of knowing that piece
15 of information?

16 A Yes, we were.

17 Q In -- in your knowledge of -- of hepatitis C and
18 hepatitis C transmission, are people exposed -- that are
19 exposed to hepatitis C, do they necessarily contract the
20 disease even with the direct exposure?

21 A No. With just about any pathogen, when you
22 expose somebody to a virus or bacteria, some people will
23 become sick; others didn't get sick for whatever reason, or
24 didn't develop an infection for whatever reason.

25 Q Okay. And are there some people who are exposed

1 to hepatitis C -- and I think you said this at the beginning
2 of your testimony, that -- that don't even know they have it,
3 and don't experience any symptoms at all, even though they may
4 be positive?

5 A That's actually the vast majority of patients,
6 85 to 90 percent of people never have symptoms of it and they
7 wouldn't know unless they were tested.

8 Q Okay. Now, in this particular case, with the
9 conclusions that -- that you drew, is -- are your conclusions
10 premised on the idea that there was just one infected vial of
11 propofol that was responsible for this on the 21st?

12 A No.

13 Q Can you explain how the transmission -- or the
14 -- the ways that you see the transmission occurring on that
15 day?

16 A Well, there's multiple ways that it could have
17 occurred. Because we didn't observe what happened on the
18 21st, we can't say exactly what happened. It's possible that
19 it could have come from one vial. There was -- looking at the
20 -- the dose that was recorded for each patient, there would
21 have been enough propofol in one vial to give a little bit to
22 each one, but that wasn't really a realistic scenario.

23 You would have a -- there were 50cc vials, so that
24 would potentially be used for multiple patients, much more
25 than a 20cc vial, obviously.

1 Q Sure.

2 A So that vial could have moved back and forth and
3 it could have been one vial. Or you could have had fresh
4 propofol drawn from that vial, and basically contaminated a
5 second vial when they went in to draw the rest of it, or
6 through, basically using it on a patient, then going into a
7 second vial.

8 So they could basically recontaminate a second or
9 third vial, as many as needed for that to happen.

10 Q Okay. And in -- is there any way -- would there
11 be any way for you to determine in that type of scenario if
12 the -- if the virus or there's -- if the virus dilutes it all,
13 or the virus, you know, somehow gets less and less in each
14 vial, or is -- is that impossible?

15 A It's likely that some dilution would occur,
16 especially if you're talking about going from one vial to a
17 second. But we didn't know how much blood was introduced. We
18 didn't know the patient's viral load. And we didn't know what
19 happened from vial to vial exactly. So there's no way we can
20 say step by step exactly what happened.

21 Q What was the -- the year that you issued your
22 conclusion regarding the -- the outbreak in this case, and how
23 it was your conclusion regarding the mode of transmission?

24 A The final report was released in 2009.

25 Q Okay. And that was the -- the conclusion was

1 the -- sort of the combination of reusing propofol vials and
2 the reuse of syringes on single patients?

3 A Yes, that's correct.

4 Q It's several years later; have your conclusions
5 changed at all since you issued your report?

6 A No.

7 Q Has anything come to your attention that makes
8 you question your conclusion that you made back in 2009?

9 A No.

10 Q Thank you.

11 MS. WECKERLY: I'll pass the witness.

12 THE COURT: All right. Ladies and gentlemen, before
13 we move into cross-examination, let's go ahead and take our
14 morning recess. We'll be in recess until about 11:15.

15 During the recess you're reminded that you're not to
16 discuss the case or anything relating to the case with each
17 other or with anyone else. You're not to read, watch, listen
18 to any reports of or commentaries on the case, any person or
19 subject matter relating to the case, and please don't form or
20 express an opinion on the trial.

21 Notepads in your chairs, and follow the bailiff
22 through the rear door.

23 And, Mr. Labus, during the break please don't
24 discuss your testimony.

25 THE WITNESS: Okay.

1 (Jury recessed at 11:01 a.m.)

2 THE COURT: I'm just waiting for them to get out of
3 the hallway. And, sir, if you want to take a break, you're
4 free to go out that door.

5 THE WITNESS: Thank you.

6 (Court recessed from 11:02 a.m. to 11:15 a.m.)

7 (Outside the presence of the jury.)

8 THE COURT: Are you going to be first, Mr. Wright?

9 MR. WRIGHT: Yep, I think.

10 THE COURT: And you -- this is going to take two
11 days?

12 MR. WRIGHT: I don't think --

13 THE COURT: Ms. Weckerly took an hour.

14 MR. WRIGHT: -- I don't think so.

15 THE COURT: Almost exactly an -- a little less than
16 an hour.

17 MS. STANISH: That's not long.

18 THE COURT: It was, like -- it was, like, no, that's
19 what I'm saying --

20 MS. WECKERLY: I'm the quickest.

21 THE COURT: -- it was 50 minutes. I mean, so --

22 MR. WRIGHT: No, I don't --

23 THE COURT: -- how do you turn --

24 MR. WRIGHT: -- think so.

25 THE COURT: -- Ms. Weckerly's 50 minutes into 2 days?

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1 MR. WRIGHT: I didn't know what it was going to be.
2 THE COURT: Right.
3 MR. WRIGHT: So I don't think it --
4 THE COURT: I mean, it was almost --
5 MS. WECKERLY: Got more narrowed, admittedly, this
6 morning, but --
7 THE COURT: -- so.
8 MR. WRIGHT: So, no, I don't see it being as long as
9 I had forecast.
10 THE COURT: All right. In other words, Ms. Weckerly,
11 be prepared to have another witness for tomorrow.
12 MS. WECKERLY: We will -- yes, try to get someone
13 together. It will -- it will in all likelihood be an
14 insurance person.
15 THE MARSHAL: Ready, Judge?
16 THE COURT: Yeah. Mr. Labus, come on back up to the
17 witness stand. The bailiff is going to bring in the jury.
18 MS. WECKERLY: Also, I did the email, everybody --
19 draft instructions.
20 THE COURT: Oh, great.
21 MS. WECKERLY: So everybody can...
22 (Off-record colloquy.)
23 THE COURT: Bring them in.
24 THE MARSHAL: Ladies and gentlemen, please rise for
25 the jury.

1 (Jury entering at 11:17 a.m.)

2 THE MARSHAL: Thank you, everybody. You may be
3 seated.

4 THE COURT: All right. Court is now back in session.

5 And, Mr. Wright, you may begin your
6 cross-examination.

7 MR. WRIGHT: Thank you.

8 CROSS-EXAMINATION

9 BY MR. WRIGHT:

10 Q Good morning, Mr. Labus. I'm Richard Wright. I
11 represent Dr. Desai.

12 A Good morning.

13 Q In preparation for your testimony here, what
14 have you reviewed?

15 A I went through my report, I went through some of
16 the notes I had from -- that I had taken in the clinic, as
17 well as an -- a number of research articles.

18 Q Okay. Did you read any of your testimony?

19 A My grand jury testimony.

20 Q Okay. Anything else?

21 A No, that's all that comes to mind.

22 Q Okay. And are you a hepatitis expert?

23 A No.

24 Q The -- your -- the definition you utilized for
25 acute hepatitis C -- well, strike that.

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1 We've had experts in here testify regarding the
2 distinction between acute hepatitis C and chronic hepatitis C,
3 and symptomatic hepatitis and nonsymptomatic hepatitis C, and
4 they have talked about the acute/chronic distinction as being
5 one of duration. In other words, acute hepatitis C is short
6 term, and chronic long term. Do you agree with that?

7 A Yes.

8 Q Okay. And they talk about acute hepatitis C as
9 -- all hep -- let me put it this way, all -- when I contract
10 hepatitis C, whether I know I have it or not, I have acute
11 hepatitis C for the first, say, six months, and I will either
12 be symptomatic or not symptomatic; does that make sense?

13 A Yes.

14 Q Okay. And I had understood your definition of
15 acute hepatitis C, it seems like you were viewing acute
16 hepatitis C as newly acquired hepatitis with symptoms --
17 symptomatic?

18 A Yes, that's correct.

19 Q Okay. So that's -- that's your definition of
20 it, correct?

21 A No, that's the -- the national case definition
22 that we use for public health surveillance. The Council of
23 State and Territorial Epidemiologists comes with -- comes up
24 with definitions, so there's one for acute hepatitis C, and
25 then there's another one they call past or present. And it's

1 because of that challenge in determining is it a newly
2 acquired nonsymptomatic case, or is it something the person
3 had for decades.

4 So for surveillance purposes and for outbreaks we
5 use the -- the acute disease with symptoms as the definition
6 for acute disease.

7 Q Okay. The -- so that when we're talking about
8 -- because some -- some of those other experts said the acute
9 hepatitis C has nothing to do with the severity of the
10 disease. But for your purposes, when we say, like, in Clark
11 County there are two to four reported cases a year; is that
12 about accurate?

13 A Yes.

14 Q Of acute hepatitis C, we're talking about
15 someone newly acquired hepatitis and they are symptomatic,
16 jaundiced, sick, everything that happens in those first six
17 months, if -- if it's symptomatic, correct?

18 A Yes, the cases I'm talking about, it's the
19 public health case definition. They're taking the medical
20 approach which they need for treatment. So it's kind of two
21 views of the same thing.

22 Q I got it. And so the -- how many -- and you --
23 you testified that acute hepatitis C with symptomatic, okay?
24 I'm -- I just got it and I'm sick.

25 A Yes.

1 Q That's reportable by physicians by law?

2 A Yes, it is.

3 Q Okay. And the first two cases that are
4 November, December were reported by physicians?

5 A Yes, that's correct.

6 Q Okay. And how many -- aside from physicians
7 reporting acute hepatitis C, the Health District also gets
8 reports from all the labs around here of positive hepatitis
9 results, my -- my terminology.

10 A Yes, that's correct.

11 Q Okay. And so every -- every one that gets a
12 blood test at any time, for whatever reason medically in Clark
13 County, if it -- if they test positive for hepatitis, that's
14 reported to the Health District?

15 A Yes, it is.

16 Q Okay. And then the Health District keeps a
17 record of all of that?

18 A Yes, we do.

19 Q Okay. A registry of hepatitis C?

20 A More of a list of just positive lab results, but
21 that kind of idea, yes.

22 Q Okay. And how many -- how many hepatitis --
23 when you get -- how many do you get a day from a lab, average?

24 A I can't say for -- per day. I'd say for -- per
25 month we get 2 to 3,000 probably. We get thousands of results

1 a month; it's a very large number.

2 Q Okay. I didn't hear you. Say that again?

3 A I said we get probably 2 to 3,000 a month, a
4 very large number.

5 Q Okay. So 2 to 3,000 a month reports come in of
6 positive blood tests for hepatitis C?

7 A Yes.

8 Q Okay. In Clark County?

9 A Yes.

10 Q I mean, is that -- that's your jurisdiction --
11 Southern Nevada Health District is co-terminus with Clark
12 County, correct?

13 A Yes, it is.

14 Q Okay. And are -- are those new reports or
15 duplicates because someone keeps getting blood tests?

16 A It would be both of those.

17 Q Okay. Both of those? Because you get -- say
18 you get 3,000 this month, some of them you may already have in
19 your database?

20 A Yes, that's correct.

21 Q Okay. When I say "you," I'm talking about the
22 Health District, obviously.

23 A Yes, that's correct.

24 Q And so it's -- of those -- say it's -- it's
25 3,000, so we're, like, talking about -- say 100 are reported

1 tomorrow, come it -- does -- does anyone contact those people
2 or do anything with that?

3 A No, we don't.

4 Q Okay. And do -- you don't know if it's newly
5 acquired -- well, you -- you would know if it's newly
6 reported, correct?

7 A Yes.

8 Q Okay. But you wouldn't know if the person just
9 got hepatitis C, and you wouldn't know if they have symptoms?

10 A Without a physician report on just the lab
11 tests, no, we wouldn't.

12 Q Okay. So when -- when this -- these first two
13 reports came in, and then we're back to January 2008 now,
14 okay? And that -- that was your initial involvement?

15 A Yes, that's correct.

16 Q Okay. And it was passed up to you because
17 you're an epidemiological investigator; is that right?

18 A Yes.

19 Q Okay. And already the two reports that had come
20 in had been investigated in the sense of your office -- or the
21 health -- someone in the Health District contacting the two
22 people, correct?

23 A Yes, that's correct.

24 Q Okay. And talking to them either by phone or in
25 person to determine risk factors?

1 A Yes, that's correct.

2 Q Okay. And do you -- you also independently test
3 them?

4 A Generally, we won't, unless there's some
5 additional reason to do so. If we have a lab test from a
6 commercial diagnostic lab, there's no reason to do additional
7 testing.

8 Q Okay. And that's -- that's reliable
9 information? I mean, you -- you have the -- it's reported by
10 a physician, and then the -- the lab tests are there showing
11 that it's positive for hepatitis C?

12 A Yes.

13 Q And then the -- the person is contacted and they
14 are symptomatic, and they're interviewed for the common risk
15 factors you all have developed, correct?

16 A Yes, but I'd say we also determine if they're
17 symptomatic. Just because a physician reports it as an acute
18 case, it may not meet our definition. It may be a
19 misdiagnosis. It may be he only had partial information. So
20 that's part of it as well.

21 Q Okay. And so someone else did that in the
22 Health District?

23 A Yes.

24 Q Okay. And they confirmed that the people are --
25 were sick, had been hospitalized or whatever and they were

1 symptomatic with acute hepatitis C?

2 A Yes, that's correct.

3 Q And then the -- the background -- the interview
4 of them for risk factors, that takes place, correct?

5 A Yes.

6 Q And as I understand it from testimony we've had
7 here, the -- the risk factors for newly acquired acute
8 hepatitis C, but symptomatic, is not as thorough an analysis;
9 is that fair?

10 A That's correct, we can't consider every
11 possibility.

12 Q Right. I mean, it's newly acquired, so just by
13 definition we know, like, within the last six months they got
14 the hep C?

15 A Right. When we do the interviews we ask about
16 those risk factors and the six months prior to the onset of
17 their symptoms, so we limit it to the -- the incubation period
18 of the disease.

19 Q Okay. As opposed to other people, if I just
20 test positive hep C, and I -- I just found out; I took a blood
21 test and just learned I had hep C and didn't even know it, an
22 interview on me on risk factors goes all the way back,
23 correct?

24 A Yes, that's correct.

25 Q The -- to -- and the most common risk factors

1 are the -- I'm not sure I'm saying it right. The most --
2 what's the most dangerous conduct? How do you rank the risk
3 factors?

4 A For newly acquired disease, the majority of
5 cases it winds up being IV drug use, so that's the big
6 question. When you look at the older cases, a lot of it was
7 blood transfusion, so before they started screening the blood
8 supply for it accurately in 1992 there was a risk of hep C,
9 and especially going back into the '70s the way they -- they
10 got blood donors. At one point they had paid blood donors and
11 it tended to attract people that were more likely to have
12 hepatitis.

13 And so there were risks from mostly blood or medical
14 procedures back then. More recently, though, it's more IV
15 drug use, and a lot of them are undetermined still.

16 Q And so now it's confirmed by your -- by the
17 Southern Nevada Health District, we have two reported cases,
18 and at that time you had the common link which was a same
19 clinic, correct?

20 A Yes.

21 Q And the -- that -- that's what caused it to come
22 to your desk to start looking into it?

23 A Yes, that's correct.

24 Q Okay. And just -- I guess, just those two isn't
25 the correct word, but, I mean, with -- with only two reported,

1 that in and of itself sends up big red flags when they are
2 connected to a common facility?

3 A Yes, for an uncommon disease like hep C.

4 Q Right. And so with -- with those two, who do
5 you reach out to first?

6 A I'll talk to my boss, I'll talk to other
7 epidemiologists or the lab, as necessary. In this case it was
8 mostly talking to my boss, and then contacting the CDC.

9 Q Okay. And your boss is?

10 A Patricia Rowley.

11 Q Okay.

12 A Or was my boss; not anymore, but she was at the
13 time.

14 Q Okay. And what is her position?

15 A She was the manager of the epidemiology office.

16 Q Okay. And how many of you epidemiologists are
17 in there?

18 A There's around a half-dozen over that time
19 period. There's a couple that do infectious disease and the
20 other ones do chronic disease, injury, all sorts of things
21 that are totally unrelated to any outbreak investigations.

22 Q Okay. 'Cause you guys go in and look at the
23 restaurants and all that stuff that we see on T.V.?

24 A That's the environmental health inspectors, but
25 if there's an outbreak there we do the restaurant outbreaks as

1 well.

2 Q Okay. And you were -- when this -- how did this
3 end up on your desk or your computer -- what would -- end up
4 on your computer?

5 A Yes, I got an email from my boss that just had
6 the details, so the -- the supervisor over the disease
7 investigators that did the interviews notified the office
8 manager, who told me about it.

9 Q Okay. And you -- were you selected -- do you
10 specialize in this type of investigation?

11 A We only had two infectious disease
12 epidemiologists and I was the senior person. So I -- I tend
13 to find out about most things, or at least at the time I did.

14 Q Okay. And had -- had you previously done a --
15 and is an investigation the correct word in your --

16 A Yes.

17 Q -- okay.

18 A Yes, it is.

19 Q The -- had you previously done an investigation
20 involving hepatitis C transmission?

21 A No.

22 Q Had you previously investigated an ambulatory
23 surgical center for a viral outbreak?

24 A No.

25 Q Okay. And by "viral outbreak", I'm talking

1 about a virus as opposed to, like, bacterial infection, right?

2 A That's correct. I haven't -- I haven't done any
3 ASC investigations before this one.

4 Q Okay. And the -- and had -- had you
5 investigated any hepatitis cases?

6 A Yes.

7 Q Okay. What type?

8 A I've done hepatitis A and hepatitis B.

9 Q Okay. And hepatitis A is generally transmitted
10 how?

11 A Hepatitis A is typically food borne, and
12 hepatitis B is the same sort of transmission generally as
13 hepatitis C.

14 Q Okay. And were those in clinics, hospitals, or
15 what?

16 A No.

17 Q They were not?

18 A That's correct.

19 Q Okay. So when -- when this initially came and
20 it -- it -- you guys deal -- that relative risk, the
21 statistics you all were talking about, that -- that had to be
22 up there high, the two within a couple of months same --
23 precisely same clinic, correct?

24 A Well, I would say a red flag was there, but I
25 wouldn't say relative risk. We use that in a different

1 context, basically.

2 Q Okay. The -- and so you -- did you talk to your
3 boss, and then initially contact CDC that very day?

4 A Yes.

5 Q Okay. And so this is January 2nd, if I recall
6 correctly?

7 A Yes, that's correct.

8 Q And so you get in touch with CDC and you tell
9 them what you have, correct?

10 A Correct.

11 Q Okay. And are you at that point requesting this
12 epi -- what they called an Epi-Aid?

13 A Not at that point. Not initially.

14 Q Okay. You are contacting them looking for
15 guidance and expertise?

16 A Yes, that's correct.

17 Q Okay. And so -- and that -- that first day
18 while you were contacting them, a third case gets reported?

19 A Yes.

20 Q Okay. And once again, that was
21 physician-reported?

22 A Yes, it was.

23 Q And it was vetted -- I mean, it was confirmed
24 it's hepatitis, it's acute, and no risk factors, and lo and
25 behold same clinic and same date as one of the others?

1 A I believe one or two of the cases also had a
2 dental procedure in the six-month window as well, but all
3 three of them had that -- that same endoscopy center link.

4 Q Okay. And so you reported that to CDC?

5 A Yes.

6 Q Okay. And then the -- the plans -- how -- what
7 happened between the 2nd and the 9th?

8 A We started discussing with CDC, was an Epi-Aid
9 appropriate? Did they have people available to come out and
10 assist us, and -- and then it was a question of which branches
11 at CDC. So we spoke with the hepatitis branch and the branch
12 that does healthcare-acquired infections, DHQP is their
13 acronym, it's Division of Healthcare Quality and Promotion.

14 So we were having discussions with them, trying to
15 figure out what the next steps were going to be. We made our
16 official Epi-Aid request, probably the -- the third, probably
17 that next day. They got their team together and said they'd
18 be able to arrive the following Wednesday.

19 Q Okay. And the Epi-Aid request, I mean, that's
20 part of the bureaucracy of government, you have to officially
21 have someone ask them?

22 A Our state epidemiologist has to make an official
23 letter of request to the CDC; and then the CDC comes up with
24 kind of a plan of why are they coming out, what are they
25 looking for, and what's the reason for the trip. Then that

1 gets approved and they find hotels and flights and all that
2 sort of stuff. But it's a pretty standard process that's used
3 all over the country, and we've had Epi-Aids before; it's not
4 a first time we've used it.

5 Q Okay. And so the -- the state epidemiologist --
6 is that?

7 A Yes.

8 Q Who is that?

9 A That's Dr. Ihsan Azzam.

10 Q Okay. And so he -- he was in the loop and
11 forwarded the request?

12 A Yes, that's correct.

13 Q Okay. And so they -- they come out and they --
14 they, from the CDC was Melissa --

15 A Dr. Schaefer --

16 Q --- Schaefer --

17 A --- and Dr. Fischer.

18 Q --- okay. And they arrive on the Wednesday the
19 9th?

20 A Yes.

21 Q And you all have a meeting with them, before
22 going over to the clinic?

23 A Yes, that's correct.

24 Q And at that meeting, yourself, Dr. Fischer, and
25 Dr. Schaefer from CDC, and people from BLC?

1 A As well as a number of other Health District
2 people.

3 Q Okay. It -- so they're -- your -- your agency?

4 A Yes.

5 Q Okay. And at that time had you been -- had you
6 made any initial determinations in your own mind as to what
7 you thought the probable cause was --

8 A No.

9 Q -- going in?

10 A No, I didn't.

11 Q Okay. Do you recall that your initial belief
12 was that it was scope-related because it was a clinic and
13 that's what you all, meaning the Health District, thought was
14 the most likely cause?

15 A I believe my boss sent an email that it was
16 concerned about the scopes because it was an endoscopy
17 clinic --

18 Q Okay.

19 A -- and that was just the initial thought, based
20 on the type of the clinic.

21 Q And it -- and it was the CDC that said, no, we
22 think that injection practices is the most likely cause, based
23 upon our past outbreak investigations?

24 A I don't think they said it was the most likely
25 cause, they said it was more likely that it was an injection

1 safety issue than the scopes, but it really could be anything
2 going into there.

3 Q Okay. But they said the first thing we want to
4 look at is injection practices?

5 A I don't know if it was the first thing they
6 said, it was something they wanted to look at, though.

7 Q Okay. The -- I read a conversation you had with
8 somebody called Nachos?

9 A It's NACCHO. It's the National Association --

10 Q NACCHO.

11 A -- of County and City Health Officials.

12 Q Okay.

13 A Yes, they get that --

14 Q Well, it's --

15 A -- all the time. It's a running joke with them.

16 Q -- N-A-A-C-H-O [sic], NACCHO?

17 A N-A-C-C-H-O, NACCHO.

18 Q And it -- and -- do you recall the conversation?

19 A I remember talking to them a number of times
20 over the years.

21 Q Okay. But the -- do you recall a conversation
22 with yourself, Dr. Sands, the -- everyone involved in this
23 with the NACCHO representatives after this outbreak and
24 investigation had occurred in which you were sharing with
25 them, your -- your -- what had occurred?

1 A Vaguely.

2 Q Okay. Do you recall -- because I recall reading
3 in there that you stated that your all's initial presumption
4 or assumption was that it was scope related, but that's why we
5 call in the experts because they said the first thing we want
6 to look at is injection practices. And I -- I'm summarizing
7 it, but --

8 A It doesn't sound incorrect. I don't
9 specifically remember the conversation, though.

10 Q Okay. And it -- it does not sound incorrect.
11 That sounds like that's accurate about the mindset on going in
12 the door.

13 A In a general sense, yeah. The scopes were on
14 the list, and I would say the injection safety was probably
15 the top of the list of things that we were looking at.

16 Q Okay. And so you all had waited for CDC to
17 arrive, and that was one week, correct?

18 A I think they officially approved the request on
19 Friday, so it was several days, yes.

20 Q Okay. The -- oh, I mean, from -- from the 2nd
21 to the 9th you all made the determination to wait, get CDC,
22 BLC involved, and don't notify the clinic until everything is
23 in place?

24 A Yes.

25 Q Okay. And that's just part of the way

1 investigations are properly done, correct?

2 A Yes.

3 Q Okay. Because the --- you want to -- to your
4 knowledge, no one at the clinic had any idea of this outbreak
5 until you called on the -- on Wednesday the 9th?

6 A As far as I know, that's correct.

7 Q Okay. And you called that afternoon, and told
8 them -- did you tell them on the phone?

9 A I think we gave them a brief overview that we
10 had a number of hepatitis C cases that were potentially linked
11 to the clinic, and we were initiating an investigation, and we
12 wanted to come over and meet with them right away.

13 Q Okay. And do you remember who you spoke with on
14 the phone?

15 A I got passed around to a couple of different
16 people, and I think the final person I really spoke to was
17 Tonya Rushing.

18 Q Okay. And so -- and then you all, within a
19 half-hour, walked across the street and --

20 A Yes.

21 Q -- into the clinic. Had you ever been there
22 before?

23 A No.

24 Q Okay. And you ultimately met with Tonya
25 Rushing, correct?

1 A Yes.

2 Q Okay. Dr. Cliff Carrol?

3 A Yes.

4 Q Okay. And Jeff Krueger or Katie Maley may have
5 been present at the first meeting?

6 A Jeff was present for most of it; Katie was kind
7 of in and out.

8 Q Okay. So most likely Jeff Krueger first
9 meeting?

10 A Yes.

11 Q And at -- at that meeting you had the two -- two
12 BLC people, two CDC people, and yourself?

13 A Yes.

14 Q Okay. And did you tell them of the three cases?

15 A Yes, we did.

16 Q Okay. And it's hepatitis C, acute,
17 symptomatic --

18 A Yes.

19 Q -- positive? And what -- what was the response
20 or reaction?

21 A They were surprised and offered whatever
22 assistance we needed in the investigation. They were very
23 accommodating when we talked to them.

24 Q Okay. And what -- you had set up with CDC a
25 game plan for the investigation, correct?

1 A Yes.

2 Q Okay. And so you told them, here's what we will
3 need when we come back tomorrow?

4 A We started to because we didn't know what
5 documents existed. So the first question is what do they
6 have, and then we can decide what sort of things we wanted to
7 look at. We -- I think we had some general categories, but
8 without visiting the clinic we didn't know exactly what to ask
9 for.

10 Q Okay. And so in visiting it -- and you actually
11 did a walk-around, correct?

12 A A brief one, yes.

13 Q Okay. And you were aware that there was a --
14 what we've called the -- the gastro side, which was medical
15 offices, and then there was actually the procedure clinic,
16 I -- endoscopy side?

17 A Yes.

18 Q Okay. And you learned that they had a patient
19 log -- patient list for both days, correct?

20 A Yes.

21 Q And patient charts, that would be, like, the
22 patient's file for those days?

23 A Well, there were two patient charts. So there
24 was the procedure chart on the endoscopy side, and then there
25 was the general medical chart of the patient on the -- the

1 gastro side.

2 Q Okay. And essentially -- and whether it was all
3 learned right at that very first afternoon -- Wednesday
4 afternoon, you became aware of all of those charts, the doctor
5 side and the procedure side, and those were presented for all
6 of the patients for July 25th and September 21st, correct?

7 A As well as a couple additional days. I think --
8 I think July 25th was a Monday, so I don't think we got any
9 charts from prior to that, but we got the -- the two or three
10 days prior to September 21st as well.

11 Q Okay. And to get -- so going -- so a number of
12 days, three or four, before the September 21st?

13 A Yes.

14 Q Okay. Now, at that first meeting Wednesday
15 afternoon, they -- they give you an overview verbally of their
16 operation?

17 A Yes.

18 Q Okay. Like, number of procedures, types of
19 procedures, types of scopes, types of processing, types of
20 medication?

21 A They talked about the number of patients and the
22 general setup. I know we talked about the medications. I
23 don't know that we went into the types of scopes and how those
24 were processed. That was maybe a little more detailed than
25 the first meeting.

1 Q Okay. And at that first meeting they -- they
2 talked about medications that they used, administered, on the
3 patients, correct?

4 A Yes.

5 Q Okay. And they talked about anesthesia?

6 A Yes.

7 Q And that they used several narcotics?

8 A Yes.

9 Q And used propofol?

10 A Yes.

11 Q And used lidocaine with propofol?

12 A Yes.

13 Q Okay. And they explained at that first meeting
14 that the lidocaine and propofol came from multidose vials?

15 A I know they explained the lidocaine did, I don't
16 know that they said it was a propofol multidose vial. I don't
17 remember specifically what they said. But I believe the
18 conversation they said they used one vial per patient, that
19 they weren't using multidose propofol vials.

20 Q Okay. You think they said they were not
21 multidosing propofol?

22 A From what I remember with the conversation,
23 Tonya said if -- if you check the Sharps container there'll
24 be, you know, vials in there with a bunch of propofol left in
25 them from the procedures.

1 Q Did you do a -- what do you call this report I'm
2 going to show --

3 A I can't see it. I don't know. Those look like
4 the incident command forms from --

5 Q Okay.

6 A -- each day.

7 Q And incident command forms. Did you prepare
8 incident command forms for this investigation?

9 A Yes.

10 Q I'm going to show you --

11 MR. WRIGHT: Can I approach, Your Honor?

12 THE COURT: Sure.

13 BY MR. WRIGHT:

14 Q -- page 9 and 10, which I think is January 9,
15 2008. Look at those, tell me if that refreshes your
16 recollection regarding that they told you that they used
17 lidocaine and propofol from multidose vials.

18 A (Witness complies.) That's what I have in the
19 note here. It still doesn't sound like exactly what happened.
20 The lidocaine was from multidose vials. The propofol, as far
21 as I knew, was not. It's not clear from the way this is
22 written, but that was the -- the conversation.

23 Q Okay. When you say, "was not," I understand
24 that the vials say -- I mean, ultimately, when you
25 investigate, the vials say single dose; but what I'm asking

1 is, did they tell you that they used propofol multi --
2 multipatient?

3 A I don't believe that they did.

4 Q Okay. What -- do you read that differently than
5 I do?

6 A Yes, it was a -- quick notes that I jotted all
7 this down at the end of the day to kind of log everything.
8 And I should have been clearer on what I wrote there, but I --
9 I wrote it as, Propofol with lidocaine is the primary
10 anesthesia used, and comes from multidose vials. The
11 lidocaine came from multidose vials, but the propofol, as far
12 as I knew, did not.

13 Q Okay. Have you looked at the BLC -- when you
14 ultimately prepared a report, did you look at their report?

15 A I've read their report, yes.

16 Q Okay. Did you look at their notes of this first
17 meeting?

18 A When I read the entire report, but it's been
19 five or six years since I read it, so --

20 Q Okay.

21 A -- that's not something I recall.

22 Q Are you aware that -- do you know who Dorothy
23 Simms is?

24 A Yes.

25 Q Okay. Was she present at this first meeting?

1 A Yes.

2 Q Okay. And she states that Jeff Krueger said
3 that they use multidose vials of propofol?

4 A Okay. If that's in the report, I can't disagree
5 with it.

6 Q Okay. Well, does that explain why you would put
7 in your January 9th incident status summary that, Propofol
8 with lidocaine is the primary anesthesia used, and comes from
9 multidose vials?

10 A It could be.

11 Q Is there any -- strike that.

12 After this first meeting on Wednesday, in the
13 afternoon, you all make plans to come back the next morning?

14 A Yes.

15 Q Okay. And you return the next morning, and
16 that's all of -- all of the same people, plus several more
17 from your office?

18 A I believe so. I think it was the same two BLC
19 investigators, plus one additional BLC person as well. I
20 think they had three people on the first day that -- that BLC
21 came back.

22 Q Okay. And that -- that first full day would
23 have been Thursday the 10th?

24 A Yes.

25 Q And that was almost exclusively devoted to

1 records review?

2 A Yes.

3 Q And you all set up in a conference room, and
4 they brought in the patient's logs -- patient lists for the
5 relevant days, and started bringing in all of the charts,
6 hospital -- or the -- ASC, the procedure records and the
7 doctor records?

8 A Yes, that's correct.

9 Q Okay. And you all started going through those
10 to put together your -- your chart, looking for commonalities?

11 A Yes.

12 Q And that -- that took place most of Thursday?

13 A Yes.

14 Q Okay. And anything else on Thursday that was
15 relevant?

16 A Well, there was a staff meeting we attended,
17 where we told them what was going on, and that we'd be
18 observing in the clinic because we planned to do observations
19 the next day, so we wanted them to know --

20 Q Okay.

21 A -- why we were there.

22 Q Okay.

23 A We also caught the end of a procedure, and then
24 saw the scope reprocessing that day, I believe.

25 Q Okay. And so the -- the staff meeting, we're

1 talking about the clinic staff, correct?

2 A It was the endoscopy center staff.

3 Q Okay. Right. Procedure -- the procedure
4 clinic's staff, and it was explained to them who you all were,
5 and why you would be lurking in the background --

6 A Yes.

7 Q -- watching?

8 A Right.

9 Q Okay. And so then you all came back on Friday,
10 and started your observations, correct?

11 A Yes.

12 Q And you were doing observations of procedures
13 that morning?

14 A Yes, that's correct.

15 Q And you were watching Linda Hubbard --

16 A Yes, I was.

17 Q -- CRNA? And what doctor; do you recall?

18 A The -- Dr. Clifford Carrol.

19 Q Okay. And did you watch a number of procedures?

20 A Yeah, a half-dozen or so.

21 Q Okay. Were they uppers or lowers or do you
22 know?

23 A I think it was a mix of the two. I remember the
24 colonoscopies. It was just a -- is a longer procedure, and so
25 there was a little more to observe. But it was just kind of a

1 mix of whatever was scheduled in whatever order. We didn't
2 choose any certain type. We just, you know, whatever they
3 brought in is what we observed.

4 Q Okay. And you are observing with whom?

5 A I was in the room with Melissa Schaefer, and BLC
6 people were kind of in and out.

7 Q Okay. And so as you're watching -- you're
8 watching Linda Hubbard's injection practices?

9 A Yes.

10 Q Okay. And she knows -- you're there, Melissa is
11 there?

12 A Yes.

13 Q And possibly another BLC or two?

14 A Yes.

15 Q Okay. And so with you all watching her, she is
16 drawing propofol and doing patient injections?

17 A Yes, that's correct.

18 Q Okay. Did you see any -- we'll get to the
19 number of propofol vials, but just on her injection practices,
20 did you see anything unsafe?

21 A Specifically, on hers, I think on one of them it
22 was the way -- or she didn't wipe the top of the vial with
23 alcohol or something like that, but nothing -- nothing major,
24 just the kind of minor, typical things that you expect to see
25 if there's, you know, slight problems here or there.

1 Q Okay. And so as far as her -- they were using
2 syringes to draw up the propofol, correct?

3 A Yes.

4 Q And so she would get a new needle, new syringe,
5 draw up propofol, inject a patient, correct?

6 A Yes.

7 Q Okay. And then, if the patient needed a second
8 dose of propofol, she would get a new needle, new syringe,
9 draw up, and dose the patient a second time?

10 A Yes.

11 Q Okay. And so -- and then she was taught
12 throwing away her needles and syringes in the Sharps
13 container?

14 A I don't know that she was taught, but that's
15 what we observed.

16 Q Okay.

17 A We did observe her recap a needle at one point,
18 which was a concern more for her safety than anything else,
19 but it wasn't a risk to the patient.

20 Q Okay. And so what is "recap a needle"? In
21 other words --

22 A So you have the -- the plastic cap on the
23 needle, you pull it off, you do the injection, taking the cap
24 and putting it back on the needle. Kind of like putting a cap
25 on a pen. You have a -- you should just put the whole thing

1 right in a Sharps container instead of accidentally poking
2 yourself while you're doing that.

3 Q Okay.

4 A So it's more of a workplace safety issue for the
5 staff than it would be -- we also saw her remove the cap for
6 one needle, put it in her mouth and pull it off with her
7 teeth, and then do it that way. So again, that's a no-no.

8 Q Okay. Like this?

9 A Yes.

10 Q Okay. And so that's -- the danger in that is...

11 A Well, there's a contamination risk from that,
12 and then, she could also poke herself with it as well. It's
13 just a bad practice all around.

14 Q Okay. And so other than those -- I don't want
15 to call them trivial, but not -- not serious transgressions by
16 Linda Hubbard, all of her injection practices, meaning, clean
17 needle, clean syringe, injection into patient, not reusing
18 needles and syringes, on all of that she was fine?

19 A Yes.

20 Q Okay. And what you did observe her doing was
21 taking propofol, using it on a patient, but there's still some
22 left in the vial, and so she'd set it aside --

23 A Yes.

24 Q -- correct? And so then a new patient comes in
25 and she starts with a new propofol vial and injects them

1 safely, and then sets aside another partially emptied one?

2 A Yes, that's correct.

3 Q And so after a number of procedures she had four
4 or five vials, all with a little bit of propofol in them,
5 still sitting there, correct?

6 A Yes.

7 Q Okay. And so then she took a syringe -- needle
8 and syringe and filled up a needle and syringe by taking the
9 remnants out of the four or five propofol vials?

10 A It was multiple syringes, but yes, that basic
11 idea.

12 Q Okay. So she filled a couple of brand new,
13 clean needles and syringes out of the four or five propofol
14 remnants?

15 A Yes.

16 Q Okay. And so you -- you were observing her
17 multi-using -- using propofol on multiple patients out of one
18 vial --

19 A Yes.

20 Q -- is what would have occurred --

21 A Treating the vial --

22 Q -- right?

23 A -- like a multidose vial, basically --

24 Q Okay.

25 A -- yes.

1 Q And she -- she was doing that, knowing that you
2 all are standing there watching her, correct?

3 A We were in the room, so I assume so, yes.

4 Q Okay. And so then did -- did you talk to her at
5 that time?

6 A No.

7 Q Okay. Her, meaning Linda Hubbard. And the --
8 this -- using propofol as a multidose vial, it caused you
9 concern?

10 A Yes.

11 Q Okay. Now, you had -- you had already known
12 that from Wednesday, correct?

13 A Potentially, yes.

14 Q Okay. And so now you're actually seeing it,
15 correct?

16 A Yes.

17 Q And did -- did you -- other than Linda Hubbard
18 on that Friday, did you observe other CRNAs?

19 A I did not, no.

20 Q Okay. So you -- your sole observations were
21 Linda Hubbard on Friday morning?

22 A Yes, that's correct.

23 Q Okay. And I know you came back a number of
24 times during the next couple of weeks to the clinic for
25 various purposes. Did you come in and do any other procedure

1 observations?

2 A No, it was all records review when I came back.

3 Q Now, your -- you had a conversation with Vincent
4 Mione?

5 A Yes.

6 Q Okay. And is that after your observations of
7 Linda Hubbard?

8 A Yes, it was.

9 Q Okay. And did you -- did you observe any
10 procedures of Vincent Mione?

11 A I did not, no.

12 Q Okay. Can you describe Vincent Mione?

13 A Average height, I believe he had gray hair, I
14 think it was shaved kind of like a buzz cut, from what I
15 remember.

16 Q It was what?

17 A Shaved kind of -- a short haircut, from what I
18 remember.

19 Q Okay. Like a --

20 A It's been a long time. I don't really remember
21 him that well.

22 Q -- okay. Well, you -- there's a couple of
23 Vinnie's that were CRNAs; is that correct?

24 A Yes.

25 Q Okay. And do you know which Vinnie you talked

1 to?

2 A I believe we spoke with Vincent Mione. I think
3 Vincent Sagendorf came in at a different time. I don't think
4 he was working. I think he came in that afternoon, and they
5 had talked to him, but he wasn't working at that clinic on
6 that day.

7 Q Okay. The -- could it be you have your Vinnie's
8 mixed up?

9 A I'm sure it's possible, but I -- from what I
10 remember on the notes and the things I took, it was Vincent
11 Mione.

12 Q Okay. I didn't see it in your notes.

13 A I --

14 Q Do you have some notes I haven't seen--

15 A I'd have to look back --

16 Q -- is what I'm saying.

17 A -- what I have. It's been a long time since
18 that conversation. So it's possible that the two were mixed
19 up, but I don't think so.

20 Q Well, do you have any -- did you write anything
21 down anywhere regarding that conversation with Vincent Mione?

22 A I don't know if I did or not. If it's not in
23 the notes, then -- then maybe I didn't. It was a brief
24 conversation. It was 30 seconds or a minute or so.

25 Q Okay. Well, I -- the -- don't take my

1 representation for it when I tell you it's not in the notes.
2 The -- I didn't see it, but I don't know that I have all of
3 your notes, okay? Do you think anywhere you made a note of
4 that? Have you seen anywhere your conversations where you
5 noted it on January 11 with Vincent Mione?

6 A I really don't remember.

7 Q Okay. Now, are you aware that Vincent Mione
8 denies the conversation with you?

9 A No.

10 Q Okay. The --- and who else was present?

11 A Melissa Schaefer.

12 Q Okay. Now, in your -- one of your interviews, I
13 believe the one -- you were interviewed by the Metropolitan
14 Police Department, correct?

15 A Yes.

16 Q Okay. Have you read that transcript lately?

17 A No, not lately.

18 Q Okay. My recollection of that is when you were
19 trying to determine who the Vinnie was you may have talked to,
20 you said it was the Vinnie who was brand new there.

21 A I don't remember that. It's possible.

22 Q Okay. Do you know which Vinnie was new -- had
23 been recently hired?

24 A No, I don't.

25 Q Well, the evidence has been that it's -- it -- I

1 mean, Mr. Mione testified in here and Mr. Sagendorf testified
2 in here -- the two Vinnies, okay? And Mr. Mione had worked
3 for a number of years at the clinic, mainly Burnham, and Mr.
4 Sagendorf had just been hired in October 2007.

5 A Okay.

6 Q Do you remember which of the two you talked to?

7 A This far after? No, I don't.

8 MR. WRIGHT: Page 28, Metro.

9 BY MR. WRIGHT:

10 Q This is a transcript from your interview
11 Metropolitan Police Department, on May 19, 2008.

12 A Okay.

13 Q Look at page 28. Look at that to yourself.

14 A (Witness complied.) Okay.

15 Q Does that refresh your recollection as to which
16 Vinnie you talked to?

17 A From the conversation here it was the newer one,
18 and I don't know enough details to say if that was Mione or
19 Sagendorf.

20 Q Okay. But the -- this was in May 2008?

21 A Yes.

22 Q So this was literally four months later,
23 correct?

24 A Right.

25 Q And you couldn't remember the last name of the

1 Vinnie you talked to, correct?

2 A That looks correct.

3 Q And what you believed was that -- whoever is the
4 newer Vincent, the one who had been there a short amount of
5 time, correct?

6 A That looks correct, yes.

7 Q So if -- if the evidence is that the person who
8 has been there the short amount of time is Vincent Sagendorf
9 and not Vince Mione, that would have been the person you spoke
10 with; is that fair?

11 A Possibly, yes.

12 Q Okay. Well, is that correct?

13 A Like I said, it's been a long time. I don't
14 remember exactly which one it was.

15 Q Okay. And you made no report of it and no notes
16 whatsoever?

17 A None that I remember, but I haven't looked at it
18 in a long time -- or haven't looked at -- for that particular
19 item in a while.

20 Q Mr. Sagendorf testified in here, and he also
21 denies any such conversation with you.

22 A Okay.

23 Q Have you spoken to Melissa Schaefer -- is that
24 her name? I get them mixed up --

25 A It's still Melissa Schaefer, yeah, she has the

1 same name.

2 Q -- Melissa Schaefer, about this?

3 A About this? No.

4 Q Okay. She does not recollect any such
5 conversation.

6 A Okay.

7 Q Have you read her grand jury testimony?

8 A Years ago.

9 Q Okay. Could -- you could be mistaken about this
10 because of the passage of time?

11 A Mistaken about what, specifically?

12 Q This conversation.

13 A That it happened?

14 Q Yes.

15 A I don't believe so.

16 Q Okay. But you don't know who it was with?

17 A I may have the incorrect Vincent, that's
18 correct.

19 Q And the -- and the conversation was what?

20 A It was a -- just a brief conversation about the
21 injection practices, about the reuse of propofol, and the
22 reuse of syringes to access vials, and he said the -- they
23 were told to reuse the syringes, but he didn't do it.

24 Q Okay. And at -- at that point it seems to me
25 you know that propofol is being multiused, correct? Treated

1 as a multidose?

2 A In general, yes.

3 Q Okay. Well, in general, it had been stated to
4 you all, and you all had observed it, correct?

5 A Yes, that was the general practice of the
6 clinic.

7 Q Okay. And at this time of this conversation
8 with a Vinnie, there hadn't been any observations of any
9 syringe reuse, correct?

10 A Not by me, that's correct.

11 Q Not by anyone at that point that you knew about,
12 correct?

13 A That I knew about at that time?

14 Q Yes.

15 A That's correct.

16 Q Okay. So it seems to me if an employee is
17 actually saying -- discussing reuse of syringes, that's the
18 first time you all are hearing it, that would be some
19 significant seminal event.

20 A I don't know about a seminal event, but it was
21 significant, yes.

22 Q Okay. But you made no -- no notation, no
23 report, it's not in your -- what do you call this thing?

24 A The ICS forms?

25 Q Right. Correct?

1 A That's correct.

2 Q When did -- you learned that Gayle Fischer had
3 observed Mr. Mathahs, CRNA, reusing a syringe to redose a
4 patient, correct?

5 A Yes.

6 Q You learned about it that afternoon, correct?

7 A Yes.

8 Q And you all then have a meeting about it?

9 A It was in the conference room where we were all
10 working together, so we were just discussing things in general
11 throughout the afternoon.

12 Q Okay. And would you -- when you were there
13 looking for unsafe practices, and/or trying to determine how
14 this transmission could have occurred, you would bring to the
15 attention of the clinic, management, anything you saw wrong,
16 correct?

17 A Yes.

18 Q Okay. Because the whole -- you weren't
19 conducting, like, a criminal investigation, correct?

20 A That's correct.

21 Q Okay. You were looking to see how -- how in the
22 world did this happen, and if we can -- how can we correct it
23 and prevent it so it's not happening again?

24 A Yes, that's correct.

25 Q Okay. And so, like, on that Friday who did you

1 meet with to tell them about propofol multiuse and syringe
2 reuse?

3 A Friday was Tonya and Dr. Carrol, I believe.

4 Q Okay. And you would share everything with them,
5 correct?

6 A Yes. We met with them each day and told them
7 what we found, and any new information, kind of what the next
8 steps were.

9 Q Okay. And so they would then implement changes
10 to prevent those things from happening again, correct?

11 A That was our request of them, yes.

12 Q Okay. And to your knowledge, they did that,
13 correct?

14 A Yes.

15 Q Okay. And so, like, it was -- these are --
16 don't use propofol for more than one patient, correct?

17 A Yes.

18 Q Okay. And on syringes don't use the same
19 syringe on the same patient to redose, correct?

20 A Yes.

21 Q Okay. And there was never anything about reuse
22 of syringes or needles -- I'm calling them as one unit, but
23 reuse of the needle and syringe multipatient, correct?

24 A That's correct.

25 Q Okay. And by multipatient I'm talking about,

1 like, if a CRNA injected one patient and then used the same
2 needle and syringe on a different patient?

3 A Yes, that's correct.

4 Q Nothing like that was ever observed, seen,
5 heard, talked about --

6 A Correct.

7 Q -- correct? And so was it your understanding
8 that as of Friday the 11th in the meeting going forward, these
9 changes would take place?

10 A Yes, we met with them late on Friday and they
11 said they would correct things for when they reopened on
12 Monday.

13 Q Okay. And the -- did you discuss with Gayle
14 Fischer what she had observed with CRNA Keith Mathahs?

15 A Yes.

16 Q Okay. And did you understand that the
17 observation was that he was using a needle and syringe, brand
18 new, dosing the patient with propofol and/or lidocaine -- I'm
19 just skipping over that -- but basically dosed the patient,
20 and then when the patient needed a redose, Mr. Mathahs was
21 taking out a brand-new needle, removing the dirty needle from
22 the syringe, placing a clean needle on the syringe, and then
23 going into propofol and drawing a second dose and then
24 injecting the patient?

25 A That's correct.

1 Q Okay. And did you discuss with her the practice
2 of changing the needle?

3 A We discussed all of those things, I guess, in --

4 Q Okay.

5 A -- throughout the day.

6 Q And what does that do, changing the needle?

7 A It doesn't really reduce risk of infection
8 because the blood can be in the syringe itself, so the needle
9 itself -- changing the needle really doesn't make a
10 difference.

11 Q Okay. And did you have any discussions with --
12 you -- with Mr. Mathahs about his belief that that was a safe
13 injection practice by changing the needle?

14 A No, I did not.

15 Q Are you aware that Gayle Fischer did?

16 A I know she talked to him, but I don't know what
17 the details of the conversation were exactly.

18 Q Okay. Now, what Keith Mathahs was observed
19 doing was an unsafe injection practice; is that fair?

20 A Yes.

21 Q Okay. And was he observed using propofol as a
22 multidose vial?

23 A Yes, I believe he was.

24 Q Okay. You believe he was?

25 A Yes.

1 Q And so if -- if he was, and that was observed,
2 that was immediately stopped?

3 A Yes. I know, Gayle said she spoke to him after
4 that procedure and -- so there wasn't an ongoing risk of
5 patients that are -- from using a contaminated vial.

6 Q Okay. And the -- if he was not using propofol
7 as a multidose vial, and was simply using needle and syringe
8 to redose a patient, okay, that would not cause any
9 transmission of hepatitis C?

10 A That's correct.

11 Q Okay. And so it was determined by you in your
12 ultimate conclusion that the likely method of transmission on
13 the dates in question was a combination of using propofol as a
14 multidose vial, and at the same time reusing syringes on
15 individual patients?

16 A Yes, that's correct.

17 Q Okay. And if that occurred, there was a chance
18 that a virus in the source patient could contaminate the vial
19 of propofol, right?

20 A Yes.

21 Q And that that could be -- that vial could then
22 be used on other -- another patient or patients?

23 A Yes, that's correct.

24 Q And, I think you've called that the serial
25 contamination of vials theory?

1 A Not just one. You would have to then take it
2 from a contaminated vial, and then essentially contaminate a
3 second vial from the --

4 Q Okay.

5 A -- first contaminated vial.

6 Q Okay. And you explained this morning that
7 theoretically this -- if the transmission occurred in the way
8 you believe it could have, that it could either have been one
9 50cc propofol vial was contaminated, correct?

10 A Yes, theoretically.

11 Q Right. And that one vial could have
12 contaminated all of the patients that were contaminated on the
13 21st of September because there was enough volume in it that
14 it could have been used on every contaminated patient, if a
15 little bit was used each time?

16 A Yes, that's correct.

17 Q Okay. And that was one -- that's just a single
18 vial contamination theory?

19 A Correct.

20 Q Okay. And then your alternative was the serial
21 contamin -- S-E-R-I-A-L contamination theory, correct?

22 A Yes.

23 Q And for your serial contamination theory, your
24 conclusion of likely -- this likely serial contamination, this
25 is the first time anyone has ever come up with such a theory,

1 correct?

2 A I don't know that that's true or not. I haven't
3 reviewed all the literature to say that nobody else has
4 thought of that idea.

5 Q Okay. Well, you have looked at the literature
6 and couldn't find any?

7 A I didn't look at the literature specifically for
8 that. I didn't do a search for any of those types of things,
9 so it's possible it's out there, I don't know.

10 Q Okay. Well, to your knowledge no one else has
11 ever come up with this serial contamination theory, correct?

12 A I guess that's true. I never really looked for
13 it, so, no -- to my knowledge, no.

14 Q Okay.

15 MR. SANTACROCE: Your Honor, I'm having trouble
16 hearing him.

17 THE COURT: All right. Well, this actually may be a
18 good time to take our lunch break, and I think some of the
19 jurors are hinting they needed a break.

20 Ladies and gentlemen, we're going to go ahead and
21 take our -- excuse me, our recess. For the lunch break we
22 will be in recess until 1:40.

23 During the lunch break you are reminded that you're
24 not to discuss the case or anything relating to the case with
25 each other or with anyone else. You're not to read, watch,

1 listen to any reports of or commentaries on this case, any
2 person or subject matter relating to the case. Don't do any
3 independent research by way of the Internet or any other
4 medium, and please do not form or express an opinion on the
5 trial.

6 Notepads in your chairs. Follow the bailiff through
7 the rear door.

8 (Jury recessed at 12:50 p.m.)

9 THE COURT: And during the break, do not discuss your
10 testimony with anybody else.

11 THE WITNESS: Can I leave the -- my notebook?

12 THE COURT: Sure.

13 All right. It's lunch.

14 (Court recessed from 12:31 to 1:43 p.m.)

15 (Outside the presence of the jury.)

16 THE COURT: Come on back. Make sure Kenny knows I
17 meant for him to bring the jury in.

18 (Off-record colloquy.)

19 THE COURT: Bring them in. We're ready.

20 THE MARSHAL: Ladies and gentlemen, please rise for
21 the presence of the jury.

22 (Jury entering at 1:47 p.m.)

23 THE MARSHAL: Thank you, everybody. You may be
24 seated.

25 THE COURT: All right. Court is now back in session.

1 And, Mr. Wright, you may resume your
2 cross-examination.

3 MR. WRIGHT: Thank you.

4 BY MR. WRIGHT:

5 Q I want to go back to the Friday afternoon,
6 January 11, 2008, when you report to the clinic that a
7 propofol issue and a reuse of syringe issue, you all had
8 determined that you had figured out the method of
9 transmission, correct?

10 A At that point it was a concern; I don't know
11 that we figured out everything about the method of
12 transmission yet at that point.

13 Q Okay. Did -- do you recall testifying:

14 Question: My understanding is that you had already
15 reached your conclusion by January 11, 2008, that the reuse of
16 syringes on multiple times on one patient, coupled with the
17 propofol vials being reused on more than one patient, was the
18 source of contamination of hepatitis C at the clinic; is that
19 correct?

20 You answered, Yes.

21 A I don't specifically remember that, but okay.

22 Q Let me show you -- so you can confirm I read it
23 right -- the deposition on February 24, 2009. And I'm looking
24 at page 211.

25 A (Witness complied.) Okay.

1 Q Is that correct?

2 A That's what it says.

3 Q Having made that determination on Friday,
4 January 11, I -- I'm now going to jump back to where I was
5 before we took lunch recess.

6 I was asking you if there were anyone, to your
7 knowledge -- well, let me put it this way: You're the first
8 person, to your knowledge, who has ever come up with a serial
9 contamination theory of -- as the mechanism of spreading a
10 virus through vials, correct?

11 A To my knowledge, yes.

12 Q And you have looked for any other cases, asked
13 CDC about other cases, looked in the literature to see if
14 there was ever any reported case of serial contamination like
15 you have theorized, correct?

16 A No, I have not reviewed the literature for that
17 specific item. I haven't done a full study to see if anybody
18 else has ever published that.

19 Q Okay. Well, you were previously asked in 2009
20 in your deposition if you were aware of any articles or cases
21 supporting your theory, correct?

22 A Yes.

23 Q And you said you were not aware, correct?

24 A That's correct.

25 Q And did you then ask the CDC, right after that

1 deposition, to determine if there were any articles or studies
2 or anything to support your position?

3 A I believe I did.

4 Q Okay. And they couldn't find any, correct?

5 A That seems to be correct.

6 MR. WRIGHT: Can I just have my next in order?

7 BY MR. WRIGHT:

8 Q Look at page 2, 3 of Q1 -- Proposed Q1, tell me
9 if you recognize that?

10 A (Witness complied.)

11 Q Do you recognize that?

12 A Yes.

13 Q Is that the email from CDC?

14 A Yes.

15 MR. WRIGHT: Move the admission of Q1.

16 THE COURT: Any objection to Q1?

17 MS. WECKERLY: Yes.

18 THE COURT: I'll see Counsel at the bench, and I'll
19 see the exhibit.

20 (Off-record bench conference.)

21 THE COURT: I mean, isn't that the import of the
22 email basically?

23 BY MR. WRIGHT:

24 Q Judge -- is that an accurate record from
25 Southern Nevada Health District emails?

1 A It looks to be.

2 Q And that is to you, reporting the results of
3 their search for publications regarding serial contamination
4 of vials, correct?

5 A Yes.

6 MR. WRIGHT: Move its admission.

7 THE COURT: Well --

8 MS. WECKERLY: Same objection.

9 THE COURT: For right now that's overruled, but you
10 can certainly ask him what they found, how many studies they
11 found, and whether or not he looked into the study they found,
12 or publication.

13 MR. WRIGHT: Can we approach?

14 THE COURT: Sure.

15 (Off-record bench conference.)

16 BY MR. WRIGHT:

17 Q Did you call Melissa Schaefer on about March 24,
18 2009, and ask her if the CDC was aware of any articles in the
19 published literature that document serial contamination of
20 vials as you presume happened in Las Vegas?

21 A Yes.

22 Q Okay. And you stated you want to cite an
23 article in your report to describe this, correct?

24 A Yes.

25 Q Okay. And at the time your report is not

1 completed?

2 A That's correct.

3 Q And then a response came from CDC containing one
4 article, correct?

5 A Yes.

6 Q And the CDC told you that it seems like there's
7 enough information --

8 MS. WECKERLY: Objection. Hearsay.

9 THE COURT: Well, go ahead and ask the question.

10 BY MR. WRIGHT:

11 Q The CDC --

12 MS. WECKERLY: Objection, Your Honor. This is the
13 content of the email.

14 THE COURT: Well, if the point is that's the only
15 article or why he was directed to that particular article --

16 MS. WECKERLY: That's not the --

17 THE COURT: -- he can answer.

18 MS. WECKERLY: -- content.

19 THE COURT: Go ahead.

20 BY MR. WRIGHT:

21 Q Did the -- did the CDC form you -- tell you,
22 pardon me. Did the CDC state that the article and -- that
23 with the article, it seems like there's enough information
24 here and from your investigation to show that this is clearly
25 a plausible explanation?

1 A Yes.

2 Q Okay. And the "plausible explanation" they're
3 talking about, is showing your -- your serial contamination
4 theory as the mechanism of transmission, correct?

5 A Yes.

6 Q And then the article they sent you involved a
7 pooling -- P-O-O-L-I-N-G, a pooling outbreak, correct?

8 A Yes.

9 Q Okay. And it really wasn't applicable to your
10 serial contamination theory, correct?

11 A I'm not sure exactly which article that is, so I
12 couldn't say.

13 THE COURT: Did you follow up and actually pull the
14 article and read the article?

15 THE WITNESS: I likely did, yes.

16 THE COURT: Do you -- I mean, don't guess because we
17 tell everyone don't speculate. If you don't remember, then
18 don't guess or speculate as to what you did.

19 THE WITNESS: Then I don't remember.

20 THE COURT: All right.

21 BY MR. WRIGHT:

22 Q Now, this is -- this is in February 2009, and
23 your report is completed in December 2009, correct?

24 A This was actually March, but yes.

25 Q Okay. March, I'm sorry. March 2009, and you

1 completed your report December 2009?

2 A Yes.

3 Q Okay. By -- by then you -- you had already had
4 published an article about the outbreak, with other authors --

5 A Yes.

6 Q -- correct?

7 A Yes.

8 Q And your theory of contamination?

9 A Yes.

10 Q And you have become a speaker at conferences?

11 A Yes.

12 Q Discussing your theory of contamination?

13 A Among other things, yes.

14 Q Okay. And had you become a celebrity within the
15 epidemiological group?

16 A No.

17 Q Okay. You were -- you would go to conferences
18 to discuss the Brian Labus serial contamination theory,
19 correct?

20 A I think you're the first person that's ever said
21 that, so I would say no.

22 Q Okay. Ever said what?

23 A The Brian Labus serial contamination theory.
24 There isn't a conference on that, and it's not a topic of
25 discussion at the conferences, really.

1 Q Okay. You didn't go put on a PowerPoint and
2 presentation of this?

3 A Yes, I did. And this was one piece of it, but
4 it wasn't about just serial contamination. It was the -- the
5 outbreak, the response, kind of the -- the entire thing from
6 beginning to end.

7 Q Okay. And so you -- you had published an
8 article, gone to conferences, plural; how many?

9 A I think I presented on this three or four times
10 at conferences, maybe.

11 Q Okay. All before you got your report out,
12 correct?

13 A No, I've presented on it since then as well,
14 but --

15 Q Pardon?

16 A No, I've presented on it since then as well, but
17 it -- there were presentations before the report was
18 completed.

19 Q To this date, 2013, are you aware of any other
20 cases of serial contamination, or any other articles other
21 than your own?

22 A No, I'm not.

23 Q Now, having reached the determination by -- by
24 Friday, January 11, in the evening, as to the method of
25 transmission, you all started then working with the clinic on

1 a plan for notification; is that correct?

2 A No, the decision to notify came after that,
3 probably not until February.

4 Q Okay.

5 A We worked with a clinic to remediate the
6 situations we found that were problems in the clinic.

7 Q Okay. To correct everything?

8 A Yes.

9 Q Okay. And the -- you on -- on your side were
10 planning a patient notification, correct?

11 A Not at that point.

12 Q Okay. Well, you'd made a determination that
13 there were unsafe-injection practices?

14 A Yes.

15 Q Okay. And so the -- the question was really the
16 scope of the notification, not whether you would notify,
17 correct?

18 A We didn't have discussions about that
19 notification yet. We needed to complete the investigation
20 before we moved into that phase, and the investigation on that
21 date still wasn't completed.

22 Q Okay. You had made your conclusion as to what
23 it was, correct?

24 A Yeah, we moved that to the top of the list.

25 Q Okay. Well, did I read accurately that you had

1 concluded it by January 11?

2 A Yeah, you did.

3 Q Okay. And your main -- and your -- aside from
4 correcting what had happened so it stops, your other major
5 concern as the Health District is to get notification to
6 anyone who could have potentially been infected by the
7 practices that preexisted your inspection, right?

8 A At some point, yes, but not at that early date.

9 Q Okay. So your -- your belief is you waited
10 until February to start determining are we going to notify
11 patients?

12 A The extent of a notification that was needed,
13 and how many people, and how to do it, yeah, that -- that
14 waited a little later.

15 Q So you -- the determination -- ultimately you
16 decided to notify all patients of what we call Shadow Lane and
17 Burnham clinics, okay, from -- for the previous four years,
18 correct?

19 A Yes, it was split up in different phases, but
20 yes, ultimately that's what we decided.

21 Q Okay. And that determination for notification
22 was made solely based upon the unsafe-injection practices and
23 the multiuse -- or the use of propofol as a multiuse vial,
24 correct?

25 A Well, I wouldn't say "solely," I'd say the fact