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ANGELA DeCHAMBEAU, and)
JEAN-PAUL DeCHAMBEAU)
BOTH INDIVIDUALLY AND AS)
SPECIAL ADMINISTRATORS)
OF THE ESTATE OF NEIL)
DeCHAMBEAU)

VS.

STEPHEN C. BALKENBUSH, ESQ.,)
AND THORNDAL, ARMSTRONG,)
DELK, BALKENBUSH and)
EISINGER, A NEVADA)
PROFESSIONAL CORPORATION,)

An Appeal from the Second Judicial District
Court, Judge Patrick Flanagan, Case
Number CV12-00571

A0166-A0288

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7 IN THE SECOND JUDICIAL DISTRICT COURT
8 IN AND FOR THE COUNTY OF WASHOE
9 THE HONORABLE PATRICK FLANAGAN, DISTRICT JUDGE

10 --oOo--

11	ANGELA DECHAMBEAU, et)	
	al.,)	
12)	
	Plaintiffs,)	
13)	Case No. CV12-00571
	vs.)	
14)	Department 7
	STEPHEN BALKENBUSH, et)	
15	al.,)	
)	
16	Defendants.)	

17
18 PARTIAL TRANSCRIPT OF PROCEEDINGS
19 TRIAL TESTIMONY OF HUGH CALKINS

20 January 20, 2017

21 9:00 a.m.

22 Reno, Nevada
23

24 Reported by: STEPHANIE KOETTING, CCR #207, RPR
Computer-Aided Transcription

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1 RENO, NEVADA, January 20, 2017, 9:00 a.m.
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3 --oOo--
4 THE COURT: Good morning, ladies and gentlemen.
5 Will counsel stipulate to the presence of the jury?
6 MR. KOZAK: We will.
7 MR. POLLARA: Yes, your Honor.
8 THE COURT: Ms. Pollara, your next witness.
9 MR. POLLARA: Thank you, your Honor. At this
10 time, we'll like to call Dr. Hugh Calkins to the stand.
11 (One witness sworn at this time.)
12 THE COURT: Ms. Pollara, your witness.
13 MR. POLLARA: Thank you, your Honor.
14 HUGH CALKINS
15 called as a witness and being duly sworn did testify as
16 follows:
17 DIRECT EXAMINATION
18 BY MS. POLLARA:
19 Q. Good morning, Dr. Calkins.
20 A. Good morning.
21 Q. Are you a medical doctor?
22 A. Yes.
23 Q. And what is your specialty?
24 A. Cardiology and electrophysiology.

1 Q. Can you tell us where do you hold licenses to
2 practice medicine?

3 A. In the state of Maryland.

4 Q. Were you contacted at some point in 2008 or 2009
5 by an attorney here in Reno who was representing Dr. Smith
6 asking if you would be willing to review this case for him?

7 A. Yes, I was contacted.

8 Q. Did you agree to do that?

9 A. Yes, I did.

10 Q. And did you subsequently receive and review
11 records from Washoe Medical Center and Dr. Smith's office and
12 the primary care doctor?

13 A. I did.

14 Q. Based upon your background, experience and
15 training and your review of those records, did you reach any
16 conclusions when you reviewed the records back at that time?

17 A. Yes, I did. I felt that Dr. Smith met the
18 standard of care.

19 Q. And then at some point, were you advised that that
20 case was terminated or over in some fashion?

21 A. Yes, I was.

22 Q. And then later were you once again contacted at
23 that point by an attorney representing Mr. Balkenbush to ask
24 if you would again review the record?

1 A. I was.

2 Q. Did you rereview the records at that time?

3 A. Yes, I did.

4 Q. Did you also review Dr. Smith's deposition
5 transcript?

6 A. I did.

7 Q. Did you review Dr. Morady's deposition transcript?

8 A. Yes.

9 Q. And as a result of that review and your background
10 and experience and training, what opinions did you have at
11 that time?

12 A. My initial opinion was that Dr. Smith met the
13 standard of care, and after rereviewing it, after reviewing
14 the depositions, I still felt he met the standard of care.

15 Q. And do those remain your opinions today?

16 A. Yes.

17 Q. Are the opinions that you're going to express here
18 today to a reasonable degree of medical certainty?

19 A. They are.

20 Q. Thank you. When you reviewed the records, and
21 focusing now on your current opinions, do you conclude that
22 Dr. Smith acted reasonably and prudently after Mr. Dechambeau
23 developed cardiac tamponade in the way that he handled the
24 situation, including performing the pericardiocentesis?

1 A. Yes, I did.

2 Q. I want to talk with you a little bit about your
3 background and your education. Dr. Calkins, where did you go
4 to medical school?

5 A. I went to Harvard Medical School.

6 Q. What year did you graduate?

7 A. 1983.

8 Q. And then after that, did you complete an
9 internship and residency?

10 A. Yes. It was Mass General Hospital in Boston.

11 Q. What was that in?

12 A. In internal medicine.

13 Q. Can you tell us when you completed that program?

14 A. 1986.

15 Q. Now, after you completed your internship
16 residency, did you then complete a fellowship?

17 A. Yes. I went to Johns Hopkins and did my
18 cardiology and electrophysiology fellowships.

19 Q. And how many years were those?

20 A. Three years.

21 Q. Are you board certified in any specialties?

22 A. Yes. I'm board certified in internal medicine,
23 cardiology, and electrophysiology.

24 Q. Can you tell us approximately when you were first

1 board certified in those areas?

2 A. Well, internal medicine would have been 1986,
3 cardiology would have been about 1990, and electrophysiology
4 in about 1992 or 3.

5 Q. All right. Thank you. Have you maintained your
6 board certifications?

7 A. Yes, I have.

8 Q. Does that require -- are you grandfathered in,
9 I've heard that term, or do you take the exams again?

10 A. So for internal medicine and cardiology, I'm
11 grandfathered in so I don't have to retake the exams. For
12 electrophysiology, I do, and I last took it three or
13 four years ago and passed.

14 Q. And where are you currently working?

15 A. I'm currently at Johns Hopkins.

16 Q. And that the School of Medicine or the Medical
17 Center or both?

18 A. It's all the same, but it's at the Hospital and
19 University and School of Medicine.

20 Q. And can you tell us, what professional
21 appointments do you currently have at Johns Hopkins?

22 A. I'm director of the electrophysiology laboratory
23 and the arrhythmia service.

24 Q. How long have you been director of the

1 electrophysiology lab?

2 A. Since 1992.

3 Q. Quite a while?

4 A. Yes.

5 Q. Do you know Dr. Fred Morady?

6 A. Yes, I do.

7 Q. How do you know him?

8 A. My first faculty job, I left my training in 1999,
9 I went to University of Michigan to work with Dr. Morady. He
10 was one of the pioneers of cath ablations in its broader
11 sense. I wanted to work with a world expert at that time, so
12 I was successful in getting my first doctor appointment at
13 the University of Michigan.

14 Q. How long were you at the University of Michigan?

15 A. I was there for three years.

16 Q. Now, we're here, as you understand it, about
17 Mr. Dechambeau, who had atrial fibrillation as an underlying
18 condition, correct?

19 A. Correct.

20 Q. We've heard a lot about this, but can you just
21 explain to us briefly what is atrial fibrillation, and then
22 tell us what has been the evolution of the treatment of that
23 disease from an electrophysiology standpoint, if you could
24 tell us about that?

1 A. So atrial fibrillation is the most common
2 arrhythmia there is. It's a total irregular and rapid
3 beating of the upper chamber. So the upper chambers are sort
4 of like a bag of worms. They're sort of fibrillating.
5 They're going extremely fast and not pumping effectively.

6 It turns out this is the most common arrhythmia
7 that is age-related. Rare before 50, by the time you're 80,
8 one in ten people have it. It's significant because can it
9 can cause symptoms, palpitations, shortness of breath --

10 Q. Doctor, let me tell you, slow down a little bit
11 for our court reporter.

12 A. It also increases your risk of having a stroke
13 five-fold. It also increases your mortality. It increases
14 your risk of dementia. Increases your risk of heart failure.
15 So it's a very significant and very common arrhythmia, but
16 it's very, very complex. It's not one single circuit. It's
17 not one single mechanism. It's sort of the most complex of
18 all the arrhythmias we deal with.

19 Right now, there's about two and a half million
20 Americans with atrial fibrillation. By 2050, it will be
21 about 12 million. So as we all age, the tsunami of afib is
22 increasing and also obesity plays a role. So as we all get
23 older and fatter, we're going to have more atrial
24 fibrillation.

1 Q. And so is catheter ablation a fairly recent
2 technique or manner in which atrial fibrillation is treated?

3 A. Well, it was first -- the current technique we
4 use, the underpinnings of that were first described in 1998.
5 So it's actually been around for about 20 years. And it
6 keeps getting better and the tools keep changing. Right now,
7 it's the most commonly performed ablation procedure in the
8 world.

9 So most electrophysiology laboratories, this is
10 how electrophysiologists spend their time performing this
11 procedure, which started about 20 years ago and it keeps sort
12 of advancing. We aren't perfect yet, but we keep trying to
13 get there.

14 Q. And so what was used before the current
15 technology?

16 A. It started out with open heart surgery to treat
17 atrial fibrillation. That was in the early '80s. Jim Cox, a
18 surgeon at Duke, developed that technique where you would
19 open a patient up, cut their chest, cut their atrium into
20 many different pieces and sew it back together. He showed
21 that you could treat atrial fibrillation with this huge
22 surgery, but it didn't catch on, because the surgery had a
23 huge complication rate, and very few surgeons were skilled
24 enough to perform it.

1 The next thing that happened is that
2 electrophysiologists like myself tried to replicate that
3 procedure from the inside with a catheter by cauterizing the
4 heart, cauterizing precise areas, and that didn't work very
5 well.

6 And then in 1998, a group in Bordeaux, France,
7 Michel Haissaguerre, discovered that afib is triggered from
8 the pulmonary vein. Pulmonary veins bring blood from the
9 lungs back into the heart. It turns out that afib is started
10 in those veins. It's like the starter for your snowblower,
11 which you'll be starting up this afternoon.

12 That starter is in the pulmonary veins. There's
13 little muscle fibers, there's nerves that extend around these
14 veins, the nerves go crazy, the muscle fibers start firing,
15 then that starts afib where you have multiple circuits going
16 in the entire atrium. But it's all about pulmonary veins,
17 and if you can get rid of the starter, if you can get those
18 pulmonary veins isolated, then you can control atrial
19 fibrillation in most patients.

20 Q. You said it's the most common ablation procedure
21 performed today. Take us back, you were doing these
22 procedures in 2006?

23 A. Yes.

24 Q. Compare 2006 to today. Has it continued to evolve

1 as far as the number of ablations that are being done? How
2 frequently was it being done in 2006?

3 A. If you think about it, in 1998, there was about
4 two hospitals in the world doing it. And then very quickly
5 over the next three years, most major leading medical centers
6 started to do it.

7 So I'd been performing it for a while, but using
8 the new technique started in 1999, 2000, and then it very
9 quickly caught on. So by the mid 2000's, the time we're
10 talking about, it had moved to smaller community hospitals
11 and was really catching on, you know, everywhere.

12 But it was compared to today, we have better tools
13 today, we have better techniques today, we have better
14 appreciation of all the aspects of the procedure. So I would
15 call that the early days of catheter ablations, atrial
16 fibrillation. It wasn't experimental. It was commonly
17 accepted, commonly performed. We had standard indications
18 for the procedure, but it was the early days.

19 Q. All right. And at the University of Michigan when
20 you were there, was that one of the centers where they were
21 working on and developing these techniques?

22 A. No. I was there from '89 to '92. So at the
23 University of Michigan then, they were the main center
24 developing catheter ablation for the simple arrhythmias where

1 there's one circuit, one pathway. So Fred Morady, Mel
2 Scheinman from San Francisco were the two world leaders and
3 they were doing arrhythmias where there's one, single burn,
4 you get one burn and the patient is cured.

5 That started at the University of Michigan in 1989
6 when I got there, but afib didn't start until about ten years
7 later as we moved on to more complex arrhythmias.

8 Q. Got it. Thank you. So while you were at the
9 University of Michigan, were you a professor there, an
10 attending?

11 A. Yeah. I was an attending and assistant professor
12 of medicine.

13 Q. Okay. Have you remained in touch with Dr. Morady?
14 Do you see him from time to time at meetings?

15 A. Yes. I see him intermittently at meetings.

16 Q. Have you ever talked with him about this case?

17 A. Never.

18 Q. Now, after you left the University of Michigan, is
19 that when you went to Johns Hopkins?

20 A. Yes. They recruited me back to be director of
21 electrophysiology at Johns Hopkins.

22 Q. In addition to being the director of
23 electrophysiology lab and the arrhythmia service, do you also
24 hold any teaching positions?

1 A. Well, I'm a Nicholas Fortuin Professor of
2 Medicine, so I have an endowed chair that supports my time to
3 teach and do research and things like that.

4 Q. Tell us a little bit about what your duties and
5 responsibilities are as a professor in that position.

6 A. Well, you know, I have teaching responsibilities,
7 clinical care responsibilities, and administrative
8 responsibilities. So from a teaching perspective, for many
9 years, I give the lectures to the medical students on the
10 cardiac arrhythmias. And after about 20 years, I let one of
11 my junior colleagues take that on.

12 Mainly, I teach the cardiology fellows, the people
13 training to be cardiologists, and the electrophysiologists,
14 people training to electrophysiologists, and it's really an
15 apprenticeship where they work by your side, work with you,
16 watch you, help you. So they learn by sort of working with
17 us. They do a lot of the -- it's sort of it works well.

18 I also give a lot of lectures both to the fellows,
19 to the residents and so forth. So education wise, I do a
20 fair amount of teaching within Hopkins and mainly it 's
21 teaching as I take care of patients and they sort of
22 participate and watching.

23 Administratively, I direct the EP lab, so I'm
24 responsible on the whole EP service, the schedules, the

1 monthly complication report, the volumes, the budgets, things
2 like that. And then I have, you know, research
3 responsibilities where I also do research.

4 Q. And so then as director of the electrophysiology
5 lab, do you also have meetings where you're reviewing cases
6 and you're looking at complications and things like that?

7 A. There's ten electrophysiologists in my group, so
8 it's a pretty big group, and we have four procedure rooms.
9 But every morning we meet every morning from 7:30 to 8:00 and
10 we go over patients we're doing that day, their history, what
11 we're planning to do. We go over the patients the day
12 before, how did the procedure go? Were there any
13 complications? And we go over the procedures the next day,
14 what's coming up? Is there anything that we need to think
15 about now and so forth? And then every month we -- so I hear
16 about complications as they occur. And then every month we
17 review all complications together in a separate one-hour
18 conference.

19 Q. And then are you also, it sounds like you've got a
20 lot on your plate, but are you also actually doing these
21 ablation procedures yourself?

22 A. Anyone in academic medicine, everyone has to pay
23 their way. Either you have grants from the NIH and that's
24 how you pay your way, or you pay your way by taking care of

1 patients, which is what I do. I go to clinic on Monday and
2 Fridays and see about 20 to 30 patients each day. And then I
3 do procedures Tuesday, Wednesday and Thursday. Usually, I'll
4 do two atrial fibrillations ablations each of those days. So
5 in an average week, I'll see about 50 patients in clinic, do
6 six procedures of which probably four are atrial fibrillation
7 procedures, and then the academic stuff is done nights and
8 weekends and things like that.

9 Q. Can you give us an estimate, Dr. Calkins, of how
10 many atrial fibrillation ablations you've done up to the
11 present time, just a ballpark?

12 A. Over 2,000.

13 Q. Now, is it your opinion in this case, Dr. Calkins,
14 that Dr. Smith is a well-trained and experienced
15 electrophysiologist?

16 A. Yes. He got very good training.

17 Q. Did you see any indication from anything that
18 you've reviewed that he just didn't know what he was doing on
19 September 7th of 2006?

20 A. No. He had completed his training years earlier
21 and he had a lot of experience. I would consider him a
22 well-trained and experienced electrophysiologist.

23 Q. Just very quickly, was Mr. Dechambeau an
24 appropriate candidate for the procedure?

1 A. Yes, he was. The indications for catheter
2 ablation at that time were symptomatic afib, refractory
3 medical therapy. The best results were if he had
4 intermittent afib. So he did exactly what the class one
5 indication, symptomatic atrial fibrillation having failed, he
6 had tried two or three different medications, so he would be
7 considered an optimal candidate for the procedure.

8 And then there was also the question about whether
9 he had a separate SVT arrhythmia which would be a further
10 reason to do the procedure.

11 Q. Ultimately, he didn't have that, but Dr. Smith
12 checked for it?

13 A. Yes.

14 Q. And he was given appropriate informed consent?

15 A. Yes.

16 Q. And let's talk about the ablation procedure
17 itself, Dr. Smith, and there is a couple of points in
18 particular. I know we saw some drawings the other day. Your
19 Honor, could I have your permission to have Dr. Calkins step
20 off the stand?

21 THE COURT: Absolutely. Mr. Kozak, you can come
22 around over here. Don't worry about the Court, just make
23 sure the jury can see.

24 THE WITNESS: Okay. I'm going to give you a

1 little tutorial on afib ablation.

2 BY MS. POLLARA:

3 Q. Let me ask a question first so we can have a good
4 record. Okay. Can you just start out and tell us, give us a
5 diagram of the heart and give us a little atrial fibrillation
6 refresher here.

7 A. Yes. So here's the heart. Let me get you
8 oriented. This is the right atrium, the right up chamber,
9 your own body's pacemaker. The sinus nodes are there. This
10 is the right ventricle, the right lower chamber where the
11 blood comes from the legs and from the head back into the
12 right atrium.

13 Q. Could you just put an RV and RA there?

14 A. RV and there's the RA. And then here's the AV
15 node. That's the normal connection system that brings the
16 impulse from the upper chamber down to the lower chamber.
17 There's special wires the impulse goes through.

18 Now, when you think atrial fibrillation, you have
19 to think about the left atrium. So this is the left
20 ventricle and this structure is the left atrium. And these
21 tubes are the pulmonary veins. I told you that afib is
22 triggered by the pulmonary veins. So there's little muscle
23 fibers in those veins, in each of the four veins. And then
24 there's nerves that sit outside the veins that have tentacles

1 that sort of extend over these veins like this that.

2 Here's the nerves that sort of -- and the
3 discovery in 1998 that the group in France discovered was
4 that afib is multiple reentry circuits swirling around the
5 atrium. But it's triggered, it starts from these veins.
6 These veins start firing about 300 beats a minute, bop, bop,
7 bop. And then in susceptible individuals that are of a
8 certain age, when you're young your atrium can handle it, as
9 you get older, your tissue gets a little older and saggier
10 and scarred and then that starts the afib.

11 So the catheter ablation of afib, initially, when
12 the group in France described it, they described doing little
13 burns around these veins of areas that seemed to be
14 irritable. And then very quickly over the next three years,
15 it was discovered that the better procedure was to put a
16 roadblock around the entire pulmonary veins.

17 And so the way -- so here's the roadblock here.
18 This roadblock is created by doing a sequence of burns. Each
19 burn is the size of a small marble. And you basically will
20 get line up of burn after burn after burn after burn after
21 burn and you go around burning all of these areas until you
22 create this rim of dead tissue.

23 So the dead tissue muscle is left, it's like a
24 wire, the dead tissue scar is like an insulator like rubber.

1 So you in essence you put a rubber gasket around the veins to
2 insulate -- you aren't blocking the blood flow, but the
3 electrical impulses that go crazy then can't get into the
4 atrium to give you afib and you also do the same thing on the
5 other side.

6 Now, to accomplish that, let me just show you the
7 catheters that we use. I'll need a different color. So to
8 do this, it was not an easy procedure. So you put a number
9 of catheters from the leg up to the heart, these catheters
10 are called sheathes are put up. And what you do is you poke
11 the septum and the sheathes go into the left atrium. So you
12 put two different sheathes from the leg. And here's another
13 sheathe coming up from the leg. And you put two sheathes
14 into the left atrium. And these sheathes are like tubes that
15 have a little gasket, a little door where we can put a
16 catheter in.

17 The patient is there, they're fully asleep. You
18 anticoagulate them, you put in your various catheters, and
19 then you poke from one side to the other side. There's a
20 natural door here that's open before we're born. So you poke
21 through that door, you reopen it, in order to do the
22 procedure.

23 And then through these tubes, you'll put two
24 catheters. One is the ablation catheter. So the ablation

1 catheter is the catheter that you use to do the actual
2 burning. And that catheter you can move with your thumb and
3 twist and this is guided by an electro anatomic mapping
4 system or GPS system. So you have sort of this GPS system
5 showing exactly where you are in free space and an X, Y and Z
6 coordinates.

7 And then the other sheathe, you put in what's
8 called a lasso catheter. It's a catheter that looks like a
9 lasso. It's a circular catheter that has 20 electrical poles
10 on it, and you put that on the veins. And the end point of
11 the procedure is having all the electrical impulses on that
12 circular catheter disappear, because you've gotten a complete
13 roadblock.

14 When you have the complete roadblock, the impulses
15 that were flowing into the veins are then blocked and there
16 will be no signals on this catheter. So this catheter you'll
17 move from this vein, this vein and this vein, as you do the
18 procedure. And between the GPS mapping system and this
19 catheter, you have what allows us to do the procedure.

20 So it takes, the procedure will typically take,
21 you know, two to four hours, three to four hours is the usual
22 length of the procedure. Some patients also have an atrial
23 flutter as Mr. Dechambeau did, which is a circuit that goes
24 around the right atrium like that.

1 When someone has that, you put in another
2 catheter, you know, into the right atrium called a decapolar
3 catheter that tells you where the circuit is, and then you
4 end up cauterizing. Again, you're down here, so the
5 procedure that Mr. Dechambeau underwent was he had these
6 veins isolated and then Dr. Smith had just completed or was
7 working on this last little flutter line, this little
8 two-inch piece.

9 One other comment, in order to kill the tissue,
10 here's the heart muscle tissue here and here's your catheter
11 against the tissue. And the way catheter ablation works is
12 you give radio frequency energy of 500,000 cycles per second,
13 very fast current, through this catheter to a patch that's on
14 the patient's back. And as the current goes through the
15 tissue, the tissue, the muscle of your heart acts like
16 resistant element. When you look at your toaster, you have
17 resistors that turn red. In the catheter ablations, it's the
18 muscle that the resistant element that starts to warm up.

19 When you get to over 50 degrees, then the tissue
20 is dead. If you get it too hot, if you get above 100
21 degrees, you'll have what's called a steam pop. You'll boil
22 the fluid and you'll have a small explosion. And I think one
23 of the hypotheses of why this tamponade occurred is as the
24 burning was going on, an area may have overheated and had a

1 steam pop, a little hole in the heart, and that's what caused
2 the tamponade. And the catheters can also poke a hole in the
3 heart at some critical parts. But that's the gist of the
4 procedure.

5 Q. Great. And, doctor, you can retake the stand.
6 We'll come back to this in a few moments.

7 Are you familiar with something called an
8 intracardiac echo catheter? We've also heard it called an
9 ICE catheter.

10 A. Yes.

11 Q. What is that?

12 A. Typically it's made by a company called Acuson.
13 It's a little ultrasound transducer that you place in the
14 heart. It's like a bread slicer where it will show you the
15 image of the heart in one view, and then by twisting it, you
16 can get a broader view of the heart. And the catheter is
17 deflectable where there's a way to manipulate it and you get
18 it up there.

19 And, typically, you know, many people use it to
20 guide the transseptal to help get from one side of the heart
21 to the other side. When this procedure was performed, it was
22 also used to help guide the procedure, because you could see
23 where the ablation catheter was relative to where you were
24 burning.

1 And I would say back when this procedure was done,
2 probably half of the centers used it and half the centers
3 didn't. I never used it, maybe once a year. More recently
4 in the last three years, I started using it more frequently.

5 Q. There's been some testimony the other day that
6 when Mr. Dechambeau arrested, that all Dr. Smith had to do
7 was turn or twist that catheter where it was located in the
8 right atrium, and he would have been able to diagnose the
9 pericardiocentesis from there, is that accurate?

10 A. No, that's not accurate. In order to look for an
11 effusion, the ICE catheter was in the ventricle, not the
12 atrium. So when you're using it to guide the procedure the
13 way Dr. Smith was to sort of see where he was burning and to
14 guide the transseptal, it's in that right upper chamber, the
15 right atrium, where it says RA on the diagram.

16 In order to see an effusion, you got to put it in
17 the right ventricle, at the tip of that right ventricle. And
18 getting the catheter from the right atrium to the right
19 ventricle is not simple, because the catheter only deflects
20 to one direction, it's fairly cumbersome, you need x-ray
21 guidance. So it's not something easy to do.

22 And in this situation, someone with no blood
23 pressure, and you say, am I going to start futzing with the
24 ICE catheter, which was already out in this case, are you

1 going to put it back in or then futz with it? Or are you
2 going to do the pericardiocentesis? If course you're going
3 to start to do the pericardiocentesis.

4 Even if it was in the heart, no, it's not simply
5 twisting it. That would be only if you previously placed it
6 in the right ventricle, and it was in the right atrium,
7 because it was being used to guide the procedure. So I
8 respectfully disagree with Dr. Seifert on that.

9 Q. Now, let's talk about pericardial effusions and
10 cardiac tamponade. First of all, tell us what is a
11 pericardial effusion and what is a cardiac tamponade?

12 A. So a pericardial effusion is fluid in the sack.
13 The heart I just drew sits in a sack and a pericardial
14 effusion is an excess of fluid in that sack. Now, everyone
15 has fluid in that sack. You'll have your 50 ccs or whatever,
16 a small amount of fluid in that sack.

17 But a pericardial effusion refers to when there's
18 an abnormal amount of fluid in that sack, where the sack
19 starts to fill up with fluid or blood or something else.
20 That's what a pericardial effusion.

21 Cardiac tamponade is when that effusion gets so
22 big that it starts putting pressure on the heart where blood
23 can't get into the heart and the blood pressure starts to
24 drop. That's referred to as cardiac tamponade.

1 Q. And is there an exact amount of fluid that you
2 know as a cardiologist, well, if we have 100 ccs, all
3 patients are going to get cardiac tamponade, or does it vary
4 from patient to patient?

5 A. It varies dramatically from patient to patient and
6 also on rate of accumulation. You know, some patients'
7 pericardial sack is relatively stiff. Other people, it's
8 much more floppy. Depending on how floppy or how stiff it is
9 will depend how much fluid you need to get in the sack to
10 start affecting the filling of the heart. So it's highly
11 variable.

12 I mean, there can be people with two liters in the
13 pericardial sack and with a normal blood pressure with no
14 tamponade. There's other patients with 300 ccs that have
15 tamponade. So it's very variable.

16 Q. And, then, doctor, is it accurate that for
17 patients who are undergoing this procedure, they are
18 typically placed on heparin?

19 A. Yes. Absolutely.

20 Q. Why do you say absolutely?

21 A. Well, one of the -- there's a number of
22 significant risks with the procedure, but, you know, one of
23 the serious ones is stroke I think is one of the more
24 important ones and that occurs in about .5 to 1 percent of

1 patients. And the way we lower that risk of stroke to what
2 we consider that low level is by aggressively anticoagulating
3 the patient.

4 So every time you put a catheter in the heart, a
5 clot can form on that catheter. It's sort of an area where
6 clots can form. So any catheter in the heart will start to
7 form clots. And we have lots of catheters in the heart for a
8 long period of time, so if we didn't anticoagulate the
9 patient, you'd have a huge risk of stroke, 15, 20 percent,
10 something like that. By aggressive anticoagulation, there's
11 guidelines as to how aggressively these patients have to be
12 anticoagulated, we can drop that risk to .5 or 1 percent. So
13 it's very important.

14 Q. So even though there's a risk of bleeding in
15 cardiac tamponade, you can't stop using the heparin because
16 of these other risks?

17 A. Correct.

18 Q. We're going to talk about the code in a moment,
19 but, first of all, I want to ask you this, doctor. Do you
20 agree that the standard of care is defined generally as
21 requiring a physician to have the knowledge and skill
22 ordinarily possessed and to use the care and skill ordinarily
23 used by reputable specialists practicing in the same field?

24 A. I do.

1 Q. Do you believe that you have the background,
2 experience and training and knowledge sufficient to discuss
3 what the standard of care is in this case?

4 A. Yes, I do.

5 Q. And why do you believe that you have that
6 background and experience in order to provide that type of
7 testimony here?

8 A. I think the most important thing is I know a lot
9 about this procedure and do this procedure. I've done over
10 2,000 of these procedures over 20, 30 years. So I do a lot.
11 I care for a lot of patients. But more importantly than
12 that, I interact with a lot of colleagues around the country
13 and around the world that do the procedure.

14 And one of the things that I've been doing in my
15 free time is I've led what's called the Heart Rhythm Society
16 Consensus Document On Catheter Ablation in Atrial
17 Fibrillation. So this is a 40- or 50-page document where
18 between 40 and 60 of the world's experts get together and put
19 together a document saying what are the standards, who should
20 get the procedure, who should not get the procedure, what are
21 the complications, what are the risks, what are the outcomes,
22 what are the best techniques.

23 So that document I first published, I was the lead
24 author in 2007, and now it was completely redone in 2012 and

1 it's going to be published again in 2017, this time with 60
2 authors and 1,500 references. So I interact. And during
3 this process, it's a consensus document, meaning we'll survey
4 the group. How many of you will give heparin before the
5 transseptal? And of the 60 people, you have to hit
6 80 percent to be a consensus. So you'll get these votes from
7 all of the world's experts, 30 experts from the U.S., 10 from
8 Europe, 10 from Japan, 10 from Hong Kong, wherever, and South
9 America.

10 So it's an international consensus document that
11 sort of defines best practices in catheter ablation. Reviews
12 the outcomes, reviews the procedure. You know, it's a big
13 effort.

14 Q. And then, doctor, can you tell us what is the
15 Heart Rhythm Society?

16 A. The Heart Rhythm Society is the leading society of
17 arrhythmia experts in the world. It has about 6,000 members.
18 It's based in the United States. And it's basically a
19 society of electrophysiologists, people like myself and
20 Dr. Smith, I think Dr. Seifert is also a member.

21 Q. And Dr. Morady?

22 A. And Dr. Morady is a member. Pretty much I'd say
23 90 percent of electrophysiologists in the U.S. are members
24 and probably 20 percent around the world are members. So

1 it's a professional society of electrophysiologists.

2 Q. And you're a member?

3 A. Yes.

4 Q. And were you the president of the society in the
5 past?

6 A. Yes. About three years ago, I was the president
7 of this organization.

8 Q. All right. So, now, let's talk about pericardial
9 effusions and cardiac tamponade in the setting of atrial
10 fibrillation ablation. In this specific case, and in the
11 surgery involving Mr. Dechambeau, do you have an
12 understanding that this event occurred suddenly and without
13 warning?

14 A. Yes.

15 Q. Is that the typical or the usual manner in which
16 cardiac tamponade occurs in this setting with atrial
17 fibrillation ablation?

18 A. No. I'd say this is an extremely uncommon
19 presentation of an uncommon complication. So cardiac
20 tamponade occurs between 1 in 100 and 1 in 200 patients who
21 undergo catheter ablation atrial fibrillation. So a busy
22 electrophysiologist will do about 100 of these procedures a
23 year, meaning about every two years, they'll have one of
24 these complications.

1 And most cardiac tamponades take place in slow
2 motion, meaning the blood pressure gets lower, the
3 anesthesiologist person says the patient's blood pressure is
4 60, I'll give them some ephedrine to get their blood pressure
5 up. You'll call for the echo. And you'll have an hour and
6 the patient never will get a blood pressure below 60 or 50 or
7 something like that. This was extraordinarily rare where the
8 blood pressure basically went to zero almost instantly.

9 So it was an uncommon presentation of an uncommon,
10 but known, everyone knows that cardiac tamponade is a
11 complication of catheter ablation atrial fibrillation and of
12 patients who die from the procedure, it's the most common
13 cause of a patient dying from the procedure.

14 Q. All right. But in this case, it was unusually
15 rapid?

16 A. Extremely unusually rapid. I've never seen it
17 this rapid.

18 Q. And you work with ten other electrophysiologists
19 in your group and so forth. At Johns Hopkins, based upon
20 your review of cases over the years, have you ever seen one
21 present like this?

22 A. No.

23 Q. Now, can you give us a sense, explain to us, Dr.
24 Calkins, let's just talk about performing a

1 pericardiocentesis, whether it's fast or slow. First of all,
2 let's talk about the pericardiocentesis tray or kit. Can you
3 tell us, what is in the kit? When Dr. Smith or some other
4 electrophysiologist says, I need the pericardiocentesis kit
5 or tray, what do they typically get?

6 A. So the tray is prepackaged from one of several
7 manufacturers. It has about ten different things in the
8 tray. In the tray, you'll have, if you think about it,
9 you'll have antiseptic solution to clean the skin before you
10 do it. You have a scalpel, because you have to nick the skin
11 before you put the needle in. You have the needle which is
12 what's called a spinal needle. It's not just a needle with a
13 point on the end. It's a needle that with an obturator, a
14 tube in the middle, a solid tube. So as you stick it in,
15 tissue doesn't fill up the tip of the syringe and block it.
16 So it has an obturator. It's a special kind of needle. So
17 it has a spinal needle.

18 You then have alligator clips so you can hook the
19 needle up to the EKG machine. You have a 20 cc syringe, no
20 bigger, just 20 cc syringe. You have the actual drain that
21 has multiple side ports. You have a stopcock to hook the
22 drain, the bag up to the needle. And, yes, I think it's, and
23 then you have lidocaine to numb the skin. So you have many
24 different things that are in this kit.

1 Q. So take us through how a pericardiocentesis is
2 performed, whether it's done rapidly, or when you have more
3 time. Just take us through the steps that you do to get that
4 done.

5 A. So, normally, you suspect a patient is in cardiac
6 tamponade, the first step is to pull all the drapes off that
7 area where you need to stick the sub xyphoid area. This
8 might be electrical cables and patches. You do, put down a
9 drape. You then get the antiseptic solution and clean the
10 skin.

11 Once the skin is cleaned, you get the lidocaine,
12 you inject the lidocaine to numb the skin. Meanwhile, you
13 felt for the landmarks. Where's the xyphoid process, the
14 bottom of your sternum? Where are the ribs? So you're
15 feeling these areas. And then you nick the skin.

16 And at that point, you get the needle, the spinal
17 needle and you hook it up to an alligator clip and you hook
18 it up to the EKG machine and then you start sticking it in.
19 And, typically, you'll stick it in about two and a half,
20 about five centimeters aiming from the left shoulder from the
21 bottom of the xyphoid process.

22 So you stick it in about five centimeters, but the
23 needle right now is a spinal needle, so it's not that the
24 blood comes spurting out, because you've blocked it. It has

1 this solid tube in the middle, this solid piece of metal in
2 the middle. You then pull out the obturator, hook it up to
3 the 20 cc syringe and see if you can pull anything back. If
4 you can't, that means you haven't gone far enough. So then
5 you put the spinal needle, the metal shaft back in and push
6 it another centimeter, then you pull it out. So you repeat
7 this process until you get blood.

8 Once you get blood, then you hookup the syringe,
9 the 20 cc syringe, and start pulling back the blood and
10 you're always watching the blood pressure. Initially, you'll
11 just pull it back and squirt it on the drapes or somewhere
12 else and you expect the blood pressure to rise.

13 If the blood pressure is not rising -- and usually
14 it's done, you've had plenty of time, you've called the echo
15 people, the echo people are there. So you have the benefit
16 of an echo image to tell you that it was then getting
17 smaller. But in a blind situation, you pull back, you look
18 at the blood pressure, nothing has happened. Then the
19 question is, well, maybe it's not -- the blood pressure might
20 not be going up, because you're in the right ventricle. You
21 go through the pericardium into the right ventricle, so
22 you're just pulling blood out of the heart.

23 So then you've got to reposition the needle, pull
24 it back. And then, you know, the way you know for sure

1 you're in the pericardial space is you put a very long wire
2 through that needle that wraps around the entire heart. If
3 you see it around the entire border of the heart, then you
4 know you're in the pericardial sack. And at that time, you
5 take the drain, this pigtail drain with many side poles, you
6 thread it over the wire, but first you have to dilate. So
7 the wire's in there. Then you have the stiff dilator that
8 you go to dilate the way. Then you put in the drain, then
9 you get the drain positioned, then you hook that up to the
10 stopcock, you hook it up to the bag, you get a syringe, and
11 then you keep pulling.

12 So there's many different steps and I'd say
13 typically it takes between 20 to 30 minutes to do a
14 pericardiocentesis.

15 Q. I was going to ask you that, it seems like there's
16 a lot of steps here.

17 A. And you'll also, one other thing is you'll have
18 the patient -- you'll want the patient partly sitting up. So
19 you'll put a support behind the patient's back. It gets
20 closer and easier to do if the patient is at a bit of an
21 angle.

22 Q. And so, Dr. Calkins, obviously, in this type of a
23 dramatic code situation where the patient doesn't have any
24 blood pressure or very little blood pressure, you don't have

1 20 minutes?

2 A. No.

3 Q. So when the pericardial effusion or the cardiac
4 tamponade is occurring more slowly, is there more time to go
5 through all of these steps?

6 A. Yes. You have usually takes half an hour, it goes
7 a while to go through and get it done carefully.

8 Q. And is there any -- as far as you know, is there
9 any standard of care as to how long it should take as a
10 minimum for an electrophysiologist to successfully do a
11 pericardiocentesis? Is there any time?

12 A. No. There's no standard of care that you have to
13 get it done in a minute, two minutes, three minutes,
14 four minutes, five minutes. The standard of care is you need
15 to recognize the tamponade and you need to do everything you
16 can to take care of the patient and get rid of it and do the
17 pericardiocentesis. That's the standard of care.

18 The standard of care is not five minutes versus
19 ten minutes. Every patient is different. Every situation is
20 different. And I think it's also important to say, I told
21 you this happens, in my case, about one in 200 procedures. I
22 do about 200 procedures a year. But the average person does,
23 we'll say, 100 a year, maybe 50 a year. That means every two
24 to three years, this happens.

1 You know, so if they're a good
2 electrophysiologist, they're doing this procedure about once
3 every two or three years. Usually, it's in slow motion. So
4 it's once in a career or never that you have this kind of
5 emergency, catastrophic, blind pericardiocentesis.

6 If you're a bad electrophysiologist, maybe you
7 poke a hole three in 100 times. Even then, it's only three
8 times in two years. But a good electrophysiologist, I've
9 done it about five times, and never in this kind of dramatic
10 situation.

11 Q. All right. So you've actually never been in the
12 same exact situation as Dr. Smith was in this case?

13 A. No.

14 Q. Thankfully?

15 A. Thankfully.

16 Q. And is cardiac tamponade always successfully
17 treated?

18 A. No. As I told you, it happens in 1 percent, .5 to
19 1 percent. It's the most common cause of death from this
20 procedure. Death is very rare. Less than one in a thousand
21 patients that die from the afib ablation. But when they do,
22 you say, what are the top causes? Cardiac tamponade is
23 number one. If it's so easy to do a pericardiocentesis, no
24 one would die from it. But it in fact is the number one

1 killer. Number two is massive stroke. Number three is
2 what's called an atrial esophageal fissure, burning a hole in
3 the esophagus, which is a different topic.

4 Q. Can we have Exhibit 6 up, please? There's a
5 little glass of water there right to your right. There's a
6 green binder and you can move that out of the way, because
7 we're not going to use the green binder.

8 If you could, Dr. Calkins, in that white binder,
9 if you could turn to Exhibit 6 for us? Do you recognize that
10 document?

11 A. Yes.

12 Q. I've blown up on the screen a small part of this
13 document down in the lower right hand corner and it says code
14 team. Do you see that?

15 A. Yeah.

16 Q. First of all, what is a code record or a code blue
17 record? What is that document?

18 A. It's a documentation of everything that happens
19 during a code, you know, who is there, the time, what
20 happens, what time does it start, what time does it end. So
21 it's a very important document, but you can see there's a lot
22 of members in this team.

23 Q. And is there a specific member of the team who is
24 called the recorder?

1 A. Yes. In this case, it was someone named Newton, a
2 nurse named Newton.

3 Q. And what is a recorder and what is the
4 significance of that position on the code team?

5 A. So that's the person on the code team that is not
6 responsible for doing anything. They're responsible for
7 documenting everything, what happens in what order. They're
8 the person that is not there taking care of the patient.
9 They're there with a clock writing down what is going on. So
10 that person specifically does not have patient care
11 responsibilities.

12 Anyone else in a procedure room has patient care
13 responsibilities, meaning you got to do everything you can to
14 take care of the patient. This nurse is documenting the
15 times and what is going on.

16 Q. The upper part of this document, do you see
17 there's a column next to oxygen saturations where there's a
18 word written in?

19 A. Yes.

20 Q. And what does that say?

21 A. Tamponade time.

22 Q. And are you able to tell whether the time is 12:42
23 or 12:41?

24 A. It looks like tamponade time is 12:41, and it says

1 12:41.

2 Q. And does this document also up at the top indicate
3 what the time of the CPR starting was?

4 A. Yes. It says the code blue started at 12:39 and
5 CPR started at 12:39.

6 Q. And you've also looked at the cath lab log, which
7 we have as Exhibit 4 in evidence. Is that fairly consistent
8 with the code record as far as when CPR was started?

9 A. Yes. I think the start of these various time
10 things is quite similar.

11 Q. Now, if you could turn to Exhibit 5 for a moment
12 in the book. Now, on the first page, doctor, now, under the
13 graph portion, this is on the first page, do you see that
14 there is a line for IV fluids?

15 A. Yes.

16 Q. And this is the first page of the anesthesia
17 record from the beginning of the procedure?

18 A. Correct.

19 Q. And does this indicate to you how much IV fluids
20 Mr. Dechambeau got leading up to the point of the code, which
21 is on the next page?

22 A. Yeah. I mean, it tells you that he has a 20-gauge
23 angio cath in his left arm and it shows you the rate at which
24 fluids is being given.

1 Q. So he either got 2000 ccs or 3000 ccs depending on
2 how the notation is interpreted?

3 A. Yes.

4 Q. And then go to page two. And so, then, does this
5 record on page two indicate that additional fluids were given
6 to Mr. Dechambeau during the code in this case?

7 A. Yeah. I mean, it tells you during the code
8 multiple extra lines were started and he got six to
9 eight liters total. So he had gotten about three, but during
10 this code, he got another five liters, it looks like, three
11 or four liters from the extra lines that were put in.

12 Q. And the extra lines would be put in by the
13 anesthesiologist?

14 A. Yes.

15 Q. Is it appropriate to give IV fluids like this
16 during the code?

17 A. Absolutely.

18 Q. Doctor, I want to ask you a little bit more about
19 your background, if I could. In addition to the teaching you
20 do at Johns Hopkins, do you also lecture from time to time
21 outside of the institution?

22 A. Yes, quite frequently.

23 Q. And, in fact, the reason you couldn't be here
24 yesterday is you were flying in from a talk you were giving

1 in Europe?

2 A. Correct.

3 Q. And you're a visiting professor in various places,
4 not only in this country, but also I think you've traveled
5 and spoken all over the world on different topics, including
6 atrial fibrillation ablation?

7 A. That's correct.

8 Q. You talked about taking the board examination to
9 become board certified. Have you also been involved in
10 actually writing the exam that the board certifies
11 electrophysiologists?

12 A. Yes. For six years, I was a member of the
13 American Board of Internal Medicine exam writing committee.
14 So I wrote the exam and my signature is on every one that
15 passed on the diploma. Now, I'm head of the ABIM SEP exam
16 committee. So there's another exam for recertification and I
17 head that committee.

18 Q. All right. And then you've written or cowritten,
19 I think it's somewhere in the order of 500 articles,
20 thereabouts, on various topics involving electrophysiology?

21 A. Yes.

22 Q. And quite a few of those are on atrial ablation
23 and atrial fibrillation ablation?

24 A. Yeah. I would say about 200 to 300.

1 Q. So we talked about this a little bit, but can you
2 explain what the standard of care is for a cardiologist, an
3 electrophysiologist who is performing an atrial fibrillation
4 ablation procedure who has a patient develop cardiac
5 tamponade? What is the standard of care in that situation?

6 A. The standard of care is to suspect it, to
7 recognize it, to -- and then do everything you can to treat
8 it. So the typical standard of care would be someone's blood
9 pressure drops during an atrial ablation procedure. You
10 suspect cardiac tamponade. It could be other things. It
11 could be an anesthesias reaction or other things.

12 But you suspect cardiac tamponade, you call for an
13 echocardiogram, you call for the pericardiocentesis tray, you
14 start doing the pericardiocentesis. If the patient's blood
15 pressure is low and there's no detectable pulse, you begin
16 CPR. There's a whole bunch of steps. And the standard of
17 care is you got to go through those steps. You got to be
18 alert. You got to go through those steps and try to take
19 care of the problem.

20 Q. Could you see from your review of Dr. Smith's
21 deposition, which was taken in about 2013, at the point he
22 testified he couldn't remember the exact sequence of steps at
23 that point?

24 A. Yes.

1 Q. Does that cause you to have any concern or
2 criticism about what he did in this case?

3 A. No.

4 Q. Would you expect someone to be able to remember
5 those details that far after the event?

6 A. No.

7 Q. There's been some suggestion from Dr. Seifert the
8 other day that this is easy, it just takes a few minutes and
9 you get the drain in and the blood comes out and the blood
10 pressure is back. If that was his testimony, do you agree
11 with that?

12 A. No. That's a bit of a fairytale. That's what you
13 hope for and you dream for, but that's not what happens.
14 It's not an easy procedure, even in someone who is a super
15 skinny person with perfect anatomic landmarks. You have a
16 big patient, you're trying to do this procedure, you don't
17 want to hit the liver, because you can lacerate the liver.
18 You don't want to go too deep, you can lacerate the bowel.
19 You can go too far and be in the RV instead of the right
20 atrium. So it's not easy under any circumstance.

21 And the usual circumstances, you have the luxury
22 of the echo being there, you have the luxury of the patient's
23 blood pressure. You're not doing it when someone is doing
24 CPR at the same time. Your blood pressures are going through

1 the roof. It's spooky to be there and everyone in the whole
2 room are doing everything you can.

3 So to say is this like sticking a balloon and
4 popping a balloon with a pin is a little bit naive. I mean,
5 it takes a lot of time. Even when you get it in the right
6 spot, you start pulling back, well, depending on how much
7 blood there is, it can take you a while to get the blood off
8 and depending on how quickly the blood is coming in. It's
9 sort of, how much is coming in versus how much is going out?

10 You could be in the right ventricle, the blood
11 could be clotted, it could be posterior, it could be a
12 loculated posterior effusion where you can't get to it from
13 the front. So it's by no means simple or easy where you just
14 pop a balloon like that.

15 If that was the case, no one would ever die from
16 this complication. That wouldn't be the number one killer in
17 atrial fibrillation procedures.

18 THE COURT: Doctor, slow down just a little bit.
19 Go ahead.

20 BY MS. POLLARA:

21 Q. I know you're passionate. Stephanie is going to
22 be killing us here at the end of the day. In this case,
23 based upon looking at the code record, where you look -- can
24 you put the code record up, please? That's Exhibit 6, then,

1 please.

2 So when you see this notation on the code record,
3 where it says tamponade time, what does that tell you about
4 Dr. Smith's thought processes at that point?

5 A. Well, you know, he appropriately recognized this
6 was a cardiac tamponade as the overwhelming likely cause.
7 The cardiac tamponade, he started everything in process in
8 terms of ordering the kit and ordering the echo and so forth.

9 Q. Let me ask you about this, because we understand
10 that at the time of the code, the echo machine was not in the
11 electrophysiology suite where this was happening. Back in
12 the 2006 time frame, Dr. Calkins, was it standard of care to
13 have that machine sitting there at the ready in case
14 something like this happened?

15 A. No. So at that time, it was not the standard of
16 care. I think it was a minority of labs that had an echo
17 machine in the room. And actually over time, if you ask
18 today what's the standard of care, things have changed. So
19 now most EP labs will have an echo machine in the room. But
20 back when this procedure was done, we didn't have an echo
21 machine in the room nor did most EP labs have an echo machine
22 in the room.

23 Q. So you're not critical of anyone in this case for
24 there not being an echo machine at the point of the code, are

1 you?

2 A. No.

3 Q. Was it appropriate for him to call for one?

4 A. Yes. I mean, that's what you do is you call for
5 an echo machine. You have to realize, back in this era,
6 these procedures weren't performed two times a day every day.
7 An echo machine is a very expensive piece of equipment. You
8 need an echocardiographer to run it. So this was something
9 that was sort of specialized equipment that in rare
10 situations you'd call for it. They would come within 10 or
11 15 minutes, as quick as they can, depending on where the
12 machine was.

13 Now, over time, it's become clear that, you know,
14 now that every EP lab, this is the main procedure they're
15 doing, and everyone recognizes now more than they did in the
16 past, the whole tamponade issue. That's why EP labs today
17 have it in their room. That's -- looking back at it, it's
18 unfortunate, but we keep learning, we keep getting better and
19 we keep trying to correct, and this is one of the things that
20 has changed.

21 Q. Well, if he's doing the pericardiocentesis -- let
22 me ask you this first. Is there any indication from anything
23 that you've seen in this case that he waited to perform the
24 pericardiocentesis until the echocardiogram machine was

1 present?

2 A. Yeah, I've seen nothing. I think there was some
3 suggestion that he just sat there sitting on his hands
4 waiting ten minutes for the echo machine to come up. And to
5 look at his deposition, he's very clear, absolutely not.
6 Plus no one in their right mind, of course you wouldn't do
7 that. No electrophysiologist would sit there with a patient
8 getting CPR and do nothing.

9 You would get the needle and you would start
10 sticking it in there and try to take care of the problem. So
11 to say that he just sat and waited ten minutes. And he's
12 very clear that he --

13 Q. Slow down.

14 A. He's very clear in his deposition, that comes
15 through right away. And I remember in my early discussions
16 with the attorney, when I was contacted way back when, I
17 asked that question. I said, what does Dr. Smith tell you
18 about what he did during the procedure, during that time?
19 And the attorney said, absolutely, he was doing the
20 pericardiocentesis. He didn't wait for the echo machine. It
21 was at that point that I wrote my initial letter of support.

22 Q. So, Dr. Calkins, when the echo machine got there,
23 do you understand that it showed that there was a persistent
24 pericardial effusion with tamponade?

1 A. Correct.

2 Q. Well, doesn't that tell you that Dr. Smith wasn't
3 doing the procedure correctly?

4 A. No. It just tells you that there still was a
5 persistent effusion. Whatever amount of blood he was pulling
6 off either was the right ventricle, from the wrong chamber,
7 or it was coming in as fast as he was pulling it off. So it
8 doesn't tell you, was he doing the right thing? Was he
9 pulling the blood off? It just tells you there was still
10 blood there and it wasn't all pulled off. That's all it
11 tells you.

12 Q. All right. Dr. Calkins, I'll represent to you
13 that Dr. Smith testified here yesterday and that he testified
14 that he was drawing blood off, but the patient wasn't
15 responding initially. And does that indicate to you that he
16 wasn't acting appropriately or within the standard of care in
17 this case?

18 A. No. I mean, pulling blood off, it's not going to
19 come shooting out at 100 miles an hour. You got to fill the
20 syringe, empty the syringe, rehook it up, fill the syringe,
21 empty the syringe, rehook it up. It's not until you get that
22 drain in and the stopcock that you can do it a little bit
23 more faster.

24 But, no, it takes a while depending on how much

1 blood there is to get it off and all the different steps
2 involved with pulling it out, ejecting the blood, rehooking
3 up the syringe, pulling it out again and all of these things.

4 Q. Is there a standard of care as to a certain number
5 of minutes to alleviate a cardiac tamponade? Is there some
6 standard that you must have this done within two to
7 five minutes or five minutes or less than eight minutes or
8 something like that?

9 A. No. No, there's not.

10 Q. All right. Are all the opinions that you've
11 expressed here today, Dr. Calkins, to a reasonable degree of
12 medical probability?

13 A. Yes, they are.

14 Q. I am paying for your time in being here today, am
15 I not?

16 A. Yes, you are.

17 Q. Your hourly rate is \$485 an hour?

18 A. That's correct.

19 Q. And I paid you or going to pay you to come here
20 from Maryland and go back?

21 A. Yes.

22 Q. Is this the first time you and I have worked
23 together?

24 A. Yes.

1 MR. POLLARA: Thank you, your Honor. I have
2 nothing further.

3 THE COURT: Thank you, Ms. Pollara. Mr. Kozak.

4 MR. KOZAK: Thank you.

5 CROSS EXAMINATION

6 BY MR. KOZAK:

7 Q. Dr. Calkins, you gave an initial expert report to
8 Mr. Lemons, is that right?

9 A. That's correct.

10 Q. Would you turn to Exhibit 16?

11 A. Okay.

12 Q. And that is your initial report?

13 A. That's correct.

14 Q. When you rendered that report, you had reviewed
15 the records of David Smith, correct?

16 A. That's correct.

17 Q. And you had reviewed the records of Washoe Medical
18 Center, correct?

19 A. That's correct. Yes.

20 Q. And you had not reviewed Dr. Smith's deposition,
21 had you?

22 A. No. But I'd asked the attorney about his actions
23 during the arrest.

24 Q. So when you wrote this report, you were relying

1 strictly on the records of David Smith, correct?

2 A. That's correct.

3 Q. And the records of Washoe Medical Center?

4 A. And the attorneys, what the attorney told me that
5 Dr. Smith is going to say when he is deposed, because we were
6 expecting a relatively soon deposition.

7 Q. Okay. But then after that case was over, you were
8 asked to do additional work?

9 A. That's correct.

10 Q. And I know you told me what you reviewed. What
11 did you review after and why did you feel it was necessary to
12 review other material?

13 A. Well, it had been so many years, I hadn't kept the
14 material, so I had to rereview everything. So I was sent the
15 original material, plus I was sent Dr. Morady's deposition,
16 plus I was sent Dr. Smith's deposition.

17 Q. Did you see Dr. Morady's affidavit?

18 A. Yes, I did.

19 Q. Would you turn to Exhibit 12? That's Dr. Morady's
20 affidavit, is it not?

21 A. That's correct.

22 Q. Dr. Morady stated in paragraph ten some of his
23 opinions, did he not?

24 A. That's correct.

1 Q. And one of his opinions was that Dr. Smith failed
2 to timely perform a pericardiocentesis on Neil Dechambeau, do
3 you see that?

4 A. Yes.

5 Q. And then he said that --

6 THE COURT: Counsel, just a minute. Do you want
7 16 into evidence?

8 MR. KOZAK: Yes, I do.

9 THE COURT: Any objections?

10 MR. POLLARA: Yes, your Honor, it's hearsay.

11 THE COURT: It's Dr. Calkins, number 16.

12 MR. POLLARA: I apologize, your Honor, no
13 objection to that.

14 THE COURT: Ms. Clerk, 16 is admitted. Mr. Kozak,
15 12 is not in.

16 MR. KOZAK: Okay.

17 THE COURT: So you can ask him if he relied upon
18 the information in Dr. Morady's affidavit, you just can't
19 read that into evidence. Go ahead.

20 BY MR. KOZAK:

21 Q. Now, in paragraph ten E states a trans --

22 MS. POLLARA: Your Honor --

23 THE COURT: You just can't read it in. Just ask
24 him if he relied upon those statements.

1 BY MR. KOZAK:

2 Q. Did you rely on the opinion expressed in paragraph
3 ten E of Dr. Morady's affidavit?

4 A. No, absolutely not. That was his opinion. I was
5 rendering my independent opinion of what I thought about the
6 procedure.

7 Q. But your opinion differed from his opinion in this
8 affidavit, correct?

9 A. It looks like it did.

10 MR. KOZAK: Your Honor, I'd like this admitted
11 into evidence, the affidavit of Dr. Morady, Exhibit 12.

12 MR. POLLARA: Your Honor, I object. It's hearsay.

13 THE COURT: Objection is sustained.

14 BY MR. KOZAK:

15 Q. Doctor, did you read paragraph ten E of Dr.
16 Morady's affidavit?

17 A. Yes, I did.

18 Q. Did you agree with that opinion?

19 A. I just read it when I was sent it in the last week
20 or two. Do I agree with it? No.

21 Q. Why do you disagree with it?

22 A. Yeah. It becomes clear that Dr. Morady, when he
23 rendered this opinion, was under the opinion -- was under the
24 impression that Dr. Smith did not start the

1 pericardiocentesis until the echo machine arrived and he
2 found fault with that.

3 What is clear in Dr. Smith's deposition and also
4 in the evidence I reviewed is that Dr. Smith did not wait
5 until the echo machine arrived, as he stated in the
6 deposition, he's very clear about this, and that's why Dr.
7 Morady has changed his opinion.

8 Q. Well, did you read the code sheet that Nurse
9 Newton dictated?

10 A. Yes.

11 Q. And that code sheet doesn't say anything about a
12 pericardiocentesis being initiated, does it, at 12:41?

13 A. Well, it says cardiac tamponade. It doesn't
14 essentially say at 12:41 pericardiocentesis starting. But
15 when you read Dr. Smith's deposition and, you know, he's very
16 clear that he started doing the pericardiocentesis
17 immediately, which, of course, he would do.

18 Q. Why do we have medical records? What's the
19 purpose?

20 A. The purpose is to document things.

21 Q. And so the pericardiocentesis was not documented,
22 isn't that correct?

23 A. Medical records -- that's correct, but medical
24 records are imperfect. They don't document everything that

1 we would want to have documented. It's only in hindsight
2 that oftentimes we wonder, why wasn't this documented or why
3 wasn't that documented? As I think you know, this is a
4 common issue, medical records aren't perfect.

5 Q. Would you agree if the time line that is stated in
6 the medical records is this, that there was a cardiac arrest
7 between 12:35 and 12:39, correct?

8 A. I think 12:39 is when it -- I think the start
9 time, 12:39, 12:41, something like that.

10 Q. 12:41, CPR commenced?

11 A. Correct.

12 Q. Doctor, what is the purpose of CPR when you have a
13 cardiac tamponade?

14 A. Well, you always do cardiac CPR. Cardiac CPR is
15 to help increase the blood pressure, get perfusion to the
16 brain by moving blood around the heart. It's not perfectly
17 effective in any situation, particularly in cardiac
18 tamponade. But it's not that if you have cardiac tamponade,
19 you shouldn't do CPR. You of course do CPR. Any patient
20 that doesn't have blood pressure, that is unresponsive, you
21 do CPR. Anyone who didn't, that would be negligent, but
22 absolutely you do CPR.

23 Q. Do you do CPR when your patient goes into a
24 cardiac tamponade at Johns Hopkins Hospital?

1 A. If I had this situation with no blood pressure,
2 absolutely.

3 Q. Have you ever done it in your career?

4 A. I told you that of the five tamponades I've had to
5 deal with, none of them did I have this kind of cardiac
6 arrest situation. Cardiac arrest equals CPR.

7 Q. So your answer is you've never done CPR when you
8 have a cardiac tamponade, have you?

9 A. I've never been in that situation where I had to,
10 no, where there was no blood pressure.

11 Q. What possible benefit could there be to massaging
12 the heart when the heart can't pump and the heart is frozen
13 because of the pericardium being filled with blood?

14 A. Well, there's never been a study of the efficacy
15 of CPR in cardiac tamponade. You're suggesting that there's
16 been studies and data showing that CPR is of no benefit in
17 the setting of tamponade. That has never been studied. And
18 certainly the standard of care is to perform CPR in patients
19 with cardiac tamponade.

20 You know, I suspect it's not of tremendous
21 benefit, because you have problems getting blood into the
22 heart when you have tamponade, it's a filling problem. But I
23 think there's some value, just by the mechanical pressures of
24 the heart, pressure in the chest goes up, pressure of blood

1 that goes in the great vessels will go up. But, no, there's
2 never been a study about the relative efficacy of CPR in
3 tamponade versus non tamponade or not, but of course you
4 would do it.

5 Q. Dr. Morady stated in his affidavit there was no
6 benefit.

7 MR. POLLARA: Excuse me, your Honor, it's hearsay.

8 THE COURT: Sustained.

9 BY MR. KOZAK:

10 Q. You did read Dr. Morady's --

11 A. Everyone is entitled to their opinion. He had his
12 opinion. I have a different opinion.

13 Q. Let's get back to the time line here. 12:44 stat
14 echo was called for. Do you agree with that from the medical
15 records?

16 A. That's what the medical record said. Exactly when
17 it was called for, I'm not sure. That's when it was
18 documented.

19 Q. 12:49, a stat echo was hooked up, correct?

20 A. Yeah.

21 Q. And they observed a large pericardial effusion,
22 correct?

23 A. Yes, that's correct.

24 Q. And we know that the pericardial effusion in this

1 case was 300 milliliters, correct?

2 A. That was the number that was documented. I don't
3 think anyone was precisely measuring how much blood was taken
4 off. But that was the estimate.

5 Q. That's Dr. Smith's own record, isn't it?

6 A. Yes. That was his estimate.

7 Q. So he's telling us that there's 300 milliliters of
8 blood that was evacuated from the pericardium, isn't that
9 true?

10 A. That's correct. That's what he estimated.

11 Q. That's not a large effusion, is it? That's a kind
12 of a medium effusion, right?

13 A. I would consider that to be a large effusion. 300
14 ccs is a large effusion.

15 Q. Now, assuming that the large pericardial effusion
16 was observed at 12:50, because they had to hookup the
17 machine. How long does it take to hookup the stat echo
18 machine?

19 A. Well, it takes a while. Depending on the machine,
20 you have to turn it on, it takes a minute or two for it to
21 rev up. Then whether you put the patient's information in,
22 you start imaging and you got to find the window, it takes a
23 little bit of time.

24 Q. Would it take a couple of minutes?

1 A. A minute or two, yes.

2 Q. So once the pericardial effusion was observed,
3 then the 300 ccs of blood was drawn off by a pericardial
4 drain, correct?

5 A. We know the echo -- when the first echo images
6 were done, there was still considerable blood in the
7 pericardial space. And the last echo images, they aren't
8 time stamped, shows that the fluid is gone. So, yes, during
9 that period of time, we have documentation of blood in the
10 sack and then no blood in the sack. We don't have a precise
11 time line, because the echo images aren't time stamped.

12 We also don't know how much blood originally was
13 in the pericardial space. It might have been 500 ccs
14 initially and then that was down to 300. I don't know.

15 Q. Well, at 12:54 was when the pulse was restored,
16 correct?

17 A. That's correct.

18 Q. So it took approximately three minutes to draw off
19 the blood that was in the pericardial sack and restore the
20 pulse, correct?

21 A. Somewhere around -- I mean, during that, I think
22 we certainly know whenever the echo was first done, there was
23 fluid in the sack, and then when the pulse was back, that's
24 when the fluid was gone. So that's the time period.

1 Exactly what the time stamps are, since the echo
2 images unfortunately aren't time stamped, I don't think we
3 can say precisely when that was. We have some times to put
4 in the chart. But, again, everyone in the room, their main
5 effort is to save the patient. It's not to document things
6 for 15 years later when we're sitting here today in a
7 snowstorm going over these records.

8 Again, people were taking care of the patient.
9 Those are the times we have. The echo images aren't time
10 stamped. The fluid eventually was evacuated and the
11 patient's blood pressure came up.

12 Q. It's Nurse Newton's job to record things as they
13 occur in the cath lab, correct? She's not involved in
14 actually treating the patient at that point, is she?

15 A. No. She's there to be documenting. But exactly
16 how well she was doing her job, we don't really know.
17 Whether she documented everything contemporaneously, I just
18 can't speak for her.

19 Q. So getting back to my time line from 12, say, 52,
20 to 12:55, that 300 milliliters of blood was evacuated from
21 the pericardial sack and the pulse returned, correct?

22 A. Again, I think we're putting too much emphasis on
23 the times. We know that the medical records don't all jive
24 in terms of the time. If you look at the anesthesia record,

1 it wasn't until 1:15 that the patient had a blood pressure.
2 We know that wasn't true, because we know at 12:54, he did
3 have a pulse. So all the times are a little bit confusing.
4 So I think we have to take that with that in mind. That,
5 again, everyone's attention is on the patient. It's not on
6 documenting. There's no timer that is set. Everyone's
7 watches are somewhat different. The echo images aren't time
8 stamped. That's too bad. I wish they were, then I could
9 agree with you on your proposed time lines.

10 Q. We don't know that the time lines are incorrect.
11 We have Nurse Newton and the defense counsel referred to the
12 code sheet, she's assuming those time lines are correct,
13 right?

14 MR. POLLARA: Your Honor, that calls for
15 speculation.

16 THE WITNESS: It's clear that you have your
17 opinion about the time line and you're entitled to hold your
18 opinion. I place less emphasis on the time line, because
19 what I've seen is that different people's clocks were
20 differing. And in my experience, when you have this kind of
21 cardiac arrest, again, people are taking care of the patient.
22 They're not talking care of the clock or the timing.

23 BY MR. KOZAK:

24 Q. Well, there's no doubt in your mind that if

1 Dr. Smith waited for the stat echo machine to get into the
2 cath lab before he did the pericardiocentesis, he was acting
3 beneath the standard of care, isn't that correct?

4 A. Well, if he had sat there for ten minutes doing
5 nothing, not trying to do the pericardiocentesis, that would
6 be negligence. But he's very clear in his deposition, and I
7 don't know what he said yesterday, but certainly his
8 deposition makes it very clear that he immediately started
9 the pericardiocentesis.

10 Q. That's just his testimony. There's nothing in
11 this medical record to substantiate that, is there?

12 A. No. But it's also, I mean, it would be -- any
13 physician would absolutely -- you know, he knew it was
14 tamponade. He knew how to treat tamponade. You get the
15 needle, you get the kit, you stick it in, and, you know,
16 that's what he's testified to. That's what any reasonable
17 physician would do. And that's what I believe occurred. But
18 I agree that documentation is less than perfect.

19 Q. In fact, it's very poor in this case, isn't it?

20 A. I wouldn't say it's very poor, but it's imperfect.
21 And exactly, you know, why was it that when we saw the fluid
22 go from a certain amount of fluid to no fluid, and how that
23 corresponds with the echo machine, was the drain adjusted,
24 was a bigger syringe used, exactly what was done differently

1 at that point that allowed, you know, there's blood coming
2 in, there's blood going out to sort of win the race. I don't
3 know.

4 Q. Well, Dr. Smith testified yesterday that he didn't
5 have any problem placing the needle and the drain and he got
6 a return of blood and a lot of blood immediately. Were you
7 aware of that?

8 A. I wasn't here for his testimony yesterday.

9 Q. You're not aware of that?

10 A. No.

11 Q. Then Dr. Smith testified that he took the
12 20-milliliter syringe and it would only take him five to
13 ten seconds to fill syringe. Were aware of that testimony?

14 A. No.

15 Q. So he's in there very quickly with his
16 pericardiocentesis tube. He's extracting blood very rapidly.
17 He's got a 20-milliliter syringe. Wouldn't you expect all of
18 that blood to be aspirated if there's just 300 milliliters
19 within three minutes at the most?

20 A. It depends, again, how much blood is coming in
21 versus how much was going out. That was his estimate of
22 time. But, again, people's sense of time in this situation,
23 your time stamp really goes to the wind as you're worrying
24 about the patient.

1 You know, all you can say is he was pulling the
2 blood out as fast as he can. Was he initially in the RV
3 instead of the pericardial space, so some of the blood was
4 from the RV and not the pericardial space? I just can't say.
5 But it's clear from what you're telling me that he was doing
6 the right thing. He was pulling blood off as fast as he
7 could and that's what you expect someone to do.

8 Q. So if he was pulling off blood as fast as he could
9 and he was evacuating it properly, you would expect the pulse
10 to be returned in five minutes, wouldn't you, at the most?

11 A. Again, it would depend on how much blood was
12 coming in. At 20 ccs every ten seconds is coming in, 20 ccs
13 going out, then you're even.

14 Q. If you're having that kind of cardiac tamponade,
15 you wouldn't expect that at 12:54 when they looked in there
16 and they saw 300 milliliters of blood and they extracted that
17 out, and there's no further bleeding, you would have to have
18 a major effusion, wouldn't you, to have 300 milliliters of
19 blood extracted and have blood still coming in? You would
20 have to call the surgeon?

21 A. It has to do with how big of a tear or hole or
22 whatever, and then a clot is forming on the hole, so at one
23 point, the clot finally plugged the hole in the heart, and
24 then he was able to get ahead of the race and get the fluid

1 off.

2 Q. Well, doctor, isn't it true, you don't have to get
3 all the fluid off before the pulse returns, do you?

4 A. That's correct.

5 Q. You just have to get a certain fraction of the
6 blood off and the pulse starts going up, correct?

7 A. How much that is varies patient by patient, varies
8 considerably. But, no, you don't have to get every last cc
9 of blood out before you see some response.

10 Q. So you would expect to see a pulse after three
11 minutes of the type of pericardiocentesis that was being done
12 by Dr. Smith, wouldn't you?

13 A. I would say you would hope to, but whether you do,
14 again, depends on all of these other factors.

15 Q. But we know that the pulse returned almost
16 instantaneously when he extracted the 300 milliliters at
17 12:52, isn't that correct?

18 A. We certainly know that a pulse eventually was
19 restored and the echo eventually showed no fluid. Exactly
20 the relative timing of those two things, again, we don't
21 know, because the echo wasn't time stamped. But there's some
22 relationship between the two, that's correct.

23 Q. Dr. Calkins, this is from the procedure report by
24 Dr. Smith and he wrote this. Did you review that?

1 A. Yes, I did. I've seen this.

2 Q. And he states that stat echo gram, echocardiogram
3 was performed, which showed a fairly large pericardial
4 effusion. That's not a massive one, is it, fairly large?

5 A. No. It's significant. It's not 2,000 ccs.

6 Q. CPR was performed and we removed approximately
7 300 milliliters of frank blood from the pericardial space
8 after doing a pericardiocentesis. A common sense reading of
9 that would indicate that when he saw the effusion, because he
10 called the stat echo to observe the effusion, right?

11 A. Correct.

12 Q. And then he drew off 300 milliliters of frank
13 blood in the pericardial space after doing a
14 pericardiocentesis. So the common sense reading of that
15 would be that he looked in the echo machine, he saw what he
16 needed to see, and he evacuated the blood at that point,
17 right?

18 A. Well, that's your interpretation of what this
19 says. I think what he said and what his deposition says is
20 that he started the pericardiocentesis well before the echo
21 machine arrived.

22 Q. I know what he said in his deposition. But
23 according to his record, that's the chronology, correct?
24 That's the record we have to deal with?

1 A. Well, it doesn't state in this note when he
2 started the pericardiocentesis. So it doesn't say -- you
3 know, there's no sentence saying, I started the
4 pericardiocentesis after the echo arrived and showed a large
5 effusion. I don't see that sentence. That sentence isn't
6 there.

7 And what he's told us is, I started the
8 pericardiocentesis blindly before the echo machine arrived.
9 When the echo machine finally arrived, there still was a
10 residual 300 ccs of fluid, and eventually we got the fluid
11 off, and the patient's blood pressure came up.

12 Q. That's part of the problem here, isn't it? We
13 don't have a good complete record by Dr. Smith as to the
14 consequence of events that happened. And this was written a
15 day after the operation, correct?

16 A. That's correct.

17 Q. Wouldn't you expect he would be able to remember
18 with a little more detail and specificity about that
19 particular -- since it led to a morbidity?

20 A. Well, again, he's documenting what went on. The
21 purpose of a procedure note is not some legal defense note.
22 You know, the purpose of a procedure note is to document what
23 happened. And certainly in procedure notes, I don't document
24 in minute detail every little step of what happened first and

1 what happened second and what time it was. Again, that's for
2 the medical records. That's for the CPR log and other things
3 to document that. I wouldn't expect that to be in here and
4 he certainly doesn't include that in his report about what
5 time the pericardiocentesis was started.

6 Q. Isn't one of the purposes of the medical records
7 to guard against liability in case of a malpractice situation
8 like this?

9 A. Yes.

10 Q. Now, the heart stops beating, every minute that
11 goes by, the brain is not getting proper oxygen, isn't that
12 correct?

13 A. Yes. There's a certain amount of oxygen left in
14 the blood initially, but, yes, that oxygen gets consumed and
15 time matters.

16 Q. So after five minutes, isn't it true that there's
17 a very high risk of anoxia for a patient?

18 A. It varies tremendously on each patient. There's
19 patients that have been in cardiac arrest for 45 minutes and
20 woken up completely. There's patients who have been in
21 cardiac arrest for three minutes that have had severe damage.
22 It's highly variable depending on other factors.

23 Q. If it's over five minutes, you're getting into the
24 area where there's an extremely high risk, correct?

1 A. Well, whether it's five minutes, 10 minutes,
2 15 minutes, certainly the longer a cardiac arrest goes on,
3 the higher the chance of injury to the brain.

4 Q. In this case, we know that there wasn't any oxygen
5 to the brain for approximately 15 minutes, correct?

6 A. Well, to say there wasn't any oxygen to the brain,
7 I think is a bit of an overstatement. There's oxygen in the
8 blood. At the time someone has a cardiac arrest, the blood
9 that's in the head or in the vessels has oxygen in it. And
10 by doing CPR, you move other oxygenated blood to the brain.

11 So it's not that the oxygen suddenly disappears
12 from the blood. The oxygen that is in the blood is being
13 consumed and cells are beginning to get hypoxic, but it's a
14 dynamic process. It's not you have a lot of oxygen and then
15 you have no oxygen. The oxygen gradually gets burned up over
16 time.

17 Q. At 15 minutes, you would expect brain damage,
18 would you not?

19 A. I think 15 minutes is a pretty long cardiac
20 arrest. I've had patients go through a cardiac arrest that
21 lasted 15 minutes and do fine and others have severe brain
22 damage.

23 Q. Now, you stated there's oxygenated blood going
24 through the body during a cardiac arrest when you're doing

1 CPR? That's not correct, is it?

2 A. There's some blood movement from doing CPR by
3 changing the intrathoracic pressure. There's a certain
4 amount of blood, oxygen in the blood. And once you have a
5 cardiac arrest and the blood flow slows or stops, the oxygen
6 that is there gradually gets consumed. So it takes so many
7 numbers of minutes for all it to be used up.

8 Q. How many minutes?

9 A. Somewhere between five and 15. I mean, it's -- I
10 mean, I think the general number is starting at about five
11 minutes. I think then you're concerned about hypoxia and not
12 enough oxygen, and then more than ten minutes, more than 15
13 minutes, more than 20 minutes, more than an hour.

14 Q. Well, when you have a cardiac arrest as a result
15 of a cardiac tamponade, isn't it true that what is going on
16 is the heart can't fill with blood, right, because it's not
17 pumping? You have a filling problem?

18 A. Yes. The pressure in the pericardiac sack is
19 greater than the pressure in the inferior vena cava. So the
20 blood that comes from the head and the feet doesn't flow
21 because you have a dam upstream pressure.

22 Q. So CPR isn't going to circulate oxygenated blood,
23 is it?

24 A. It will circulate some blood just by the

1 mechanical force by the chest squeezing in, the pressure in
2 the chest goes up. That means the blood that is outside the
3 chest gets a sudden pulse, a sudden increase in pressure that
4 moves some of the other blood around.

5 Q. Certainly not enough to stave off anoxia?

6 A. Again, it depends on all these different
7 variables. But to say it's unhelpful and you shouldn't do
8 it, I think is a misstatement. I think that's incorrect.
9 You always do CPR in any arrest situation where you have no
10 blood pressure.

11 Q. Doctor, you would be extremely concerned if you're
12 not restoring the pulse during a cardiac tamponade within
13 five minutes?

14 A. You want to do it as quickly as possible. You
15 hope to do it with five minutes, 10 minutes, 15 minutes,
16 20 minutes. You do it as quick as you can.

17 Q. You've never had a situation where you didn't
18 restore the pulse within five minutes when you have a cardiac
19 tamponade, have you?

20 A. I've never had a situation where I've completely
21 lost the pulse.

22 Q. No. My question was, you've never had a situation
23 where you did not restore the pulse within five minutes when
24 you had a cardiac tamponade and you were doing a catheter

1 ablation, correct?

2 A. That's because I've never experienced this
3 situation. But in patients that are hypotensive, I told you
4 it takes between 20 and 30 minutes to do the
5 pericardiocentesis, typically.

6 Q. So your statement is if it takes 20 or 30 minutes
7 to do a pericardiocentesis, that's acceptable?

8 A. That's the standard, yes. It takes that long to
9 do it. It depends on the clinical situation. What I'm
10 referring to are patients where their blood pressure is 60
11 and then you give them pressers, you get their blood pressure
12 up to 90. This was a really unusual case where the blood
13 pressure was literally zero or 20 and it was an emergency and
14 you had to -- everyone was moving as fast as they could.

15 Q. So Dr. Seifert testified that he's had about 20 of
16 these situations where there was a very sudden drop in blood
17 pressure and he was able to resuscitate the patient within
18 five minutes. Would you agree that that's probable?

19 A. Well, I'm shocked by his high complication rate.
20 It's a little bit worrisome if he's had so many of these.
21 I've had zero and he's had 20, I don't know what that says
22 about his skills and experience as an electrophysiologist.
23 I'm glad he was successful in resuscitating all of these
24 patients, but he should be a little bit more careful when he

1 does the procedure.

2 Q. Regardless of that, doctor, if he was able to
3 resuscitate the patient, that's the issue in this case, isn't
4 it?

5 A. I suspect those were not patients with no blood
6 pressure where CPR was going. That's what I suspect. I
7 think he's the most experienced person in the world dealing
8 with this, then. He's really a world's authority on this,
9 but he also has the highest complication rate of any
10 electrophysiologist that I've heard of.

11 Q. You know Dr. Seifert, don't you?

12 A. Yes. I knew him many years ago.

13 Q. He's respected physiologist, isn't he?

14 A. I have no knowledge of his -- what his reputation
15 is now. I know 30 years ago, he was a nice guy training at
16 Hopkins. But I have no idea about what kind of
17 electrophysiologist he's become. But this data you just told
18 me makes me a little concerned about his skills.

19 Q. He's done thousands of these operations just like
20 you have, hasn't he?

21 A. I don't know. I wasn't here for his testimony and
22 I haven't seen him in probably 10, 15 years.

23 Q. So, really, the basis of your opinion here is the
24 testimony of Dr. Smith, not the medical records, is that

1 correct?

2 A. No. That's not correct. What the medical records
3 say is that we have somewhere between, whatever, 12:42 and
4 12:54, so it's about 12 minutes that this whole thing took
5 place from CPR to returning a pulse. And I think 12 minutes
6 is doggone acceptable to restoring the pulse within 12
7 minutes. I think he did a very good job. It didn't turn out
8 the way we all would hope and I think we all feel terribly
9 sorry about that.

10 But I think to say, you have an unbelievably rare
11 situation occurs, and within 12, 13 minutes you've restored
12 the pulse, despite having to call for the echo machine,
13 despite the patient being obese, despite all the other
14 problems, I think this is very respectable and certainly well
15 within the standard of care.

16 Q. So did you review that anesthesiology report and
17 the statements there by Dr. Kang?

18 A. I did.

19 Q. Now, Dr. Kang says that the cardiac arrest
20 occurred at 12:50, chest compression, and then he
21 administered atropine and vasopressor, whatever it is?

22 A. Yeah.

23 Q. Would you do that in a situation of a cardiac
24 arrest in this situation? Would you prescribe those drugs?

1 A. Yes.

2 Q. Then he says at 13:00, they had the transthoracic
3 echo, correct?

4 A. Correct.

5 Q. And then he says they observed a large pericardial
6 effusion, correct?

7 A. Yeah.

8 Q. And then there was several hundred ccs aspirated
9 and there was a pericardial drain in place, right?

10 A. Yes.

11 Q. So apparently Dr. Kang supports the record that
12 says that the echo machine was used to observe the
13 pericardial effusion and then we had the pericardiocentesis,
14 correct?

15 A. That's not correct. I mean, one, you can see they
16 have problems with the time stamp. So here the
17 anesthesiologist states that at 12:50 the cardiac arrest
18 occurred. We've heard earlier, it's 12:41 or 12:42, so he's
19 off by eight minutes. And then he's saying by 1:00 the echo
20 machine arrives. We know by 12:54, he already had a pulse,
21 so we know these times are way off, and the echo machine
22 arrives and you got to hook it up and do all these other
23 things.

24 So, again, I think the anesthesiologist was

1 focused on the patient. He was getting the lines in, he was
2 getting the fluid in, and he was giving these medications,
3 and then retrospectively he went in and put the rough times
4 down. We all agree they don't jive. He didn't say
5 transthoracic echo, pericardiocentesis then started to be
6 performed. You know, it doesn't say anything about when did
7 the initial attempts at pericardiocentesis start. That's not
8 mentioned in this anesthesia note. Just like it's not
9 mentioned in the procedure note. So that time point is not
10 documented in these medical documents with variable clocks
11 going.

12 Q. Aside from the time, which we agree is off, the
13 events is what we're talking about here. And he describes
14 the events just the way Dr. Smith did in his procedure notes,
15 right? These were the same events he's talking about that
16 Dr. Smith was talking about in his procedure note?

17 A. Yeah. I think the question at hand is whether
18 Dr. Smith sat there for ten minutes and didn't try to do a
19 pericardiocentesis waiting until the echo machine showed up.
20 I know your perspective and Dr. Seifert's perspective is that
21 he sat on his hands and waited ten minutes.

22 Certainly, Dr. Smith is very clear and any prudent
23 physician, you would start doing it. Whether he was
24 successful or not, that's another story. But, again, this

1 note doesn't document the time of initial attempts at
2 pericardiocentesis. And the standard of care isn't that you
3 be successful, it's that you try. And that's the time that
4 is not documented in these notes.

5 Q. And neither is it documented that there was a
6 pericardiocentesis initiated at 12:41, isn't that correct?
7 That's not in the records?

8 A. Yes, I agree.

9 MR. KOZAK: No further questions.

10 MR. POLLARA: Just a couple of questions.

11 REDIRECT EXAMINATION

12 BY MS. POLLARA:

13 Q. You would agree, Dr. Calkins, the code note
14 actually says cardiac tamponade at either 12:41 or 12:42,
15 depending on which number you're looking at?

16 A. Yes. It's very clear that it says cardiac
17 tamponade, 12:41. And any electrophysiologist, you know
18 cardiac tamponade, you got to do a pericardiocentesis. It's
19 a largely mechanical problem.

20 Q. All right. And what you're saying is it would be
21 unreasonable to think that Dr. Smith was not being honest
22 when he gave his deposition about the fact that when he made
23 that diagnosis, he immediately initiated that process?

24 A. Correct.

1 Q. One last point -- well, two last points. The
2 anesthesiologist, is he generally documenting as the code is
3 going?

4 A. No. The anesthesiologist, he's a member of the
5 team caring for the patient. So in this case, we knew he put
6 in extra lines, he got three liters of fluid in, gave all
7 these medications, so he's working hard. He's not sitting
8 there writing down the times. He's taking care of the
9 patient trying to save his life.

10 Q. Lastly, with regard to Dr. Morady, you understood
11 that he had one opinion at the time that he authored or
12 signed the declaration, correct?

13 A. Correct.

14 Q. But you later learned, did you not, and you read
15 his deposition, where you he testified that he changed that
16 opinion, correct?

17 A. That's correct.

18 Q. And, in fact, when he changed his opinion, he
19 concluded Dr. Smith complied with the standard of care in all
20 respects, just like you did?

21 A. Correct.

22 Q. Seems reasonable to you?

23 A. Yes.

24 MR. POLLARA: Thank you. That's all I have.

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THE COURT: Mr. Kozak.

RE CROSS EXAMINATION

BY MR. KOZAK:

Q. Doctor, Dr. Morady never said why he changed his opinion, did he, in his deposition?

A. No, he didn't.

Q. Okay. And you testified you haven't talked to Dr. Morady at all, right?

A. That's correct.

Q. As we sit here today, we don't know why Dr. Morady changed his opinion, do we?

A. No. We just know he changed his opinion.

MR. KOZAK: Thank you.

THE COURT: Thank you, doctor. Just leave that there and watch your step going down. Good time to take a break?

MR. POLLARA: It's a wonderful time.

--oOo--

1 STATE OF NEVADA)
2) ss.
3 County of Washoe)

4 I, STEPHANIE KOETTING, a Certified Court Reporter of the
5 Second Judicial District Court of the State of Nevada, in and
6 for the County of Washoe, do hereby certify;

7 That I was present in Department No. 7 of the
8 above-entitled Court on January 20, 2017, at the hour of 9:00
9 a.m., and took verbatim stenotype notes of the proceedings
10 had upon the trial in the matter of ANGELA DECHAMBEAU,
11 Plaintiff, vs. STEPHEN BALKENBUSH, et al., Defendant, Case
12 No. CV12-00571, and thereafter, by means of computer-aided
13 transcription, transcribed them into typewriting as herein
14 appears;

15 That the foregoing transcript, consisting of pages 1
16 through 81, both inclusive, contains a full, true and
17 complete transcript of my said stenotype notes, and is a
18 full, true and correct record of the proceedings had at said
19 time and place.

20 DATED: At Reno, Nevada, this 27th day of January 2017.

21
22 S/s Stephanie Koetting
23 STEPHANIE KOETTING, CCR #207
24

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6 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
7 IN AND FOR THE COUNTY OF WASHOE
8

9 ANGELA DeCHAMBEAU and JEAN-
10 PAUL DeCHAMBEAU, both individually
and as Special Administrators of the Estate
11 of NEIL DeCHAMBEAU,

12 Plaintiffs,

13 vs.

14 STEPHEN C. BALKENBUSH, ESQ.; and
THORNDAL ARMSTRONG DELK
15 BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

16 Defendants.
17
18

Case No. CV 12-00571

Dept. 7

19 JUDGMENT ON JURY VERDICT

20 WHEREAS, pursuant to the Court Order dated August 27, 2013 granting
21 Defendants' Motion to Bifurcate the underlying medical malpractice matter from the legal
22 malpractice matter, trial as to the medical malpractice matter commenced January 17, 2017,
23 Honorable Patrick Flanagan, District Court Judge Presiding, at the completion of which,
24 after due deliberation, the jury rendered a verdict finding "No Negligence" by David
25 Smith, M.D. in the underlying medical malpractice matter, and as a verdict of "Negligence"
26 by David Smith, M.D., as a matter of law, is a necessary element of the legal malpractice
27 claim asserted against Defendants STEPHEN C. BALKENBUSH, ESQ. and THORNDAL
28

1 ARMSTRONG DELK BALKENBUSH & EISINGER, the Court rules, finds, and orders as
2 follows:

3 IT IS ORDERED, ADJUDGED AND DECREED that judgment shall be entered on
4 the Plaintiffs' complaint in favor of Defendants STEPHEN C. BALKENBUSH, ESQ. and
5 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER and the action will be
6 dismissed with prejudice, and Defendants STEPHEN C. BALKENBUSH, ESQ. and
7 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER shall recover their costs
8 of suit according to proof in their Verified Memorandum of Costs.

9 Dated this 25 day of January, 2017.

10 Patrick Flanagan
11 PATRICK FLANAGAN
12 DISTRICT JUDGE

13 APPROVED AS TO FORM:

14
15 By: _____
16 Charles R. Kozak, Esq.
17 Nevada Bar No. 4245
18 3100 Mill Street, Suite 115
19 Reno, NV 89502
20 Attorney for Plaintiffs
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Return Of NEF

Recipients

DOMINIQUE POLLARA, ESQ. - Notification received on 2017-01-25 14:50:44.271.

R. LUSIANI, ESQ - Notification received on 2017-01-25 14:50:44.193.

CHARLES KOZAK, ESQ. - Notification received on 2017-01-25 14:50:44.333.

***** IMPORTANT NOTICE - READ THIS INFORMATION *****
PROOF OF SERVICE OF ELECTRONIC FILING
-

A filing has been submitted to the court RE: CV12-00571

Judge:

HONORABLE PATRICK FLANAGAN

Official File Stamp:

01-25-2017:14:49:16

Clerk Accepted:

01-25-2017:14:49:57

Court:

Second Judicial District Court - State of Nevada
Civil

Case Title:

A.DECHAMBEAU ETAL. VS. STEPHEN
BALKENBUSH ETAL.(D7

Document(s) Submitted:

Judgment on Verdict

Filed By:

Judicial Asst. KSims

You may review this filing by clicking on the following link to take you to your cases.

This notice was automatically generated by the courts auto-notification system.
-

If service is not required for this document (e.g., Minutes), please disregard the below language.

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CHARLES R. KOZAK, ESQ. for JEAN-PAUL
DECHAMBEAU et al

DOMINIQUE A. POLLARA, ESQ. for STEPHEN
C BALKENBUSH

R. CRAIG LUSIANI, ESQ for JEAN-PAUL
DECHAMBEAU et al

The following people have not been served electronically and must be served by traditional means (see Nevada Electronic Filing Rules.):

THORNDAL, ARMSTRONG, DELK,

1 [2535]

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6 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
7 IN AND FOR THE COUNTY OF WASHOE
8

9 ANGELA DeCHAMBEAU and JEAN-
10 PAUL DeCHAMBEAU, both individually
and as Special Administrators of the Estate
11 of NEIL DeCHAMBEAU,

12 Plaintiffs,

13 vs.

14 STEPHEN C. BALKENBUSH, ESQ.; and
15 THORNDAL ARMSTRONG DELK
BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

16 Defendants.
17

Case No. CV 12-00571
Dept. 7

Trial Date: January 17, 2017

18 NOTICE OF ENTRY OF JUDGMENT ON JURY VERDICT
19

20 TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD HEREIN:

21 NOTICE IS HEREBY GIVEN that on January 25, 2017, the Court entered Judgment
22 on Jury Verdict in favor of Defendants STEPHEN C. BALKENBUSH, ESQ. and
23 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER. A copy of the Judgment
24 on Jury Verdict is attached hereto as Exhibit 1.
25

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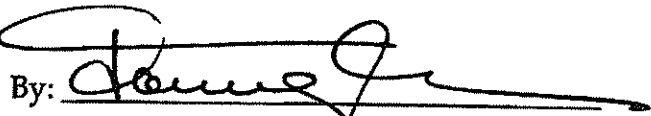
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AFFIRMATION

The undersigned does affirm, pursuant to NRS 239B.030, that the foregoing document does not contain the social security number of any person.

Dated: January 25, 2017

POLLARA LAW GROUP

By: 

DOMINIQUE A. POLLARA, ESQ.
Nevada Bar No. 5742
3600 American River Drive, Ste. 160
Sacramento, CA 95864
(916) 550-5880
Attorneys for Defendants STEPHEN C.
BALKENBUSH, ESQ. and THORNDAL
ARMSTRONG DELK BALKENBUSH &
EISINGER

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CERTIFICATE OF SERVICE BY SERVICE

Pursuant to NRCP 5(b), I hereby certify I am an employee of Reno Carson Messenger and that on 27th day of January, 2017, I caused the foregoing NOTICE OF ENTRY OF JUDGMENT ON JURY VERDICT to be served on all parties in this action by:

- ☐ placing an original or true copy thereof in a sealed envelope, postage prepaid, in the United States mail at Reno, Nevada.
- ☒ personal delivery.
- ☐ facsimile (courtesy copy).
- ☐ electronically served by the Court upon filing of document(s).
- ☐ email (courtesy copy).
- ☐ UPS/Federal Express or other overnight delivery.

fully addressed as follows:

Attorney	Representing	Phone/Fax/E-Mail
Charles R. Kozak, Esq.	Plaintiff	(775) 322-1239
3100 Mill Street, Suite 115		chuck@kozaklawfirm.com
Reno, NV 89502		

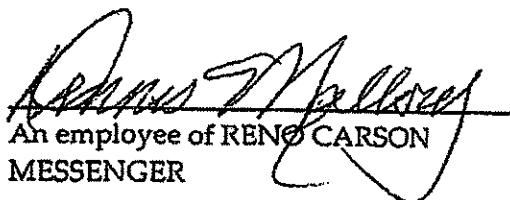

An employee of RENO CARSON
MESSENGER

EXHIBIT 1

EXHIBIT 1

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
IN AND FOR THE COUNTY OF WASHOE

ANGELA DeCHAMBEAU and JEAN-PAUL DeCHAMBEAU, both individually and as Special Administrators of the Estate of NEIL DeCHAMBEAU,

Case No. CV 12-00571

Dept. 7

Plaintiffs,

vs.

STEPHEN C. BALKENBUSH, ESQ.; and THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER, a Nevada Professional Corporation,

Defendants.

JUDGMENT ON JURY VERDICT

WHEREAS, pursuant to the Court Order dated August 27, 2013 granting Defendants' Motion to Bifurcate the underlying medical malpractice matter from the legal malpractice matter, trial as to the medical malpractice matter commenced January 17, 2017, Honorable Patrick Flanagan, District Court Judge Presiding, at the completion of which, after due deliberation, the jury rendered a verdict finding "No Negligence" by David Smith, M.D. in the underlying medical malpractice matter, and as a verdict of "Negligence" by David Smith, M.D., as a matter of law, is a necessary element of the legal malpractice claim asserted against Defendants STEPHEN C. BALKENBUSH, ESQ. and THORNDAL

1 ARMSTRONG DELK BALKENBUSH & EISINGER, the Court rules, finds, and orders as
2 follows:

3 IT IS ORDERED, ADJUDGED AND DECREED that judgment shall be entered on
4 the Plaintiffs' complaint in favor of Defendants STEPHEN C. BALKENBUSH, ESQ. and
5 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER and the action will be
6 dismissed with prejudice, and Defendants STEPHEN C. BALKENBUSH, ESQ. and
7 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER shall recover their costs
8 of suit according to proof in their Verified Memorandum of Costs.

9 Dated this 25 day of January, 2017.

10 Patrick Flanagan
11 PATRICK FLANAGAN
12 DISTRICT JUDGE

13 APPROVED AS TO FORM:

14
15 By: _____
16 Charles R. Kozak, Esq.
17 Nevada Bar No. 4245
18 3100 Mill Street, Suite 115
19 Reno, NV 89502
20 Attorney for Plaintiffs
21
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Return Of NEF

Recipients

DOMINIQUE POLLARA, ESQ. - Notification received on 2017-01-27 16:13:30.932.

R. LUSIANI, ESQ. - Notification received on 2017-01-27 16:13:30.87.

CHARLES KOZAK, ESQ. - Notification received on 2017-01-27 16:13:31.057.

***** IMPORTANT NOTICE - READ THIS INFORMATION *****

PROOF OF SERVICE OF ELECTRONIC FILING

-

A filing has been submitted to the court RE: CV12-00571

Judge:

HONORABLE PATRICK FLANAGAN

Official File Stamp:

01-27-2017:16:12:24

Clerk Accepted:

01-27-2017:16:12:56

Court:

Second Judicial District Court - State of Nevada
Civil

Case Title:

A.DECHAMBEAU ETAL. VS. STEPHEN
BALKENBUSH ETAL.(D7

Document(s) Submitted:

Notice of Entry of Judgment

Filed By:

Dominique A. Pollara

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-

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The following people were served electronically:

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DECHAMBEAU et al

DOMINIQUE A. POLLARA, ESQ. for STEPHEN
C BALKENBUSH

R. CRAIG LUSIANI, ESQ for JEAN-PAUL
DECHAMBEAU et al

The following people have not been served electronically and must be served by traditional means (see Nevada Electronic Filing Rules.):

THORNDAL, ARMSTRONG, DELK,

Return Of NEF

Recipients

DOMINIQUE POLLARA, ESQ. - Notification received on 2017-02-08 15:45:05.421.

R. LUSIANI, ESQ. - Notification received on 2017-02-08 15:45:05.359.

CHARLES KOZAK, ESQ. - Notification received on 2017-02-08 15:45:05.484.

***** IMPORTANT NOTICE - READ THIS INFORMATION *****
PROOF OF SERVICE OF ELECTRONIC FILING

-

A filing has been submitted to the court RE: CV12-00571

Judge:

HONORABLE PATRICK FLANAGAN

Official File Stamp:

02-08-2017:15:35:44

Clerk Accepted:

02-08-2017:15:43:20

Court:

Second Judicial District Court - State of Nevada
Civil

Case Title:

A.DECHAMBEAU ETAL. VS. STEPHEN
BALKENBUSH ETAL.(D7

Document(s) Submitted:

Mtn for New Trial or JNOV

- **Continuation
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Filed By:

Charles Kozak

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The following people were served electronically:

CHARLES R. KOZAK, ESQ. for JEAN-PAUL
DECHAMBEAU et al

DOMINIQUE A. POLLARA, ESQ. for STEPHEN
C BALKENBUSH

R. CRAIG LUSIANI, ESQ for JEAN-PAUL
DECHAMBEAU et al

The following people have not been served electronically and must be served by traditional means (see Nevada Electronic Filing Rules.):

THORNDAL, ARMSTRONG, DELK,

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COMES NOW WHO DEPOSES AND SAYS AS FOLLOWS,

I, Dr. Mark Seifert, being first duly sworn, deposes and states as follows:

- A0262
Scanned by CamScanner

1 e. He then testified that his basis for believing Dr. Smith over the medical record was that the
2 suggestion that he (Smith) just sat there sitting on his hands waiting ten minutes for the echo
3 machine to come up...of course you wouldn't do that. No electrophysiologist would sit
4 there with a patient getting CPR
5

6 And do nothing.

7 f. The medical records contradict Dr. Smith's testimony in the following regards.
8

9 (1) The medical scribe in the operating room did not note in the code blue sheet that Dr.
10 Smith commenced a pericardiocentesis at 12:41. This was her sole responsibility
11 during the emergency.

12 (2) Dr. Smith's own record in his Procedure Report clearly states as follows:

13 (3) Dr. Smith testified he had no trouble placing the needle in order to initiate the
14 pericardiocentesis upon visualizing a fairly large pericardial effusion once the echo
15 machine arrived in the catheter lab at 12:49.
16

17 (4) Dr. Smith in his own records reported the effusion was 300 ccs of blood when
18 evacuated.

19 (5) The Code records state that the pulse was restored immediately after the
20 pericardiocentesis was completed at 12:54.

21 (6) Had Dr. Smith begun the pericardiocentesis when he said he did at 12:41 instead of
22 calling and waiting for the stat echo before doing so, it would have resulted in a
23 pulse being restored within just a few minutes, typically under 5 minutes time. This
24 is particularly true when the pericardiocentesis procedure is described as not being a
25 difficult one to perform, there is not a large effusion volume to withdraw, and there
26 is no ongoing bleeding into the pericardial space following initial drainage.
27
28

1 5. Unfortunately, Dr. Calkin's opinion that Dr. Smith did not breach the standard of care in this
2 case, is based entirely on his personal belief, rather than the medical record. His conclusions are
3 inconsistent with the overwhelming medical and scientific evidence in this case and amount to
4 little more than personal speculation.
5

6 6. I would further testify that my opinions are consistent with Dr. Morady, the other defense expert
7 in this case. His affidavit states:

8 "10. I believe to a reasonable degree of probability that the care provided by
9 David Smith, M.D. was negligent and breached the standard of care to Neil
10 DeChambeau in the following particulars:
11

12 a) David Smith M.D. failed to timely diagnose that Neil DeChambeau
13 was experiencing cardiac tamponade.

14 b) David Smith, M.D. failed to timely perform a pericardiocentesis
15 procedure on Neil DeChambeau.
16

17 e) A transthoracic echocardiogram was not ordered until approximately
18 12:44 p.m. on September 7, 2006 and did not arrive until approximately
19 12:49 p.m. The transthoracic echocardiogram was performed too late to
20 benefit Neil DeChambeau."
21

22 7. I would further testify that all of my testimony regarding my opinions in this case are to a
23 reasonable degree of medical probability.

24 ///

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26 ///

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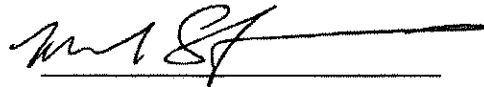
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FURTHER YOUR AFFIANT SAYETH NAUGHT.

Dated this 8th day of February 2017.



DR. MARK SEIFERT

Subscribed and sworn to before me
this 8 day of February 2017.


Notary Public



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6 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
7 IN AND FOR THE COUNTY OF WASHOE
8

9 ANGELA DeCHAMBEAU and JEAN-
10 PAUL DeCHAMBEAU, both individually
and as Special Administrators of the Estate
11 of NEIL DeCHAMBEAU,

Case No. CV 12-00571
Dept. 7

12 Plaintiffs,

13 vs.

14 STEPHEN C. BALKENBUSH, ESQ.; and
15 THORNDAL ARMSTRONG DELK
BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

16 Defendants.
17

18 AMENDED JUDGMENT ON JURY VERDICT
19

20 WHEREAS, pursuant to the Court Order dated August 27, 2013 granting
21 Defendants' Motion to Bifurcate the underlying medical malpractice matter from the legal
22 malpractice matter, trial as to the medical malpractice matter commenced January 17, 2017,
23 Honorable Patrick Flanagan, District Court Judge Presiding, at the completion of which,
24 after due deliberation, the jury rendered a verdict finding "No Negligence" by David
25 Smith, M.D. in the underlying medical malpractice matter, and as a verdict of "Negligence"
26 by David Smith, M.D., as a matter of law, is a necessary element of the legal malpractice
27
28

1 claim asserted against Defendants STEPHEN C. BALKENBUSH, ESQ. and THORNDAL
2 ARMSTRONG DELK BALKENBUSH & EISINGER, the Court rules, finds, and orders as
3 follows:
4

5 IT IS ORDERED, ADJUDGED AND DECREED that judgment is entered on the
6 Plaintiffs' complaint in favor of Defendants STEPHEN C. BALKENBUSH, ESQ. and
7 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER and the action will be
8 dismissed with prejudice, and Defendants STEPHEN C. BALKENBUSH, ESQ. and
9 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER shall recover their costs
10 of suit in the amount of Seventy-Five Thousand, Eight Hundred Eighty-Six Dollars and
11 Forty-Nine Cents (\$75,886.49).
12
13

14 Dated: *FEBRUARY 13, 2017.*
15

16 *Patrick Flanagan*
17 HONORABLE PATRICK FLANAGAN
18 DISTRICT JUDGE
19
20
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1 [2535]

2 DOMINIQUE A. POLLARA, Nevada SBN 5742
3 POLLARA LAW GROUP
3600 American River Drive, Suite 160
4 Sacramento, California 95864
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5 KIM MANDELBAUM
6 Nevada Bar No. 318
7 MANDELBAUM ELLERTON & MCBRIDE
2012 Hamilton Lane
8 Las Vegas, Nevada 89106
(702) 367-1234
Email: filing@memlaw.net

9 Attorneys for Defendant STEPHEN C. BALKENBUSH, ESQ.
10 and THORNDAL ARMSTRONG DELK BALKENBUSH &
EISINGER

11
12 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
13 IN AND FOR THE COUNTY OF WASHOE
14

15 ANGELA DeCHAMBEAU and JEAN-
16 PAUL DeCHAMBEAU, both individually
and as Special Administrator of the Estate
17 of NEIL DeCHAMBEAU,

18 Plaintiffs,

19 vs.

20 STEPHEN C. BALKENBUSH, ESQ.; and
THORNDAL ARMSTRONG DELK
21 BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

22 Defendants.
23

CASE NO. CV-12-00571

DEPT. 7

Trial Date: January 17, 2017

24 NOTICE OF ENTRY OF AMENDED JUDGMENT ON JURY VERDICT
25 TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD HEREIN:

26 NOTICE IS HEREBY GIVEN that on February 13, 2017, the Court entered an
27 Amended Judgment on Jury Verdict. A copy of the Amended Judgment on Jury Verdict
28 is attached hereto and incorporated herein by reference as if set forth in full as Exhibit 1.

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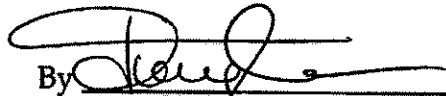
AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding does not contain the social security number of any person.

Dated: February 13, 2017

POLLARA LAW GROUP

By 

DOMINIQUE A. POLLARA
Nevada Bar No. 5742
3600 American River Drive, Suite 160
Sacramento, CA 95864
(916) 550-5880
Attorneys for Defendant STEPHEN C.
BALKENBUSH, ESQ. and THORNDAL
ARMSTRONG DELK BALKENBUSH &
EISINGER

EXHIBIT 1

EXHIBIT 1

1
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6 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
7 IN AND FOR THE COUNTY OF WASHOE
8

9 ANGELA DeCHAMBEAU and JEAN-
10 PAUL DeCHAMBEAU, both individually
and as Special Administrators of the Estate
11 of NEIL DeCHAMBEAU,

12 Plaintiffs,

13 vs.

14 STEPHEN C. BALKENBUSH, ESQ.; and
15 THORNDAL ARMSTRONG DELK
BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

16 Defendants.
17

Case No. CV 12-00571
Dept. 7

18 AMENDED JUDGMENT ON JURY VERDICT
19

20 WHEREAS, pursuant to the Court Order dated August 27, 2013 granting
21 Defendants' Motion to Bifurcate the underlying medical malpractice matter from the legal
22 malpractice matter, trial as to the medical malpractice matter commenced January 17, 2017,
23 Honorable Patrick Flanagan, District Court Judge Presiding, at the completion of which,
24 after due deliberation, the jury rendered a verdict finding "No Negligence" by David
25 Smith, M.D. in the underlying medical malpractice matter, and as a verdict of "Negligence"
26 by David Smith, M.D., as a matter of law, is a necessary element of the legal malpractice
27
28

1 claim asserted against Defendants STEPHEN C. BALKENBUSH, ESQ. and THORNDAL
2 ARMSTRONG DELK BALKENBUSH & EISINGER, the Court rules, finds, and orders as
3 follows:
4

5 IT IS ORDERED, ADJUDGED AND DECREED that judgment is entered on the
6 Plaintiffs' complaint in favor of Defendants STEPHEN C. BALKENBUSH, ESQ. and
7 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER and the action will be
8 dismissed with prejudice, and Defendants STEPHEN C. BALKENBUSH, ESQ. and
9 THORNDAL ARMSTRONG DELK BALKENBUSH & EISINGER shall recover their costs
10 of suit in the amount of Seventy-Five Thousand, Eight Hundred Eighty-Six Dollars and
11 Forty-Nine Cents (\$75,886.49).
12

13 Dated: *FEBRUARY 13, 2017.*
14

15 *Patrick Flanagan*
16 HONORABLE PATRICK FLANAGAN
17 DISTRICT JUDGE
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CERTIFICATE OF SERVICE BY SERVICE

Pursuant to NRCP 5(b), I hereby certify I am an employee of Reno Carson Messenger and that on 4th day of February, 2017, I caused the foregoing NOTICE OF ENTRY OF AMENDED JUDGMENT ON JURY VERDICT to be served on all parties in this action by:

- ☒ placing an original or true copy thereof in a sealed envelope, postage prepaid, in the United States mail at Reno, Nevada.
- ☐ personal delivery.
- ☐ facsimile (courtesy copy).
- ☐ electronically served by the Court upon filing of document(s).
- ☐ email (courtesy copy).
- ☐ UPS/Federal Express or other overnight delivery.

Fully addressed as follows:

Attorney	Representing	Phone/Fax/E-Mail
Charles R. Kozak, Esq.	Plaintiff	(775) 322-1239
3100 Mill Street, Suite 115		<u>chuck@kozaklawfirm.com</u>
Reno, NV 89502		


An employee of RENO CARSON
MESSENGER

IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
IN AND FOR THE COUNTY OF WASHOE

ANGELA DECHAMBEAU, et al., Case No.: CV12-00571
 Plaintiff, Dept. No.: 7
 vs.
STEPHEN C. BALKENBUSH, ESQ.,
et al.,
 Defendants.

ORDER

Currently before the Court is Plaintiffs ANGELA DECHAMBEAU ET AL.'s (hereinafter "Plaintiffs") *Motion for a New Trial*, filed on February 8, 2017. On February 17, 2017, Defendants STEPHEN C. BALKENBUSH ET AL. (hereinafter "Defendants") filed *Opposition to Plaintiffs' Motion for New Trial*. On February 27, 2017, Plaintiffs filed *Reply Brief In Support of Plaintiffs' Motion for New Trial*. On March 7, 2017, this matter was submitted to the Court for decision.

Factual Background

The legal malpractice lawsuit arose from a medical malpractice lawsuit filed in Washoe County by Defendants on behalf of Plaintiffs. On September 7, 2006, the decedent Neil DeChambeau died after an atrial fibrillation ablation procedure performed by David Smith, M.D. failed. The underlying malpractice suit was filed in September 2007 by Defendants. Attached to the underlying *Complaint* was the *Affidavit* of Dr. Fred Morady, dated August 29, 2007. Based on review of the medical

1 records provided to him, Dr. Morady opined that Dr. Smith's conduct fell below the
2 standard of care. However, after review of the "Prucka" recording, also called the
3 "EPS data," Dr. Morady changed his opinion and no longer believed that Dr. Smith's
4 conduct fell below the standard of care. Dr. Smith was represented by Edward
5 Lemons, Esq., who disclosed in March 2010 Hugh Calkins, M.D. as his standard of
6 care expert in the underlying malpractice action. Mr. Lemons proffered a declaration
7 signed by Dr. Calkins setting forth his opinions that Dr. Smith complied with the
8 standard of care. After Dr. Morady's change of opinion, the medical malpractice action
9 was voluntarily dismissed and subsequently, the legal malpractice action against the
10 Defendants was commenced.

11 In their legal malpractice lawsuit, Plaintiffs asserted that Defendants had
12 breach their duty to Plaintiffs by mismanaging the medical malpractice case and
13 voluntarily dismissing the action without obtaining necessary discovery to move the
14 case to trial. The district court entered an *Order* granting Defendants' *Motion for*
15 *Summary Judgment*, finding that the Plaintiffs failed to demonstrate the causation
16 element of their cause of action, that is, whether Defendants' failure to engage in
17 written discovery and move the case to trial caused any damages. On November 30,
18 2015, the Nevada Supreme Court issued *Order of Reversal and Remand*, finding that
19 there was a triable issue of material fact and directing the district court to conduct
20 proceedings consistent with the Court's *Order*.

21 The primary issues in which Plaintiffs' *Motion for a New Trial* arises is
22 whether the disclosure of Hugh Calkins M.D. was improper and whether the district
23 court erred in precluding Plaintiffs' proffered rebuttal witness. The Court finds that
24 it was not an improper expert witness disclosure and the preclusion of the rebuttal
25 witness was appropriate.

26 Standard of Review

27 A new trial may be granted where an aggrieved party's substantial rights have
28 been materially affected by an: (1) irregularity in the proceedings...or abuse of

1 discretion by which either party was prevented from having a fair trial; or (7) an error
2 in law occurring at the trial and objected to by the party making the motion. ¹ A new
3 trial should be granted if the jury verdict resulted in manifest injustice.² A trial court
4 is obliged to use "great caution" in exercising its power to set aside a jury verdict.³
5 The decision to grant or deny a motion for a new trial rests within the sound
6 discretion of the trial court, and this court will not disturb that decision absent
7 palpable abuse.⁴

8 Discussion

9 Plaintiffs argue that they are entitled to a new trial due this Court's abuse of
10 discretion when issuing its February 2, 2016 *Scheduling Order* and reopening of
11 discovery, and for permitting Dr. Calkins to testify as to what Plaintiffs' believe was
12 a new theory of the case. Furthermore, it was improper for the Court to preclude a
13 rebuttal witness after the testimony of Dr. Calkins. By permitting such disclosure of
14 Dr. Calkins and permitting him to testify, Plaintiffs assert that they were precluded
15 from having a fair trial under NRCP 59. Essentially, Plaintiffs assert that
16 Defendants' expert disclosures are bound by the August 17, 2012, *Joint Case*
17 *Conference Report*, requiring the disclosure of expert witness be 120 days prior to
18 June 17, 2013. Therefore, Plaintiff argues that Defendants' expert disclosure of Hugh
19 Calkins, M.D., on September 2, 2016 is untimely and should be stricken.

20 Plaintiffs rely on *Douglas v. Burley*, wherein the Mississippi Supreme Court
21 held that an order reversing a district court's ruling and remanding it back consistent
22 with the order did not eliminate the trial court's prior scheduling order and discovery
23 deadlines, so as to permit plaintiffs to designate new accident reconstruction expert
24 on remand.⁵ Therefore, because Defendants did not file a motion to extend the
25 deadline for expert disclosures, they were bound by the deadline set forth in the *Joint*

26 ¹ NRCP 59(a); *Edwards Indus. v. DTE/BTE, Inc.*, 112 Nev. 1025, 1035, 923 P.2d 569, 576 (1996).

27 ² *Frances v. Plaza Pac. Equities*, 109 Nev. 91, 847 P.2d 722 (1993).

28 ³ *Fox v. Cusick*, 91 Nev. 218, 220, 533 P.2d 466 (1975).

⁴ *Edwards Indus., Inc. v. DTE/BTE, Inc.*, 112 Nev. 1025, 1036, 923 P.2d 569, 576 (1996).

⁵ 134 So. 3d 692 (Miss. 2012).

1 *Case Conference Report*. The Court does not agree. The present case is
2 distinguishable in that the court in *Douglas v. Burley* did not issue a new scheduling
3 order, therefore their designation of an expert witness was bound by the initial
4 scheduling order. In the present case, this Court did issue a new *Scheduling Order*,
5 under its discretion to do so, and the Defendants timely disclosed Dr. Calkins as an
6 expert witness. Pointedly, that very same court clearly stated that the decision to
7 "reopen discovery and other pretrial matters in a case is left squarely within the
8 sound discretion of the trial court."⁶ The finds that it was within its discretion to issue
9 a new scheduling order.

10 By entering its *Order* granting *Defendants' Motion for Summary Judgment*,
11 this Court dismissed Plaintiff's claims set forth in their *Complaint*. Thus, the Court
12 does not find that the parties should not have been bound by the August 17, 2012
13 *Joint Case Conference Report* discovery deadline. Therefore, the Court finds that the
14 February 2, 2016, *Scheduling Order* is appropriate and properly sets forth the
15 discovery deadlines in this matter and the disclosure of Dr. Calkins was timely and
16 appropriate.

17 Plaintiffs' next argument is that Dr. Calkins' testimony was not proper expert
18 testimony because his testimony exceeded the scope of disclosure and that Dr.
19 Calkins did not base his opinions on the medical records. The Court finds there is no
20 evidence to support either contention. Looking at the expert disclosure of Dr. Calkins
21 on September 2, 2016, Defendants indicated that: "Dr. Calkins is anticipated to
22 testify regarding the underlying standard of care as to the medical care and
23 treatment of decedent Neil DeChambeau, causation, and the standard of care as to
24 Defendant David Smith M.D."⁷ After reviewing the testimony, the Court finds that
25 Dr. Calkins' testimony was proper and within the scope of the disclosure. Plaintiffs
26 cannot point to any testimony that deviates from the disclosed nature of Dr. Calkins

27 ⁶ *Id.* at 697.

28 ⁷ Pl.s *Motion*, Ex. 6.

1 testimony and it appears to this Court that his testimony was in line with the NRCP
2 16.1 disclosure.

3 As to Plaintiffs' contention that Dr. Calkins did not base his opinion on the
4 medical records but rather the testimony of Dr. Smith, the Court finds this argument
5 is without merit. From Dr. Calkins' testimony, it appears to this Court that his
6 opinion was based on the records of Washoe Medical Center, Dr. Smith's office, and
7 the office of Mr. DeChambeau's primary care doctor. The Court does not find any
8 evidence that Dr. Calkins' testimony was based on anything other the medical records
9 of Neil DeChambeau and the facts adduced at trial. In conjunction with the special
10 knowledge, skill, experience, training, and education of Dr. Calkins, the Court finds
11 that Dr. Calkins expert opinion on the present case was proper.

12 Plaintiffs' next argument is that Dr. Calkins' testimony against Dr. Morady's
13 August 29, 2007 *Affidavit* essentially raised a new theory of liability. After due
14 consideration, the Court does not find any merit in Plaintiffs' argument. As stated
15 above, Dr. Morady had changed his opinion as to causation and liability after he was
16 given the opportunity to review the "Prucka" or EPS data. Therefore it would be
17 inconsistent, to say the least, for Plaintiffs' to rely on an *Affidavit* of an expert of
18 whom subsequently changed his opinion to one different than the one stated in the
19 *Affidavit*. As such, the crux of Plaintiffs' argument seems to be bellied by the
20 subsequent opinion of very doctor to which the Plaintiffs rely. Therefore, the Court
21 does not find that Dr. Calkins' testimony raised a new theory of liability.
22 Furthermore, the fact that Plaintiffs' counsel had the opportunity to depose Dr.
23 Calkins prior to trial but chose not to, supports the finding there is no evidence of a
24 manifest injustice as a result of Dr. Calkins' testimony that would warrant an order
25 for a new trial.

26 Plaintiffs' next argument rests on the Court's refusal to allow Plaintiffs to
27 recall Mark Seifert, M.D. Plaintiffs assert that they should have been permitted to
28 recall Dr. Seifert after Dr. Calkins allegedly raised a new theory of causation and

1 liability based on "unsupported speculation." As to the Court's refusal to allow
2 Plaintiffs to recall Dr. Seifert, the Nevada Supreme Court has held that the trial court
3 possesses the inherent power to "control the disposition of the causes on its docket
4 with economy of time and effort for itself, for counsel, and for litigants."⁸
5 Furthermore, this Court is obligated to "secure fairness in administration, [and
6 ensure] elimination of unjustifiable expense and delay, and promotion of growth and
7 development of the law of evidence to the end that the truth may be ascertained and
8 proceedings justly determined."⁹ The Court made its determination to refuse recalling
9 Dr. Seifert based on the fact that Dr. Seifert was no longer in the state and thus the
10 proceedings would have had to be extended unnecessarily, causing undue delay and
11 expenses. Based on judicial economy, the nature of Dr. Seifert's testimony, and the
12 fact that Plaintiffs could have deposed Dr. Calkins prior and thereafter question Dr.
13 Seifert regarding on such deposition testimony, the Court finds that it did not abuse
14 its discretion in refusing Plaintiffs' request to recall Dr. Seifert.

15 After due consideration of all the evidence submitted herein, the Court does
16 not find that Plaintiffs have met their burden in establishing that a new trial is
17 warranted. Accordingly, and good cause permitting, Plaintiffs Motion for a New Trial
18 is DENIED.

19 IT IS SO ORDERED.

20 DATED this 31st day of March, 2017.

21 
22 PATRICK FLANAGAN
23 District Judge
24
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27 ⁸ See *Maheu v. Eighth Judicial Dist. Court in and For Clark County*, Dept. No. 6, 89 Nev. 214, 216,
28 510 P.2d 627, 629.

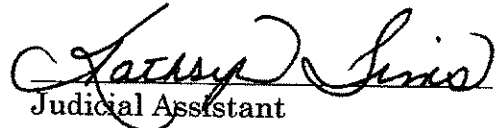
⁹ NRS 47.030.

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of the Second Judicial District Court of the State of Nevada, County of Washoe; that on this 3rd day of March, 2017, I electronically filed the following with the Clerk of the Court by using the ECF system which will send a notice of electronic filing to the following:

Charles R. Kozak, Esq., attorney for Plaintiff; and
Dominique A. Pollara, Esq., attorney for Defendants.


Judicial Assistant

1 [2540]
2 DOMINIQUE A. POLLARA, Nevada SBN 5742
3 POLLARA LAW GROUP
4 3600 American River Drive, Suite 160
5 Sacramento, California 95864
6 (916) 550-5880 - telephone
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8 KIM MANDELBAUM
9 Nevada Bar No. 318
10 MANDELBAUM ELLERTON & MCBRIDE
11 2012 Hamilton Lane
12 Las Vegas, Nevada 89106
13 (702) 367-1234
14 Email: filing@memlaw.net

15 Attorneys for Defendants STEPHEN C. BALKENBUSH, ESQ.
16 and THORNDAL ARMSTRONG DELK BALKENBUSH &
17 EISINGER

18
19 IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
20
21 IN AND FOR THE COUNTY OF WASHOE

22 ANGELA DeCHAMBEAU and JEAN-
23 PAUL DeCHAMBEAU, both individually
24 and as Special Administrator of the Estate
25 of NEIL DeCHAMBEAU,

26 Plaintiffs,

27 vs.

28 STEPHEN C. BALKENBUSH, ESQ.; and
THORNDAL ARMSTRONG DELK
BALKENBUSH & EISINGER, a Nevada
Professional Corporation,

Defendants.

CASE NO. CV-12-00571

DEPT. 7

Trial Date: January 17, 2017

NOTICE OF ENTRY OF ORDER DENYING
PLAINTIFFS' MOTION FOR NEW TRIAL

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD HEREIN:

NOTICE OF HEREBY GIVEN that on March 31, 2017, the Court entered an
Order Denying Plaintiffs' Motion for New Trial. A copy of the Order is attached hereto

1 and incorporated herein by reference as if set forth in full as Exhibit 1.

2 **AFFIRMATION**

3 The undersigned does affirm, pursuant to NRS 239B.030, that the foregoing
4 document does not contain the social security number of any person.

5 Dated: March 31, 2017

6 **POLLARA LAW GROUP**

7
8 By 

9 DOMINIQUE A. POLLARA
10 Nevada Bar No. 5742
11 3600 American River Drive, Suite 160
12 Sacramento, CA 95864
13 (916) 550-5880
14 Attorneys for Defendants STEPHEN C.
15 BALKENBUSH, ESQ. and THORNDAL
16 ARMSTRONG DELK BALKENBUSH &
17 EISINGER
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CERTIFICATE OF SERVICE BY SERVICE

Pursuant to NRCP 5(b), I hereby certify I am an employee of Reno Carson Messenger and that on 31ST day of March, 2017, I caused the foregoing NOTICE OF ENTRY OF ORDER DENYING PLAINTIFFS' MOTION FOR NEW TRIAL to be served on all parties in this action by:

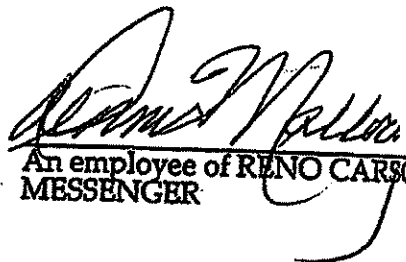
- ☐ placing an original or true copy thereof in a sealed envelope, postage prepaid, in the United States mail at Reno, Nevada.
- ☒ personal delivery.
- ☐ facsimile (courtesy copy).
- ☐ electronically served by the Court upon filing of document(s).
- ☐ email (courtesy copy).
- ☐ UPS/Federal Express or other overnight delivery.

@fully addressed as follows:

Attorney
Charles R. Kozak, Esq.
3100 Mill Street, Suite 115
Reno, NV 89502

Representing
Plaintiff

Phone/Fax/E-Mail
(775) 322-1239
chuck@kozaklawfirm.com


An employee of RENO CARSON
MESSENGER

Return Of NEF

Recipients

DOMINIQUE POLLARA, ESQ. - Notification received on 2017-03-31 17:34:27.78.

R. LUSIANI, ESQ. - Notification received on 2017-03-31 17:34:27.718.

CHARLES KOZAK, ESQ. - Notification received on 2017-03-31 17:34:27.858.

***** IMPORTANT NOTICE - READ THIS INFORMATION *****
PROOF OF SERVICE OF ELECTRONIC FILING
-

A filing has been submitted to the court RE: CV12-00571

Judge:

HONORABLE PATRICK FLANAGAN

Official File Stamp:

03-31-2017:17:32:47

Clerk Accepted:

03-31-2017:17:33:56

Court:

Second Judicial District Court - State of Nevada
Civil

Case Title:

A.DECHAMBEAU ETAL. VS. STEPHEN
BALKENBUSH ETAL.(D7

Document(s) Submitted:

Notice of Entry of Ord
- **Continuation

Filed By:

Dominique A. Pollara

You may review this filing by clicking on the following link to take you to your cases.

This notice was automatically generated by the courts auto-notification system.

-

If service is not required for this document (e.g., Minutes), please disregard the below language.

The following people were served electronically:

DOMINIQUE A. POLLARA, ESQ. for STEPHEN
C BALKENBUSH

R. CRAIG LUSIANI, ESQ for ANGELA
DECHAMBEAU et al

CHARLES R. KOZAK, ESQ. for ANGELA
DECHAMBEAU et al

The following people have not been served electronically and must be served by traditional means (see Nevada Electronic Filing Rules.):

THORNDAL, ARMSTRONG, DELK,

1 Code \$2515
2 CHARLES R. KOZAK, ESQ. (SBN 11179)
3 chuck@kozaklusianilaw.com
4 R. CRAIG LUSIANI, ESQ. (SBN 552)
5 craig@kozaklusianilaw.com
6 KOZAK LUSIANI LAW, LLC
7 3100 Mill Street, Suite 115
8 Reno, Nevada 89502
9 (775) 322-1239; Fax (775) 800-1767
10 *Attorney for Plaintiffs*

11 **IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA**
12
13 **IN AND FOR THE COUNTY OF WASHOE**
14

15 ANGELA DeCHAMBEAU and
16 JEAN-PAUL DeCHAMBEAU, both
17 Individually and as SPECIAL
18 ADMINISTRATORS of the ESTATE
19 of NEIL DECHAMBEAU,

Case No. CV12-00571

Dept. No. 7

20 Appellant,

21 vs.

22 STEPHEN C. BALKENBUSH, ESQ.,
23 THORNDAL, ARMSTRONG, DELK,
24 BALKENBUSH and EISINGER,
25 A Nevada Professional Corporation,
26 & DOES I through X, inclusive,

27 Respondent.
28 _____ /

NOTICE OF APPEAL

29 ANGELA DeCHAMBEAU and JEAN-PAUL DeCHAMBEAU, both Individually and as
30 SPECIAL ADMINISTRATORS of the ESTATE of NEIL DECHAMBEAU, hereby appeals, to the
31 Supreme Court of Nevada, the Judgment on Jury Verdict entered on, the abuse of discretion of the Court in re-
32 opening discovery on February 1, 2016, approximately three years after close of discovery, February 17, 2013, the

1 Amended Judgment on Jury Verdict awarding attorney's fees entered on February 13, 2017, the Order on
2 Plaintiffs Motion for a New Trial entered on March 31, 2017.

3 **Affidavit: Pursuant to NRS 1239B.030 the undersigned certifies no Social Security numbers are**
4 **contained in this document.**
5

6 Dated this 17th day of April 2017.

7 /s/ Charles R. Kozak, Esq.
8 CHARLES R. KOZAK, ESQ. (SBN #11179)
9 chuck@kozaklusianilaw.com
10 R. CRAIG LUSIANI, ESQ. (SBN# 552)
11 craig@kozaklusianilaw.com
12 KOZAK LUSIANI LAW
13 3100 Mill Street, Suite 115
14 Reno, Nevada 89502
15 Tel (775) 322-1239; Fax (775) 800-1767
16 *Attorney for the Appellant*
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CERTIFICATE OF SERVICE

Pursuant to NRCP Rule 5(b), I hereby certify I am an employee of Kozak Lusiani Law, LLC and that on April 17, 2017, I electronically filed the **PLAINTIFFS' ANGELA DeCHAMBEAU and JEAN-PAUL DeCHAMBEAU, both individually and as SPECIAL ADMINISTRATORS of the ESTATE of NEIL DeCHAMBEAU NOTICE OF APPEAL** with the Clerk of the Court by using the electronic filing system which will send a notice of electronic filing to the following:

Dominique Pollara, Esq.
Pollara Law Group
3600 American River Dr., #160
Sacramento, CA 95864

Kim Mandelbaum, Esq.
Mandelbaum Ellerton & McBride
2012 Hamilton Lane
Las Vegas, Nevada 89106

DATED April 17, 2017.

/s/ Dedra L. Sonne
Dedra L. Sonne
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