IN THE SUPREME COURT OF THE STATE OF NEVADA

FERRELLGAS, INC. a foreign corporation, Petitioner, v. EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK; THE HONORABLE JOANNA S. KISHNER, DISTRICT JUDGE, and JOSHUA GREEN, an individual, Respondents.	CASE NO. 82670 DISTRICT COURT CASE NO. A-19-795381-C

PETITIONERS' REPLY APPENDIX

(VOLUME 8)

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APPENDIX TO PETITION FOR WRIT OF MANDAMUS

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PETITIONERS' REPLY APPENDIX

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VOLUME 8

NUMBER	DOCUMENT	BATES NUMBER
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DATED this 20th day of July, 2021

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 20th day of July, 2021, I sent via e-mail a true and correct copy of the above and foregoing **PETITIONERS' REPLY APPENDIX (VOLUME 8)** by electronic service through the Nevada Supreme Court's website, (or, if necessary, by U.S. Mail, first class, postage pre-paid), upon the following:

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more exact, but it means the same thing.

Q. Did you rule that out --

A. I --

Q. -- or did you not rule that out?

A. I don't know whether -- and I don't think it's particularly -- no one is going to know this. I don't think it's particularly case relevant.

Q. Fair enough.

A. I'm not going to use it in my opinion. I just said that this was on the PAI and --

Q. So when we come right down to it --

A. Yes.

Q. -- I want to make sure that I got it all. So what I am getting is you believe that he has a -- and I don't know if he still has it -- you believe he has alcohol abuse?

A. Yes. By history. It may be over because he said he hasn't used it since 2008 or something like that.

MR. RANALLI: '08.

THE WITNESS: So if that's true -- now he has also said in the past he wasn't using but was.

BY MR. VANNAH:

Q. Well, just because -- yes.

A. If we assume it's true, then he had alcohol

abuse up until 2008 to some point.

Q. All right.

A. That is with the -- by history.

Q. And do you have -- I mean, you know, sometimes people, regardless if they're not being candid about that, there's ways to find out. For example, if they're in a hospital and they do a blood alcohol on them or they get a DUI or there's lots of ways you can find out, Well, that person obviously is wrong about not having a problem because they're not drinking. But have you seen any evidence to indicate to you in any way, shape, or form that he isn't being true when he said he hasn't drank since he stopped in 2008?

A. There is no way of finding out if that is incorrect.

Q. So let me ask you this: As a psychologist, if he has ceased drinking for over two years, does that mean he no longer has a legitimate diagnosis of alcohol abuse?

A. Yes.

Q. So right now you don't have an opinion to a reasonable degree of psychological certainty that he has an alcohol abuse diagnosis at this time; right?

A. Correct.

Q. So I'm looking at this time. So if I

understand your diagnosis, it would be the Pain Disorder, which falls within the Somatoform Disorder; right? That would be one?

A. Yes.

Q. And then he had the Major Depressive Disorder, Single Episode. That would be number two, second diagnosis?

A. And that followed the trial, and that's in full remission. So if we're using those criteria, he doesn't have that now any longer.

Q. So right now, all he would have is the Somatoform Disorder with the subcategory of Pain Disorder?

A. And that pain-related disability of malingering, meaning that --

Q. Oh, yeah.

A. -- he's -- he could be -- he's feigning or that he isn't capable of doing any type of work when he is capable probably -- I believe he's capable. And I think his doctors who have treated him have -- have told him that he is capable of going back to some sort of employment.

Q. And so do I, by the way?

A. Oh.

Q. But it doesn't mean that there are any jobs

for him because of his lack of education. I actually believe that. I'm more cynical about people hiring people who can't do the work.

A. Okay.

Q. It's a buyers' market out there right now. I mean, they're getting incredibly talented people very cheaply. You would be amazed what I can get for $8.50 an hour with a college education. I will have to hire George.

A. No. I am working -- I am working as an attorney for three different law firms. They hired me at $10.50 an hour.

Q. Well, I was going to offer you a job today.

A. I am trying to work my way up to a decent hourly wage.

Q. I am going to hire you as a paralegal. Everyone has that ability.

A. These aren't coming to trial, right?

Q. No, of course not.

I think I'm with you. So what we have now is the diagnosis now would be the Somatoform Disorder, which specifically is the pain disorder we have talked about?

A. Yes.

Q. And malingering as it relates specifically to

his ability to work?

A. Yes.

Q. Right?

A. With a past history of alcohol abuse, a past history right after the accident of an adjustment disorder with depressed mood, meaning after the accident as a result of the accident he had pain and this hurt and that hurt. And he had surgery, so he became depressed, and we know that. So that is there --

Q. And let me just interrupt you. And that you believe was caused by the accident --

A. Yes.

Q. -- to a reasonable degree of probability?

A. Yes.

Q. Okay. Go ahead.

A. And then the major depressive disorder was not caused by the accident. It was caused by losing the -- what do we call it now?

Q. By the earlier proceedings?

A. By the earlier proceedings. And that's pretty much a lot better. And I think there's probably more going on in his marriage than either of them may be willing to admit on -- in terms of pre-existing problems in the marriage. And I think those stressors

in the marriage, his wife had her own back surgery. His wife had --

Q. All of which -- all of which we can't bring in either.

MR. RANALLI: Well, that -- if Dr. Etcoff testified to that to a reasonable degree of probability, that's according to Bixler.

MR. VANNAH: Well, actually you don't have a reasonable degree of probability that anything in the marriage is caused -- in other words, we know that early in the marriage they had a disagreement. I don't know -- are they still married?

MR. RANALLI: They got a divorce and then got remarried.

MR. VANNAH: Which is strange, but whatever.

BY MR. VANNAH:

Q. Not that people get a divorce and get remarried. It's just the way it happened. You know, they signed the papers before they got fully married, whatever that means. I don't know. I don't do divorces.

A. I don't know.

Q. But certainly, I have heard you use the word -- and I know you are very straight with me -- you have used the words that you have had some suspicions

there's more going on in the marriage than meets the eye; right? Actually, every marriage -- I look at marriages all the time and say, Oh, this is the greatest couple I've ever met. And, I mean, a month later, they are divorced and the woman tells me, He was the biggest pig I've ever met. I've hated him for the last ten years. And I was like, Wow. At dinner you seemed so friendly and lovey-dovey. So as you sit here today, I know you've got thoughts of maybe there was something in his marriage, but you certainly are not going to state to a reasonable degree of psychological certainty or probability that there's some sort of -- that the marriage itself is causing psychological issues; fair to say?

A. I think it would be fair to say that there had to be some psychological issues with this guy within his marriage previously because of the fact that his wife was mentally ill, if the records about her are true, that she cuts herself, that she has been a bipolar disorder and disassociated disorder, he couldn't have possibly been married to a mentally -- a seriously mentally ill person and not have stress. So I can reasonably say that there was stress in their relationship as a result of her mental illness. To what extent? I don't know. But was -- was there

stress that would have made the marriage harder? Absolutely.

Q. No, no. I mean, there's stress in any marriage. But if you have a wife and she's mentally ill --

A. Mentally ill, yeah.

Q. -- it would make it worse.

A. If she has been that -- if she has been so bad that she can't work, that she has psychotropic drugs, that she has dissociative disorder, had some terrible trauma in her past, this has to have affected the relationship.

Q. Right. But you are not saying to a reasonable degree of psychological certainty that that's caused any major portion of this pain disorder, for example, that he has?

A. I think the psychological portion of the pain, I think that it has some -- something to do with the pain disorder. In other words, his -- the stress in his life is causing him to believe that he's in more pain than he necessarily needs to be in. The stress in his marriage, the stress in his life as a whole has something to do with that.

I mean, even the literature shows that if you want -- people who are chronically in pain, if you -- I

know Dr. Dunn said, Well, let's do another level -- he will probably need another level of cervical surgery and lumbar surgery because, you know, there's breakdown. The research shows that it's hardly ever that a bigger part of someone's pain is emotional and psychological, even greater than anything absolutely wrong with their spine. I mean -- I'm talking back problems. So I think that this guy psychologically for reasons with his marriage, maybe reasons within his past, or all sorts of things made his pain greater than it needed to be.

Q. In any event, it all pre-existed this accident?

A. It pre-existed this accident.

Q. All right. So everybody has stress in their marriage; right? You agree with that?

A. Yes.

Q. I just don't think I can think of any marriage that isn't a life stressor.

A. Everybody's marriage has stress.

Q. Not because of anything that I do. But my wife and kids cause me stress. Believe me, if they weren't around all the time -- my wife has been gone for a week, and my stress level has gone down, other than eating -- or foraging for food.

A. That's bad.

Q. So what you are saying is that he had some stress in his marriage?

A. Yes.

Q. And that's --

A. Beyond ordinary marital stress because of his wife's mental illness. That adds to stress.

Q. Right. Well, we will see what the judge says --

A. Okay.

Q. -- but I don't think the judge is going to let all that crap in, but, you know, I don't know.

A. I don't know.

Q. But I don't think he should. And, you know, we already had a retrial once, and I don't want to do this again.

So the bottom line is that it's your opinion that because of certainly problems that Ms. Alvarez had in the past that this marriage was maybe even more stressful than the ordinary marriage would be --

A. And may still --

Q. -- or any ordinary marriage is?

A. -- have in the present. She may still have in the present if she is mentally ill and all of those treatments -- if these are still in existence.

Q. Let me ask you a question: You don't know one way or another what she is going through right now; right?

A. Other than I saw her in the videotape, and she is certainly sad -- I mean, she is a very attractive, well spoken, intelligent, but she looked depressed and angry, intense, and anxious. She didn't look happy.

Q. You could see that in the videotape?

A. Yes.

Q. She just looked like an unhappy person?

A. She looked like an unhappy person.

Q. And maybe she is.

A. Maybe it was just that day.

Q. How many times did you see her? Just that one time?

A. Yes.

Q. Well, I look happy today. But, you know, if you saw me a couple of nights ago when I was --

A. It may have just been a bad day for her.

Q. Fair to say -- let me just put it this way: You can't look at the videotape and say to the jury, I saw a videotape of her where she looked unhappy.

A. (Witness nods.)

Q. Therefore, in my opinion, she has got a personality disorder; right? You are not going to say

that?

A. No, I'm not.

Q. I know you are not.

Would it be fair to say that you are not in a position at this point in time to make any diagnoses of her as having any kind of personality disorders at all?

A. Of course not.

Q. And you have never looked at any testing done on her; right?

A. Correct.

Q. And you have never interviewed her to try to make that determination; fair?

A. Yes.

Q. Did she come with her husband when you interviewed him?

A. No.

Q. So you have never met her, actually?

A. No.

Q. Okay. I didn't know that.

Okay. Well, that's really -- well, I always ask you this question: Is there anything that I haven't covered today that you think, Hey, I expected you to talk about --

A. No.

MR. VANNAH: That's fair. I don't have any

further questions.

EXAMINATION

BY MR. RANALLI:

Q. I just have a few follow-ups. I want to make sure all your opinions are out there so there's no issues. First I want to follow up with Bob's question regarding Ms. Centeno's prior condition. You reviewed the last several depositions that I sent to you of the daughters as well?

A. Yes.

Q. I believe either the daughters or the mom indicated that she still has her psycho -- I think she still self-mutilates is what one of the witnesses just recently testified to?

A. Yes.

Q. What effect, if any, does that have to a reasonable degree of psychological probability based on your expertise the fact that she doesn't work since -- I believe she had her incident back in '96. She had a lumbar fusion as well. The psycho -- how do you pronounce that, the type of drugs that she's on?

A. Psychotropic.

Q. Psychotropic drugs.

MR. VANNAH: Tropic.

MR. RANALLI: Tropic, sorry.
BY MR. RANALLI:
Q. According to her testimony, I believe the husband told the children that she's depressed, her back hurts, she's restricted, the fact that she self-mutilates, she has posttraumatic, I believe, stress disorder as well. How does it, if at all, affect him in terms of his mood, depression, things like that to a reasonable degree of your professional opinion?
A. It has to make him less happy and more anxious and sometimes more irritable and angry. It would be a negative -- together or even separately, there's a lot of stress in his life.
Q. Does that also bleed into common sense? For example, if I live with a partner and they're cutting themself, they're self-mutilating, they're constantly depressed, they don't work, they can't do the functions around the house, does that affect the partner, the nonaffected partner that doesn't have those symptoms?
A. Of course.
Q. So everything wouldn't be blamed on this accident?
MR. VANNAH: Well, wait a minute. That's so broad. What do you mean by everything when you are

saying that?

MR. RANALLI: Understood. That's fair.

BY MR. RANALLI:

Q. So in terms of this chronic depression, obviously there was a big part given the prior proceeding. But the chronic depressive state, the other moods that he has would not all be the same --

MR. VANNAH: Let me -- let me -- because I'm going to try to help here because I understand what you are saying with this. I don't think he said there's chronic depression, actually. I don't think there's such a diagnosis of chronic depression right now. I think there was major depressive disorder.

BY MR. RANALLI:

Q. I may have mispronounced it, but the depressive disorder is what I'm speaking about.

A. The major depressive -- and the question again is?

Q. I know you attributed 80 to 90 percent as a result of a prior proceeding. What part does the wife's medical condition play into that disorder as well?

MR. VANNAH: And let me help you. I'm not going to argue that there was major depressive disorder that he went through is related at all to this

accident. I'm not making that claim.

MR. RANALLI: Okay.

BY MR. RANALLI:

Q. No. But since the time of the accident -- I mean, did you believe when you were discussing with Mr. Vannah that prior to the accident that he would have had these type of stressors in his life already --

A. Yes.

Q. -- which would have continued throughout after the accident? Is that what you are saying as well?

A. Yes.

Q. And that's to a reasonable degree of psychological probability?

A. Yes.

And if he's still depressed some and it's no longer a major depressive disorder, he -- some of his depression may likely -- more likely than not be related to his wife's mental illness, some would be his physical condition, some would be his being in litigation, some would be things I don't even know about.

Q. I understand. Pain is subjective from a psychological standpoint as well?

MR. VANNAH: Pain is subjective from any standpoint.

THE WITNESS: Yes.

BY MR. RANALLI:

Q. Just making sure. Okay.

I want to explore a little more regarding Karen Crawford, the functional capacity we located in someone else's medical records and the difference between the outcome of the FCE with Karen Crawford versus the outcome with Terrence Dineen and the alcohol abuse and between that time.

A. You know, that's -- there's so many records. One of the things I -- I saw was in -- and I have a little outline of what went -- you know, what came first and just sort of a chronology. And it was, I think, November 15, 2006, Karen Crawford did a functional capacity evaluation or examination and determined that Mr. Alvarez couldn't do heavy labor any longer but could do a medium physical demand, whatever that is. I don't know what that is. Four days later, he was hospitalized at North Vista Hospital having admittedly consumed a dozen beers the night before at a boxing match and having severe GI distress for which he needed to be hospitalized.

I thought that was an interesting coincidence that he passed an examination suggesting -- indicating that he could go back to work, and four days later, he

got so drunk that he needed to be hospitalized. And that got my antenna up. I wondered if he got drunk -- I said to myself, I wonder if he got drunk because he did well on that examination and knew that they're going to say he has to go back to work. Then I didn't come to any conclusion, but then a day later after he left the hospital, he saw another expert, Terrence Dineen, for examination and told Mr. Dineen, after five days ago being cleared, that he can't bend from the waist or carry more than eight pounds for short distances.

Q. Did it just contradict what he did five days ago?

A. I guess it did. So that was really -- that -- that sort of still --

Q. What's your opinion to a reasonable degree of psychological probability regarding this finding?

MR. VANNAH: Which finding?

BY MR. RANALLI:

Q. The --

MR. VANNAH: The speculation that he went out and got drunk because he didn't like the FCE?

THE WITNESS: I can't prove that, but I think that it is --

MR. VANNAH: So you don't have an opinion to a

reasonable psychological degree that he went out and got drunk because he didn't like the FCE?

THE WITNESS: I can't prove that.

MR. VANNAH: Because he drank anyway like that?

THE WITNESS: Could be. Could be.

MR. VANNAH: He drank when he saw the soccer game and his team lost?

BY MR. RANALLI:

Q. What you do have is you have two competing FCE exams?

A. I have two competing, only five days apart with completely different findings.

Q. This happened obviously after the incident of why we're here today?

A. Yes.

Q. And then he was able to manage his way to a boxing match as well; right?

A. Yes.

Q. He wasn't working at all?

MR. VANNAH: He wasn't boxing.

MR. RANALLI: I got you.

BY MR. RANALLI:

Q. But, yeah. He can't work, but he managed to get himself to watch boxing; right?

MR. VANNAH: Yeah. He was able to sit down and watch a boxing match.

MR. RANALLI: All right. That sounds good.

BY MR. RANALLI:

Q. In terms of your opinion to a reasonable degree of psychological probability regarding alcohol use after the accident, what's your opinion regarding that alcohol abuse?

A. He used alcohol before the accident excessively, he used it after the accident excessively.

Q. How does that affect his pain behaviors, assuming his pain behaviors are true?

A. Well, it's not good for his pain behaviors. It's exacerbating. If he's using alcohol and using these pain medications together, I think it's dangerous and it's against doctors orders, and it makes him more impaired than he needs to be. It's hurting yourself when you drink that much and you're taking psychotropics, narcotics, and diuretics, antidepressants, muscle relaxants. It's not good for you. So he's harming himself by doing that.

Q. Did you read Dr. Dunn's testimony regarding his opinions to a probability regarding alcohol, consuming alcohol while taking narcotic medications?

A. I did.

Q. Would you agree with those --
A. Yes.
Q. -- from your psychological standpoint?
A. Yes.
Q. Work is therapeutic from a psychological standpoint?
A. Yes.
MR. VANNAH: I disagree.
MR. RANALLI: I don't have anything else. Well, let me just -- wait a second. I'm done.

FURTHER EXAMINATION

BY MR. VANNAH:
Q. How much have you charged for all this stuff?
A. I don't have my -- this week? I mean --
Q. Just give me --
A. -- the bills?
Q. Well, I mean, that's a lot of crap to read. And you are here -- you met with George this morning?
A. Yes. For 20 minutes.
Q. What time did you guys get together?
A. Around 8:30.
Q. Did you talk to him about this little sheet you had? Because he was really --
A. Oh, yeah.

Q. Did you tell him these are things that I can bring up?

A. I had mentioned when I was doing my timeline that I had seen this --

Q. But I noticed he didn't really get into that. He just happened to ask you about the question you had all written down, so I assume that you --

A. Well, it's just the timeline.

Q. You brought that to his attention and said I thought this might be helpful?

A. Well, I just said this is something that I noticed in all of this.

Q. But did you say to him, This might be helpful. You might want to bring this out? It might be helpful to your case. Truthfully.

A. I may have. I don't know if I said it. He may have said it.

MR. RANALLI: Well, I'm going to use it in trial. I will tell you right now.

THE WITNESS: I believe I may have recognized it, but he --

MR. RANALLI: You mean comparing the FCEs?

THE WITNESS: Yeah.

MR. VANNAH: I don't doubt you are going to do a lot of stuff in trial.

BY MR. VANNAH:

Q. My point was if you said, Hey, I have got some stuff here that might be helpful to you?

A. No. I don't talk that way. I mentioned that by the way -- and he didn't think he would remember this part, so I mentioned that he thought it was pretty positive, and he didn't say, you know, talk about it. He just was here and -- and I could tell he liked it.

MR. RANALLI: I forgot about the boxing match for the first trial, but I am going to bring the gloves this time.

THE WITNESS: Yeah. This is like a boxing match.

BY MR. VANNAH:

Q. We are back to money. I mean, so what have you billed?

A. What have I billed?

Q. Yes. What have you -- yeah. I just want --

A. The whole thing?

Q. Yeah. The whole thing?

A. We have billed out, and not counting preparation for things I have no clue --

Q. Right.

A. We billed out November 12, 2008 was $13,000 -- no. It was $13,742.55.

Q. That was what year?
A. That was 2008. That was the records review. I spent 17.25 hours and Dr. Belmont, my associate in organizing and going through and reviewing the records and dictating that review, 28 hours. Then in -- May 27, 2010, the work for the actual IPE or independent psychological evaluation was $7,037.50, of which I spent 13.5 hours and Dr. Belmont 8.25 hours. And a month later, more records came. June 25, 2010, there was a bill for $2,832.75, of which I spent 5.5 hours and Dr. Belmont 3.25 hours. And that's it.
Q. And --
A. No other bills have been made.
Q. Obviously, I have paid you today two hours for how much?
A. For you?
Q. Yeah, for me.
A. Tell the --
Q. Yeah. For me it was double, but --
A. I think it's like $500.00 per hour. It's like $1,000.
Q. That's --
A. That's my understanding. I think that's it.
Q. And I think --
A. You may have paid that already.

Q. No, I'm sure I did. Well, honestly, I know we did.

A. I know. You are --

Q. For trial, what do you charge?

A. I think for half day $1,750 and for full day twice that.

Q. You are probably going to spend some time getting ready. You have got to go through this to get ready. What do you think that's going to cost, just a rough estimate? Because you want to be prepared and thorough, because you know I'm going to be asking you questions.

A. I have no clue. I guess five to ten hours in preparation. That's a guess.

Q. What do you charge per hour when you are doing that kind of work?

A. Free.

Q. What do you charge per hour?

A. Free.

Q. Three?

A. No, free.

Q. Seriously?

A. No. I charge $350.00.

Q. So it looks like, I mean, a reasonable estimate you would have charged 13 plus 7 -- 14 plus 7,

21 plus 3, 24, 25 -- 26, 27, 28, 29 -- about $30,000?

A. Makes sense.

Q. Have you worked with George before or is this your first time?

A. No. I think we have done a couple of cases before. Not a zillion. I -- I don't -- he would know better than I do. I don't even try to remember.

Q. Thirty bazillion?

A. I don't know. A couple. I know it's not that much.

Q. What percentage of your time in the last few years have you been doing defense medical/legal -- I call it medical/legal, but psychological/legal versus plaintiff?

A. It's all 80/20, defense versus plaintiff, in that area.

MR. VANNAH: Okay. That's all the questions I have.

MR. RANALLI: That's all I have.

MR. VANNAH: Thanks.

THE WITNESS: Thank you.

(Thereupon, the deposition concluded at 11:18 a.m.)

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

* * * * *

I, LEWIS M. ETCOFF, Ph.D., deponent herein, do hereby certify and declare under the penalty of perjury the within and foregoing transcription to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition.

_____

LEWIS M. ETCOFF, Ph.D., Deponent

CERTIFICATE OF REPORTER

STATE OF NEVADA)
COUNTY OF CLARK)

I, Michelle R. Ferreyra-Marez, a Certified Court Reporter licensed by the State of Nevada, do hereby certify: That I reported the deposition of LEWIS M. ETCOFF, Ph.D., commencing on Saturday, September 25, 2010, at 9:02 a.m.

That prior to being deposed, the witness was duly sworn by me to testify to the truth. That I thereafter transcribed my said stenographic notes into written form, and that the typewritten transcript is a complete, true and accurate transcription of my said stenographic notes, and that a request has been made to review the transcript.

I further certify that I am not a relative, employee or independent contractor of counsel or of any of the parties involved in the proceeding, nor a person financially interested in the proceeding, nor do I have any other relationship that may reasonably cause my impartiality to be questioned.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this 27th day of September, 2010.

MICHELLE R. FERREYRA-MAREZ, CCR No. 876

EXHIBIT "6"

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CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

MITCH WILSON, Plaintiff, vs. SCOTT YANCEY, ET AL., Defendants.	CASE NO. A680635 DEPT. 16

BEFORE THE HONORABLE BONNIE A. BULLA, DISCOVERY COMMISSIONER

FRIDAY, APRIL 3, 2015

RECORDER'S TRANSCRIPT OF PROCEEDINGS
YANCEY DEFENDANTS AND GOLIATH PROPERTIES LLC'S MOTION TO COMPEL INDEPENDENT MEDICAL EXAMINATION

APPEARANCES:

For the Plaintiff:	ADAM GANZ, ESQ., JASON LATHER, ESQ.
For the Defendants:	WILLIAM MAUPIN, ESQ.
For Amy Yoncey/Scott Yancey/Goliath:	STACEY A. UPSON, ESQ.

RECORDED BY: FRANCESCA HAAK, COURT RECORDER

Las Vegas, Nevada - Friday, April 3, 2015, 10:30 a.m.

* * * * *

DISCOVERY COMMISSIONER: Wilson.

MR. GANZ: Good morning, Your Honor. Adam Ganz, on behalf of the Plaintiff, Mitch Wilson.

DISCOVERY COMMISSIONER: Good morning.

MR. GANZ: And my associate, Jason Lather.

DISCOVERY COMMISSIONER: Good morning.

MR. LATHER: Good morning. Do you need Bar numbers, or do you --

THE CLERK: You're in the computer.

DISCOVERY COMMISSIONER: You're in the computer, so you're fine.

MS. UPSON: Good morning. Stacey Upson, on behalf of the Yanceys and the Goliath enterprise.

DISCOVERY COMMISSIONER: Good morning.

MR. MAUPIN: Bill Maupin, Bar number 1315.

DISCOVERY COMMISSIONER: And you are here for?

MR. MAUPIN: For the Defendants.

DISCOVERY COMMISSIONER: Thank you. All right. Everyone may have a seat. I'm going to give both sides time to argue, but I felt that it was just important for me to make a couple of preliminary observations and hopefully try to reinforce what I think my role is as Discovery Commissioner.

First of all, I do not have the authority nor will I prevent Dr. Duke from performing Rule 35 exams in the Eighth Judicial District Court; that is not within my purview. I can't make that type of a decision. I have to look at each case individually, and there have been cases where I have disqualified him from performing the Rule 35 exams for

very specific reasons, and there was a case recently I believe either Wednesday or last week -- it all sometimes runs together -- where I allowed him to perform that Rule 35 exam. So I am looking at these issues on a case-by-case basis, and if there are rumors or -- out in the community that I've disqualified this gentleman, that is just not correct. So make sure that you properly indicate what I have done.

Number two, a Rule 35 exam is not a matter of right, nor are Defendants automatically entitled to one. It is within the Court's discretion, and there are some very persuasive language in a case called Storlie, S-T-O-R-L-I-E, versus State Farm, it's 2010 Westlaw 549.0777. It is not reported in F2d, but of course we can cite to those decisions as persuasive authority even though they're not reported, but I can't cite to unreported Supreme Court decisions and neither can you all. So that's just a little bit of a tip for you, and I would highly recommend you read that case.

Number three, a Rule 35 examiner must be free from bias, and this is from the American Medical Association which was actually cited in one of the other cases called Hudson, and the case number for that, if you choose to look it up, is A676211. But what the American Medical Association says is the examiner is independent and must arrive at his or her diagnoses and opinions independently of the referring source, renumeration, others' opinions, or personal bias. The examiner is a medical professional who is not involved in the patient's care, and by not being involved in the patient's care, that means not advocating one way or the other.

Number four, the Court does have the authority to exclude evidence. Now, I can just make a recommendation. The District Court Judge has to turn it into an order by signing the Report and Recommendation. But that includes preventing a Rule 35 examiner from conducting a Rule 35 exam based on bias. And Magistrate Judge Foley persuasively explained in the Pham versus Walmart Stores case, 2012 Westlaw 195.7987; this too is not

reported; and Pham, by the way, is P-H-A-M versus Walmart Stores. And he says in that opinion: A physician who engages in a pattern or practice of providing improper, inflammatory opinions may justify an order barring him from performing a medical exam pursuant -- or medical examination pursuant to Rule 35. The Court, however, will not disqualify -- in this case it was Dr. Cash -- based on a single report in an unrelated case.

So if I was just looking at one other report by Dr. Duke in an unrelated case, that is not sufficient under at least Judge Foley's analysis, and I'm not sure just one report is the standard anyway, but you have to take a look at what is being said and analyze it as it's intended. So clearly one report is not sufficient.

Before proceeding any further, I do want to make sure that I am correct on a couple of facts. Number one, Dr. Duke did not perform a records review on Mr. Wilson in this case, is that correct?

MS. UPSON: Correct.

DISCOVERY COMMISSIONER: Okay. Number two, defense counsel, you have worked with Dr. Duke and he has performed Rule 35 exams for your firm on multiple occasions.

MS. UPSON: Correct.

DISCOVERY COMMISSIONER: Mr. Ganz, your firm has deposed Dr. Duke on multiple occasions involving Plaintiffs where he has performed a Rule 35 exam on your clients.

MR. GANZ: Correct, Your Honor.

DISCOVERY COMMISSIONER: And I don't want to put words in anyone's mouth, but having reviewed some of those transcripts, is it fair to say that there are some -- a little bit of animosity between the Plaintiff's firm and Dr. Duke?

MR. GANZ: It hasn't been brought out in court documents, Your Honor, but I can

tell you that Dr. Duke, and me, and the firms that I've been involved in, have at least a ten- to fifteen-year history of some problems that occurred between former partners of his, between former partners of mine, between issues that were going on with Federal investigations. There's a whole lot of stuff that was going on back in the day, and I think some of that has spilled over into this stuff. I didn't bring any of that stuff out only because I was dealing with specifically the cases that I had presented to you last time were all, if I'm not mistaken, all my cases that I had taken his deposition on.

DISCOVERY COMMISSIONER: But Dr. Duke knows who you are.

MR. GANZ: Oh, I presume so. Yeah, I've -- oh, yeah, absolutely, he knows who I am, I mean, and --

DISCOVERY COMMISSIONER: And he knows you can depose him and take a deposition, at least in one exchange I saw. And I don't think -- and let me just state this. It's very difficult when you're reading a document to know what dynamics are going on. I didn't see -- I mean, Dr. Duke didn't say anything improper. I don't think Plaintiff's counsel said anything improper. But it was definitely a cross-examination.

MS. UPSON: And I would just put for the Court's record in relation to that is when we had the conference call a couple weeks ago on this issue, and you said you thought there were issues with counsel, and I said I wasn't aware, and you said I should talk to Dr. Duke, I did, and Dr. Duke said he has had depositions with him. There's nothing personal in his mind regarding the depositions. He knows Plaintiffs' counsel go after him. It's no different than them or any of the others, and he has no personal animosity one way or the other to any of the Plaintiffs' attorneys in town.

DISCOVERY COMMISSIONER: Thank you. All right. So I need to know what the current condition is of the Plaintiff now --

MR. GANZ: Sure.

DISCOVERY COMMISSIONER: -- 'cause we've spent a couple of months --

MR. GANZ: And I think that's a absolutely great point to start at, Your Honor.

First of all, I need to apologize because I've heard that you've had other hearings, some references, that somehow that I proliferated this particular prior ruling in another one of my cases, and I wanted you to understand that I had nothing to do with it.

My original intent was for my cases and my clients, and that's why I provided information from my cases to you in order to make those decisions. I didn't go out and get hundreds of reports and try to say that he's a bad guy in the community. I try to really focus it on my clients and my cases, so I really want you to understand that that is --

DISCOVERY COMMISSIONER: For the record, the Court's not saying he's a bad guy either. That's not the issue, just as it's not personal animosity from Dr. Duke to the Plaintiffs. It's not personal animosity by the Court to Dr. Duke. The issue is whether or not he should be performing the Rule 35 exam in this case.

MR. GANZ: And --

DISCOVERY COMMISSIONER: Just so we're clear.

MR. GANZ: And here's the --

DISCOVERY COMMISSIONER: Go ahead.

MR. GANZ: -- the facts on that, Judge. They asked to use Dr. Duke. We said no. They filed a motion. We did an opposition. We outlined the stuff, and then we get this reply brief that wasn't heard before the last hearing. And in the reply brief it talks about, well, the client, Mr. Wilson, has not been truthful with this person, has not been truthful with this person, and it's not uncommon that people, you know, doctors can come to those conclusions based upon inconsistent testimony, and so on and so forth. And in her brief she actually said that the causation is ultimately gonna be the issue in this case as it is in many cases with IME doctors, and so on and so forth. What that doesn't do, Your Honor, is it

doesn't put my client's physical condition in controversy, and that's what the point of the Rule 35 exam should be.

Just saying causation doesn't necessarily -- my client's had two major surgeries, neck and low back, already, already had the surgeries, so --

DISCOVERY COMMISSIONER: How is your client doing today?

MR. GANZ: He's doing relatively well, but I do believe, in all candor to the Court, that future damages will be at issue and in controversy. I'm not trying to say that I don't believe that will be. So a limited examination with regard to that by somebody who's unbiased I would have absolutely no qualms with, and that's what I've tried to convey to Ms. Upson on a couple different occasions.

The problem is, Your Honor, is I don't believe that his condition with regards to all the stuff that she wanted to talk about in that reply brief, causation, and whether or not he told this doctor this, and whether or not he told that doctor that, that stuff's not his physical condition at issue and should not be the subject of a Rule 35 examination.

DISCOVERY COMMISSIONER: I agree with you.

MR. GANZ: They could do a records review on that. She's already pretty much written it for him in this -- I don't mean it that way.

DISCOVERY COMMISSIONER: Oh, he writes quite well by himself.

MR. GANZ: My point is the issues have already been well outlined. Those issues are already decided. There's no reason why he needs to put my client in a room by himself and go through a physical examination on those issues and redepose him himself and come up with his own bases for saying that he's inconsistent and add additional evidence to what she's already got for no reason when his physical condition is not at issue. That's the first issue.

The second part of that is exactly what you talked about in the Pham case. It

must be somebody who is unbiased. He's already, in my opinion, biased towards my Plaintiffs in my cases. It's pretty obvious. I haven't had a single issue, and I've showed you just on five, and I didn't go back more than even three or four years. I could show you that his opinions are if they file a lawsuit they have secondary gain issues. Well, how do you explain the pain that they had on that particular day? Well, they have a lawsuit and, therefore, I believe they're just exaggerating those complaints over that period of time.

There is nothing specific about any of my people other than the fact that they filed a lawsuit, and that's what I tried to bring out to Your Honor, and I don't believe that's the appropriate person to put hands on my client.

DISCOVERY COMMISSIONER: Thank you. All right. Do -- would you prefer to hear what I found in my limited review, or would you prefer, Ms. Upson, Mr. Maupin, to make some statements for the record? I'm happy to do it either way.

MR. GANZ: Are they both going to be able to argue, Your Honor? They represent one individual here.

DISCOVERY COMMISSIONER: Well, do you want your associate to argue too? I'll listen to what he has to say as well. I mean, listen, here --

MR. GANZ: I understand.

DISCOVERY COMMISSIONER: Here's --

MR. GANZ: It's a big issue and I understand.

DISCOVERY COMMISSIONER: This is a huge issue, and we've got -- and as I understand it, Mr. Maupin is actually here for Dr. Duke on some level, but he has associated in with the Defendants.

MR. MAUPIN: I am -- just to clarify that, I am here to represent the Defendants in this case.

DISCOVERY COMMISSIONER: Okay.

MR. MAUPIN: I also separately represent Dr. Duke, and I was retained by him to deal with the, primarily, the improper and egregious use of your order in the Thorne case for impeachment in front of a District Court Judge who he persuaded to allow that impeachment with no briefing.

DISCOVERY COMMISSIONER: Well, I really don't know what to say to that other than I think my orders have been very clear that they've been case specific. That's all I can say.

MR. MAUPIN: And I agree with that.

DISCOVERY COMMISSIONER: And that's what is important, and I just said I allowed Dr. Duke to perform a Rule 35 exam within the last week, and I wouldn't strike him. So the issue is this case. That's what it is. And, you know, because of that I was almost hesitant to review -- I have three boxes of these materials, and they weren't provided to me in any meaningful way. The reports weren't stapled together. They weren't divided by year. They didn't point out the reports that found injury and those that didn't. They were just thrown in the boxes. And so I picked one box to review and did not review -- and I declined to review anymore.

MS. UPSON: Can I just make one brief comment?

DISCOVERY COMMISSIONER: Yes.

MS. UPSON: He put those in boxes. They were separated by no injury, soft tissue injury, and more significant injury and our cover letter when they came over -- obviously, I didn't have the box to open them -- but the cover letter said which box was which.

DISCOVERY COMMISSIONER: No, it didn't, and maybe -- I don't know.

MS. UPSON: We had a cover letter that came with this because he told --

DISCOVERY COMMISSIONER: All right. Well, then that is -- then I will take responsibility for that, but I just got the three boxes in my office, that's what I got, with your

cover letter saying these are the three boxes.

And, you know, I find that interesting because I went through what I would call box one and I found no injury and injuries in box one. So I'm not sure how they were divided. I found all different years, Ms. Upson. I found 2011, 2012, 2014, all just put together.

I am going to decline to go through the other boxes. I am telling you though that in box one that I reviewed, I did, in fact, find ten cases where he recommended some form of surgery, and then in the -- there were a certain number of cases where he did not. But you know what? The injury-noninjury really isn't the dispositive issue here, so I'm glad you told me that. I will certainly go back and look at your cover letter. But that's really not the issue here.

The issue is whether or not there's bias or prejudice, and these are -- and I will tell you this is what I looked at. I looked at whether or not in that report, somewhere in that report, there was an indication of secondary gain. That's one thing I looked for. And then the next thing I looked for is whether or not there was some suggestion that the Plaintiff had some psychological issue or psychiatric underlay that is an explanation for the injuries, and the reason I looked at those two things in particular and, again, is because that's what I would consider to be inflammatory under the Federal Court case, and this is why -- because what -- and to Dr. Duke's credit, many times, not every time, but many times he says it could be conscious or subconscious, but that's not really -- it's not about the person being examined. It's about his point of view. It's what he's looking for because we're trying to figure out what his objectivity is.

Now, and also in fairness to Dr. Duke -- and I gave this lecture the other day when I had to clarify my Report and Recommendation in the other case again, although it's clearly in my recommendation what I said -- I see the same Plaintiffs' doctors over and over

and over again. So it is no wonder that on the Rule 35 exams you see the same defense examiners over and over and over again. You know, when I get a time, maybe I'll rewrite Rule 35. I think it is being used as a litigation tool and it is not being used for the purpose it is supposed to be, which is really trying to figure out if something's wrong with the Plaintiff and what's related and what is unrelated, and right now it's just -- it's a tool. It's no more than a -- it's litigation bullying is what it is, with all due respect to my defense friends out there. That's what it is. It's using a rule to bully in litigation and, frankly, I don't think Dr. Duke deserves to be used that way or any other physician, and I think it's the Bar's responsibility to get hold of this Rule and figure out how it should be used because, frankly, it's very distressing to me.

So I reviewed box one, and I'm not sure, Ms. Upson, whether -- I can tell you I did find ten cases that had injury, multiple cases had no causation, some cases had minimal injury, so I'm not sure they were actually divided that way. I'm not disputing what you said. I'm just saying in this box one I found a little bit of both.

So all I'm really concerned about today are the two issues I talked about, whether or not there was secondary gain and whether or not there was some psychological underlay that caused the problem because to me those are the two inflammatory issues. People can have psychiatric or psychological problems ten years ago, but that shouldn't preclude them from recovering ten years later in an auto accident if they're genuinely hurt. But if that's the, you know, if that's the underlying analysis, then that could be a problem. If in cases it's always secondary gain, or that's the reason for the causation, that could be a problem because when juries hear that objectively, oh, they just want money, okay, that's inflammatory, or they're just nuts, or they're acting strange so they can't, you know, really be having all these injuries. That's also inflammatory.

I reviewed 87 -- or, I'm sorry, I apologize. I reviewed 86 cases in box one.

There were more in there, but many of them were duplicative. They had the -- I think I had three reports from the same patient that were exactly alike, and there were a couple reports I wasn't sure were complete, so I didn't want to take a look at those. So the number that I reviewed in this box was 86.

Then what I did was I came up with four categories -- secondary gain; second, minimal treatment; third, no causation; and four, psychological underlay or psychiatric underlay or -- and I also included drug abuse in there because that seemed to go hand-in-hand with the psychological problems, and it may well, in fact, be part of the same problem.

MR. GANZ: What was category number three, Your Honor? I missed it.

DISCOVERY COMMISSIONER: Causation.

MR. GANZ: Causation. Thank you.

DISCOVERY COMMISSIONER: Lack of causation.

The way these reports are written, they're all the same format, which actually was very helpful to me because then I could just go to the discussion section, and I would expect him to follow the same format. That's reasonable, and it makes it easier to follow what he's doing, so I just went to the discussion section.

Of the 86 cases I reviewed, 52 of them had either comments on secondary gain, psychological problem with the Plaintiff or both. I was wondering if over the years it changed, so I looked at these per year, you know, as the more he did, the more he developed this belief that there was secondary gain or psychological overlay, but that's not what I found.

In 2011, for the cases, I reviewed 22 cases total in 2011, and of that 8 cases had some secondary gain, and 9 cases had some underlying psychiatric issue.

And then in 2012 there was only one case that had the secondary gain, and then there were a few cases that had the underlying issue.

In 2013 there were 26 cases, 14 cases had either secondary gain or psychiatric issues mentioned.

And, finally, in 2014, there were 23 cases, 12 of which had secondary gain or psychiatric issues mentioned as the reason why the Plaintiff was not healing or had the problems the Plaintiff had.

Well, that's more than one case, and the substantial majority of the cases that I reviewed mentioned that, and the issue really becomes is that, in and of itself, inflammatory to disqualify Dr. Duke. Even if I say no, in and of itself, it isn't, I still have to go back to this case and look at the context, and this is my concern, and actually, believe it or not, my concern is for the defense -- I know you find that shocking, but it's true, and for Dr. Duke -- because here's what I don't want to have happen after all these discussions we've had, after all the cross-examination that the Plaintiff has done, after Dr. Duke, preparing all these materials and feeling probably not really happy about it, and the discussions that have been ongoing, and the one case that got taken out of context and used in another case, and I -- what I don't want to have happen is I don't want him to be skittish -- I don't like that word. I just can't think of a better word at the moment -- for doing the Rule 35 exam. He needs to be able to do the Rule 35 exam how he sees fit, and he's not going to be able to do it here because he knows what he's up against. And then we devalued his role as the Rule 35 examiner, and in this case, and specifically with this firm and this lawyer they've been going at it with Dr. Duke.

So how is that fair to the Defendant, who you represent, Ms. Upson, or to the Plaintiff, who has to be examined? In this case, I don't think it's fair. I have no problem giving you your Rule 35 exam, but it's not going to be with Dr. Duke in this case for those reasons. And you are welcome to object to my Report and Recommendation, absolutely welcome to.

And I want to make it clear that that does not mean I am striking Dr. Duke in every case. Another case that I allowed him to go forward in, neither the Plaintiffs or the Defendants really had any exposure to him, and everybody was fine with it. We put some parameters in place. Fine. And understand that in terms of the impeachment of all the evidence that's out there, you know, he's a retained expert technically, so he'll have to deal with that on his own, and I'm sure he will. I've heard he's very persuasive in trial, and he obviously has worked very hard over the years in doing these examinations.

So I looked at the totality of the circumstances -- love that phrase -- and I looked at it from what I found in the box of materials, and I, you know, I just took one box at random, and I looked at the briefing again. I looked at the cross-examination in the depositions. I looked at this firm and the fact that this firm has a longstanding history, and I looked at your firm, Ms. Upson. You used him quite a bit.

So I think on balance in this case only I'm going to disqualify him, not -- let's say not disqualify. I'm going to require you to use someone else, not Dr. Duke. But you can have your Rule 35 exam, and you have plenty of time because your initial disclosure is not 'til September, so go find a practitioner if you want your Rule 35 exam.

Now, let me make this clear because you're going to need to add this, Plaintiff's counsel, to the Report and Recommendation. Dr. Duke can testify as an expert in this case.

MR. GANZ: We understand.

DISCOVERY COMMISSIONER: He can testify as a retained expert. I'm not -- that is not within my purview to strike him, and I'm not going to. He is certainly capable of doing that, and, you know what, sadly, he may or may not be right on his, you know, review of the records. I don't know. Seems like you're very confident in your Plaintiff's injuries, and he certainly was injured.

So having said all that, he can testify. He just cannot perform the Rule 35 exam. And the last time I checked, experts can look at materials that are even hearsay, so he could certainly look at the Rule 35 report and make comment on it, and whether or not that that's cumulative evidence is for the Judge to decide, not for me.

Anything further?

MS. UPSON: I have a few comments, but you can go first.

MR. MAUPIN: I am here strictly to address a finding that was made in the Thorne case that got --

DISCOVERY COMMISSIONER: Yeah. I don't think I can do that unless I have counsel present --

MR. MAUPIN: Oh, I'm not asking --

DISCOVERY COMMISSIONER: -- in all that case.

MR. MAUPIN: I'm not representing anybody in the firm. I'm talking about how it got used in another case, and --

DISCOVERY COMMISSIONER: Okay.

MR. MAUPIN: -- I'm not asking you to rule in the other case.

MR. GANZ: You're asking -- she's -- counsel for that case is not here. I don't think he is, number one. Number two, he doesn't have any standing in the Thorne case.

DISCOVERY COMMISSIONER: Yeah.

MR. MAUPIN: I'm not arguing the Thorne case. I'm arguing the effect of this because the Court, this Court, this morning brought up the problem of using this, these -- a bias finding. You didn't make that finding this morning, and, as I understand it -- and I'd like to, in some clarification, might ease all of the controversy over this. As I understand it, the order today is that the motion to have Dr. Duke perform the independent medical examination is denied. We believe that that is the appropriate method by which you should

deal with a motion like this, on a case-by-case basis.

The problem is -- and I understand that you have made no findings of bias because that would end up in a -- if he was actually used as a witness in a case, that would be a subject of cross-examination at the trial as I understand the explanation of the ruling this morning. So the problem has been that this -- the ruling in this other case that he's biased against all Plaintiffs I think has been undermined by the examination this morning, and the transcript of the hearing indicates, of the hearing in front of Judge Bare, over the probative value of the finding in the Thorne case of bias, is pretty egregious.

DISCOVERY COMMISSIONER: Well, again --

MR. MAUPIN: And --

DISCOVERY COMMISSIONER: -- Mr. Maupin, it's not that I -- I don't mean to cut you off, but I just don't feel comfortable talking about that case because I don't have the attorneys here that are present. And I understand the concern about the ruling as it relates to this case, and, again, I looked at the totality of the circumstances here. But I am going to -- you know, a part of what I did look at was the two inflammatory statements, and, you know, and those two I talked about, and they came out in a majority of the one box that I reviewed, and that gave me cause for concern, and it is a bias issue, and I'm not specifically finding in this case that he is bias, but I looked at that, and those are, in my humble opinion in reviewing the case law and looking at his documents, I think that is clearly a problem. I think it is bias and inflammatory.

But I don't want to go there anymore because I am concerned about this Report and Recommendations being misused, and I don't want it misused. It's for this case, and I'm looking at the totality of the circumstances, but I don't want anyone to think that somehow I don't think he's -- I think everything he's doing is okay. I don't think that. I am very concerned that in 50 -- the majority, the substantial majority of the reports, I have these, what

I consider to be, inflammatory. And we don't have to explore it further because it is not alone -- you know, by itself it's not the basis for my ruling, and I don't know how much more clear to say that.

I don't want to be taken -- I can't -- I'm not in a position to understand or defend what happened before that District Court Judge, and I'm not going to do that today because that would be improper. But I understand the concern, so I'm trying to make it really clear, and I do expect to see in the Report and Recommendation section that this ruling is only for this case.

MR. GANZ: But it will include the terms bias, and it will include these issues on those specific cases that you found that raised concern.

DISCOVERY COMMISSIONER: Because that's what I looked at.

MR. GANZ: Exactly.

DISCOVERY COMMISSIONER: That's what I looked at, and I think there is a problem here.

MR. MAUPIN: Well --

DISCOVERY COMMISSIONER: But I don't have to reach the ultimate conclusion today.

MR. MAUPIN: Well, I'm not here to -- my role here is not to litigate the merits of the disqualification in this case. The -- what I am requesting is a statement from the Court that the review of these records is not to be understood that Dr. Duke has a bias or prejudice involving all personal injury Plaintiffs.

DISCOVERY COMMISSIONER: I appreciate what you're saying, but I'm not going to do it, and the reason I'm not going to do it is because it's not -- was not specifically what I addressed today, and I just don't think it's proper. If somebody -- but, you know, part of the problem in that other case, Mr. Maupin, is no one objected to the Report and

Recommendations.

MR. MAUPIN: That is -- then that's a very good point. The reason that there was no objection was that the -- after the ruling, your ruling in the discovery dispute, the lawyers and the principal, as they call themselves -- I think it's the insurer -- decided simply not to use Dr. Duke, hire someone else, and then not challenge the report. No one told -- no one told Dr. Duke anything about this, that his bias was being litigated, until --

DISCOVERY COMMISSIONER: I'm sorry I opened --

MR. MAUPIN: -- after the order --

DISCOVERY COMMISSIONER: -- the door.

MR. MAUPIN: -- was -- no, no -- until after the order approving the DCRR was entered. He has never been asked to contribute to any of this business, and this -- and in that case this has -- this is neither the Court nor Your Honor was given the opportunity to even hear from him, not because of this lawyer here, but because the lawyer that hired him.

DISCOVERY COMMISSIONER: Well, here's my belief. If that's going to be litigated in a evidentiary hearing type format, a District Court Judge has to do that. I'm not -- it's not me. All I'm looking at -- and, again, obviously I am saying he can testify as the retained expert, so I'm not making a ruling on his ability to do that. I'm just looking at, in this case, whether or not he's the proper person, the proper doctor, independent of his qualifications -- we're not talking about that -- independent of his qualifications to perform the Rule 35 exam, and the test is his independence and his bias, and I am concerned that in the majority of the reports I looked at that there were secondary gain issues, psychological underlay that explained all the patient's complaints, and it just was more than one report. And if you have that perception going in because you've prepared so many of the Rule 35 exams and so often you find that, then, yes, I think that rises to the level of potential. I'll say that -- potential bias. But I don't even have to go there completely.

You know, this is not the basis for my decision completely. I'm looking at the totality of the circumstances. But I don't want anyone to walk away thinking I don't think there's a problem here because there is. There is a problem, and it falls into the category of inflammatory statements which the rules say goes to bias. So the bias word is appropriate, but the issue isn't whether he's bias. It just relates to this case. So I guess from that perspective don't put in that he's biased against all personal injury Plaintiffs because I'm not finding that today.

MR. GANZ: Okay.

DISCOVERY COMMISSIONER: Okay. Yes, ma'am.

MS. UPSON: Thank you. I understand the Court's ruling, and I just want to make a couple of comments on the record, obviously, because the Report and Recommendation's coming out. First I want to address the comment about litigation bullying and the defense bar, and is that what is occurring, and is there --

DISCOVERY COMMISSIONER: Well, let me say this clearly. It's on both sides, because I see the same treating doctors on both sides, but we're using the Rule 35 exam I think improperly.

MS. UPSON: But in relation to that, when you look at who's involved in litigation in the community, you do see the same Plaintiff treaters over, and over, and over, and over. In those cases there's not always objective medical evidence regarding an injury, and if there's not objective medical evidence regarding an injury, there has to be some type of cause or analysis of why they may be continuing to complain of subjective complaints.

So the fact that Dr. Duke has put in reports notations regarding secondary gain and psychological issues, that, in and of itself -- and we respectfully disagree with the Court's comment -- doesn't create an inflammatory basis or a bias, and I just want to put on the record why. In every single case that we deal with involving Plaintiffs with the same

doctors you see over and over -- you could say Dr. Cass, Grover, all of those guys -- they, in every single case, address secondary gain issues through their treatment. They do that in the form of Waddell findings. They don't really use the term Waddell findings anymore. They say secondary gain. They look for things that are inconsistent within the records.

DISCOVERY COMMISSIONER: Well, then when I see them before me, I'll take that into account.

MS. UPSON: But that's what has to be looked at here, is if there's a bias or inflammatory statements made by Dr. Duke.

DISCOVERY COMMISSIONER: And I believe that there is, so let me make that very clear, you know, and I don't want to -- I appreciate everybody's position here. But based on what I reviewed -- and that includes the cases that the Plaintiff's counsel submitted to me that they've been involved in --there are two inflammatory and I'm going to say potentially biased problems, and that is the secondary gain issue and the psychological underlay or psychiatric underlay that the patient presents with. And, yes, I do believe those are inflammatory, and I think I found that today.

MS. UPSON: But for the record, in relation to what's inflammatory, what he's doing is a forensic review and he's giving forensic opinions based upon his review. His review and analysis of those particular issues are no different than the analysis of any other doctor in this community. So to say he is somehow bias because it's in some of the reports, if he held a true bias, you would see it in every single report; it's not there, so that --

DISCOVERY COMMISSIONER: Well, because it's not always appropriate. He has found cases where there's been injury, but he has, in a substantial majority of the cases, referred to secondary gain and psychiatric issues in a substantial majority. We're not talking about one or two cases. We're talking in one box, 57. That is substantial, and part of it is because he's done so many of these exams, which brings me back to my concern in this case.

I don't think it's fair for -- to ask him to be the Rule 35 examiner in this case because if it's true, that the Plaintiff is malingering or whatever your defense is on this case -- I don't know what your causation defense is or if he has other issues -- Dr. Duke, to put him in a position of having to decide that with the background would not be fair to him. Do you understand what I'm saying? Because then he would -- would he go, oh, I can't say that. I've got to step back. Just kind of like I feel right now talking about a ruling in another case. Do I need to back down from what I'm doing today because somebody is upset that it was taken out of context? Is he going to have to back down from performing a proper Rule 35 exam because, oh, my gosh, maybe I'll be challenged on my objectivity even though I really believe this person is completely making all this stuff up? That's the problem. And the reason it's a problem in this case is that there's history between your firms and Dr. Duke, and I just think at the end of the day it's not fair to ask the Plaintiff, who chose his lawyer, and was unaware probably of all these other Rule 35 exams, was unaware of them, to ask him to submit now to a Rule 35 exam by an examiner who there is clearly history with this Plaintiffs' firm. That's what concerns me.

MS. UPSON: But then what's gonna happen every single time there's a case with Mr. Ganz, he's gonna use that and say, no, Dr. Duke can't be used. It should be Dr. Duke doing a forensic review, giving forensic opinions. If he then makes an opinion that's completely contrary to what he's done before and he doesn't think that it's there, that's an issue for cross-examination.

DISCOVERY COMMISSIONER: Ms. Upson, I don't know why you're fighting so hard on this, and I appreciate your loyalty to Dr. Duke. But this is a situation that could hurt the Defendant. I would find another Rule 35 examiner without the same concerns. It doesn't mean that you can't use Dr. Duke as your retained expert. But I think the examination needs to be done by somebody else. And, unfortunately, when you are this active in the litigation

community and perform I think -- the last, one of the last motions I had, someone said 375, and I might be off a little bit, but Rule 35 exams, that's a lot. And that's not the test, but when you see the repetitive statements, it's a problem, and I don't want to restate my ruling, so.

MS. UPSON: And I accept. I'll just put two more comments on, and then we'll stop, and we'll just reserve it. My loyalty isn't to Dr. Duke. It's to the process. And what we have in this --

DISCOVERY COMMISSIONER: Mine is too.

MS. UPSON: -- to this community is only so many doctors that do this type of work. You have -- and just by way of example, in the last trial I just had with Dr. Lemper, over the last five years he indicated he's had several thousand patients from Glen Lerner's office, several thousand. We only have a few doctors in this community that do IMEs in relation to the neck and spine, less than five, so they're --

DISCOVERY COMMISSIONER: Well, maybe I'll just start denying all IMEs. Maybe we just won't do any more. You know, with all due respect, I care about the process too, and that's why I'm taking the time with this, because I know how important it is. So please don't think I don't care about the process.

MS. UPSON: I wasn't even implying that. I was just saying I didn't want the Court or the record to reflect that my loyalty was to Dr. Duke. It was to the process of the defense as a whole, and I was not implying that the Court is, in any way, not taking the process just as seriously.

DISCOVERY COMMISSIONER: Okay.

MR. MAUPIN: May I just? This is gonna sound strange coming from one of the parties, but the personal injury litigation system, and not only that, the commercial tort litigation system has -- is obviously a forensic exercise. When a treating physician, however

that physician comes to be retained, is performing clinical functions, but when you take that doctor and put him on the stand, or have him write a report, and then he's -- he or she is asked the question did what you saw in the clinical environment, does it relate to some event that has legal significance, and if you think so, you must so state, to a reasonable degree of medical probability; that is where the clinician switches from the clinician into a forensic witness because that's a forensic exercise. The term reasonable degree of medical probability has absolutely zero meaning in the clinical environment. No doctor ever thinks about that.

Rule 35 is simply a process or defines a process that addresses the fact, that shift from the clinical side to the forensic side, and the idea is to level the playing field. Now, I must say on -- you know, in fairness to Dr. Duke, he's just a -- he's a doctor. He gets called for these exams. The legal significance of the number of exams he's done, I think he's now aware of it because he knows full well he can be cross-examined about all that.

But make no mistake about it. The process that you're engaged in right now about how to use Rule 35, what's the scope of discovery, what's the fairness with regard to how personal injury litigants, both Plaintiffs and Defendants, should be treated is part of a commitment that the Discovery Commissioners have made to this process since the Discovery Commissioner system was invented back in the 1980s. And so there's no question about that the process of developing that balancing test is a difficult one.

And I have to simply state that there is -- one of the considerations in the order today has to do with the fact that the animosity or dynamic between this lawyer and Dr. Duke. It has been said that he has said that Dr. Duke hates all personal injury clients. I want to make sure that, from my interaction with him, Dr. Duke doesn't hate anybody.

DISCOVERY COMMISSIONER: Thank you, Mr. Maupin. Anything further?

MR. GANZ: Very quickly, Your Honor. Procedurally, because there may potentially

be a objection --

DISCOVERY COMMISSIONER: Objection, right.

MR. GANZ: -- to this, can we ask you to preserve what you have been provided until that ruling is done or --

DISCOVERY COMMISSIONER: I was absolutely going to say that.

MR. GANZ: Okay.

DISCOVERY COMMISSIONER: I'm hanging on to everything so that I've marked my box one so it's box one, and candidly, you know, I apologize that I missed I guess the breakdown here, but --

MS. UPSON: If I could interrupt briefly. I got the E-mail from Cathy on the letter. She didn't put it in the letter, so I take back what I said before.

DISCOVERY COMMISSIONER: Okay.

MS. UPSON: But she was supposed to have put in the letter what each box was. We will do a new letter saying what each box was.

DISCOVERY COMMISSIONER: Okay. That's fine. You can. Just send a copy to the Plaintiff so it's not ex parte.

[Counsel conferring off the record - not transcribed]

DISCOVERY COMMISSIONER: And I'll put it with the box, but I -- again, just to give some comfort here to the defense, that really wasn't, you know, my concern because in this box I'm not sure how the breakdown really worked 'cause I found both. I did find there he recommended surgery in several of the cases I looked at, so, you know, I'm not sure how the breakdown worked with this particular box. That's all that I'm saying.

MR. GANZ: Your Honor, the last thing I'd like, if I could, just say is I recognize this put a great strain on you, and I do appreciate you taking the time. I know Ms. Upson does as well, Mr. Maupin as well.

DISCOVERY COMMISSIONER: I know you both do. I understand.

MR. GANZ: This is not easy, and you're being thrown right into the fire; that is hard to make decisions either way. So I appreciate you taking the time, and certainly we will work with them getting an order that all can be content with and make sure we talk about potential bias and also talk about with this specific case, and make sure that that is strictly adhered to.

DISCOVERY COMMISSIONER: And I will be very careful when I review the report. I do want to say this. I think it's all of our responsibility, the bench, the Bar, everybody's responsibility to figure this out because it is very distressing to see the same treating doctors on one side to, as you said, there's a limited pool I guess of Rule 35 examiners. I think I can count, when I was in private practice, I think I can count on one hand the time I did Rule 35 exams. Now, I did a different practice area. I didn't do the automobile. But I have a very wise teacher who really, you know, we used them when we had to, not as a matter of course, and that's where I think we need to change our focus.

But, Plaintiff's counsel, you all have responsibility too. So everybody has responsibility. So on that happy note, have a wonderful weekend. Thank you. Plaintiff's counsel, you prepare my Report and Recommendation.

MR. GANZ: Ten days, is that what you need?

DISCOVERY COMMISSIONER: Ten days. Run it by both Mr. Maupin and Ms. Upson, please, and to approve as to form and content. And the status check for that will be?

THE CLERK: May 8th at 11.

DISCOVERY COMMISSIONER: But don't be here for that, Plaintiff's counsel.

MR. GANZ: We'll get it done.

DISCOVERY COMMISSIONER: Get the homework done. Okay. Great. Thank you very much. Have a nice weekend.

MR. MAUPIN: You have a nice weekend yourself.

[Proceeding concluded at 11:21 a.m.]

* * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-video recording of this proceeding in the above-entitled case.

FRANCESCA HAAK
Court Recorder/Transcriber

EXHIBIT "7"

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EGLET PRINCE

DISTRICT COURT

CLARK COUNTY, NEVADA

MITCH WILSON, an individual,

Plaintiff,

vs.

SCOTT YANCEY, an individual; AMY YANCEY, an individual; GOLIATH COMPANY, LLC, a domestic limited-liability company; GOLIATH INVESTMENTS, LLC, a domestic limited-liability company; GOLIATH PROPERTIES, LLC, a domestic limited-liability company; GOLIATH-CITY COMPANY, LLC, a domestic limited-liability company; GOLIATH LAND & DEVELOPMENT, LLC, a domestic

CASE NO.: A-13-680635-C
DEPT NO.: XVI

AMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW IN SUPPORT OF ORDER PRECLUDING DEREK DUKE, M.D., FROM CONDUCTING A RULE 35 EXAMINATION

limited-liability company; GOLIATH-JUPITER INVESTMENTS, LLC, a domestic limited-liability company; JUPITER REAL ESTATE HOLDING COMPANY, LLC, a domestic limited-liability company; BAD ASS GOLF CARTS, a domestic corporation; A&E TELEVISION NETWORKS, LLC, d/b/a A+E NETWORKS, LLC, a foreign limited-liability company; LIONS GATE ENTERTAINMENT INC., d/b/a LIONSGATE TELEVISION, INC., a foreign company; LOVEABLE SCOUNDRELS, INC., a foreign company; DOES I through XX, and ROE CORPORATIONS III through XX, inclusive,

Defendants.

This Court conducted an evidentiary hearing on Defendants' Objection to the Discovery Commissioner's Report and Recommendation, and Plaintiff's related request to disqualify Derek Duke, M.D. from conducting an NRCP 35 examination. Plaintiff, MITCH WILSON, appeared by and through his attorney, ADAM GANZ, ESQ., of the law firm of GANZ & HAUF, and ROBERT T. EGLET, ESQ., of the law firm of EGLET PRINCE, specially appearing. Defendants Scott Yancy, Amiee Yancey, Goliath Properties, LCC, and Bad Ass Golf Carts, appeared by and through their attorneys, STACY UPSON, ESQ. of the law firm of UPSON SMITH and WILLIAM MAUPIN, ESQ., of the law firm of MAUPIN, NAYLOR BRASTER.

After review and consideration of the points and authorities on file herein, and having heard oral arguments of counsel in this matter, the Court hereby finds and concludes as follows:

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I. BACKGROUND FACTS

A. Procedural History

1. On February 18, 2012 Mitch Wilson alleges that he was thrown from a custom golf cart, manufactured by Defendant Bad Ass Golf Carts and driven by Defendant Scott Yancey. Mr. Wilson alleges that he suffered significant injuries that lead to a spine fusion.

2. Plaintiff filed his complaint on April 23, 2013.

3. Defendants Scott Yancey, Amiee Yancey, and Goliath Properties, LCC, answered on December 4, 2013.

4. On November 10, 2014, the Yancey Defendants requested that Plaintiff, Mitch Wilson, submit to an examination pursuant to NRCP 35 at the hands of their chosen doctor, Derek Duke, M.D.

5. Plaintiff responded that he was willing to undergo a Rule 35 examination, but not with Dr. Duke on the basis that Dr. Duke is known to be biased against plaintiffs in personal injury actions.

6. On December 9, 2014, the Yancey Defendants filed a Motion to Compel a Rule 35 examination before the Discovery Commissioner, Bonnie Bulla. The Plaintiff filed an Opposition on December 26, 2014, and the Yancey Defendants filed his Reply on January 5, 2015.

7. During a telephonic conference between the parties and Commissioner Bulla, during the week of January 12, 2015, the Commissioner ordered Dr. Duke to produce the last four years of Rule 35 reports to assess how many times Dr. Duke concluded an injury occurred as a result of an accident.

8. Dr. Duke produced three large boxes of NRCP 35 reports and record reviews. The Commissioner reviewed only one box of reports that Dr. Duke had apparently classified as

both "injury" and "no injury" opinions between 2011 and 2014. In total, the Commissioner reviewed reports from approximately 86 different cases.

9. After multiple continuances and conferences on the issue, Commissioner Bulla held a hearing on Defendants' Motion to Compel on April 3, 2015.

10. Dr. Duke was not present at the hearing, but his personal counsel William Maupin, Esq. made a special appearance for Dr. Duke at the hearing.

11. After hearing argument, the Discovery Commissioner found that she did not have the authority to prevent Dr. Duke from performing a Rule 35 exam across the board in the Eighth Judicial District, and that each request for a Rule 35 exam would have to be evaluated on a case-by-case basis.

12. The Commissioner also found that a Rule 35 exam is not a matter of right, however, and that it is within the Court's discretion to allow or deny a Rule 35 exam.

13. The Commissioner also found that a Rule 35 examiner must be free from bias and arrive at his or her opinions independently of the referring source and without advocating one way or the other.

14. Specific to her review of the materials provided by Dr. Duke, the Commissioner's focus was on potential bias or prejudice, which may lead to disqualification of a Rule 35 examiner.

15. Specifically, the Commissioner reviewed the reports for any indication of what she perceived to be potentially inflammatory issues, including, findings of secondary gain motivation, and suggestions of a psychological issues/underlay.

16. Because the substantial majority of the sampling of reports reviewed by the Commissioner referenced potentially inflammatory issues, the Commissioner had concerns about Dr. Duke's potential bias against personal injury plaintiffs.

17. The Commissioner was also concerned that Rule 35 exams were being used as a litigation tool, for litigation bullying, rather than to properly evaluate plaintiffs' medical conditions.

18. The Commissioner recommended that Dr. Duke not be permitted to conduct a Rule 35 examination in this case.

19. On June 22, 2015, the Yancey Defendants timely filed an Objection to the Discovery Commissioner's Report and Recommendation.

20. Plaintiff requested that Dr. Duke be barred from performing a Rule 35 examination or from serving as an expert witness. Counsel requested an evidentiary hearing on the matter with the Court, and the Court granted the request.

B. Other Proceedings Related To Dr. Duke

21. During the course of this evidentiary hearing, the Court was made aware of other proceedings involving similar claims that Dr. Duke has a bias against personal injury plaintiffs.

22. In *Thorne v. Miles*, District Court Case No. A699470, Commissioner Bulla, issued a similar Report and Recommendation, wherein it was recommended that Dr. Duke be excluded as a Rule 35 examiner because he was biased against all plaintiffs who file personal injury claims.

23. The Honorable Mark Denton signed the Report and Recommendation without objection on February 23, 2015, and Notice of Entry of Order was filed on February 25, 2015, in the Thorne matter.

24. Subsequently, Dr. Duke, via Mr. Maupin filed a motion to Intervene with the limited purpose of objecting to and seeking an amendment to the Discovery Commissioners report and recommendation affirmed and adopted on the February 23, 2015 Order.

25. Judge Denton entered another order on June 3, 2015 that modified some of the language in original *Thorne* Report and Recommendation. Judge Denton did not alter Commissioner Bulla's finding that Dr. Duke is biased against personal injury Plaintiffs, however, he advised that his Order be confined to the facts of the *Thorne* case.

26. In the *Thorne* case, as in this case, at the time the plaintiff objected to the Rule 35 examination, Dr. Duke had never been provided any records about the plaintiff, and he had never met the plaintiff. Defense counsel had merely requested to use Dr. Duke as a Rule 35 examiner, but the plaintiff would not agree. Thereafter, as here, the Defendant filed a motion in to compel the plaintiff to submit to a Rule 35 examination with Dr. Duke.

C. Evidentiary Hearing Before This Court

27. Prior to the commencement of the evidentiary hearing, the Court ordered briefing from the parties on the scope of the subject hearing. On May 5, 2016, Plaintiff filed his brief regarding the scope of the evidentiary hearing regarding Dr. Duke. On June 16, 2016, Defendants filed their brief regarding the scope of the evidentiary hearing regarding Dr. Duke. Defendants also filed supplements to their briefs on July 13, 2016, and July 18, 2016.

28. On July 8, 2016, the Court began the evidentiary hearing regarding Dr. Duke's bias against plaintiffs in personal injury matters.

29. Testimony and evidence was submitted to this Court on eleven (11) separate days. Specifically, July 8, 2016 (Day 1), July 18, 2016 (Day 2), July 19, 2016 (Day 3), August 8, 2016 (Day 4), August 9, 2016 (Day 5), August 10, 2016 (Day 6), August 12, 2016 (Day 7), August 16, 2016 (Day 8), August 17, 2016 (Day 9), September 8, 2016 (Day 10) and September 9, 2016 (Day 11). Closing arguments were thereafter heard on November 9, 2016 and November 10, 2016.

30. In connection with this hearing, both parties produced additional documents related to Dr. Duke's methodology and alleged bias against personal injury plaintiffs.

31. On day 1 of the evidentiary hearing, Plaintiff produced a chart summary of Dr. Duke's compiled reports previously disclosed by Defendants to the Discovery Commissioner, and additional reports produced by Plaintiff prior to the evidentiary hearing.

32. The chart was admitted as Exhibit 3, and the summary of the chart was admitted as Exhibit 4 to the Hearing. A Final Amended Chart was admitted as Exhibit 11, and a Final Amended Summary was admitted as Exhibit 12 pursuant to NRS 52.275.

33. The Court has reviewed all of the reports provided by the parties and that Plaintiff claims are summarized in both the Final Amended Chart and Final Amended Summary. The Court finds that the evidence at the Evidentiary Hearing and the admitted documents generally supports the following conclusions in the Final Amended Chart and Final Amended Summary: Out of the approximately 371 distinct reports authored by Dr. Duke between 2011-2015,

a. Approximately 333 include at least one opinion that this Court finds to be an inflammatory category; or approximately 90% of the time.
b. Dr. Duke disagrees with the treating doctor approximately 95% of the time.
c. Dr. Duke includes opinions regarding opiates and drug seeking behavior in approximately 95 cases, or 25% of the time.
d. Dr. Duke finds symptom magnification to be a factor in approximately 108 cases, or 29% of the time.
e. Dr. Duke finds pending litigation to be a factor in approximately 178 cases, or 48% of the time.
f. Dr. Duke finds secondary gain to be a factor in approximately 177 cases, or 48% of the time.

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g. Dr. Duke finds psychological factors (anxiety or depression) to be a factor in approximately 161 cases, or 43% of the time.

h. Dr. Duke suggests that the patient is not being truthful or giving inconsistent information in 149 cases, or 40% of the time.

i. Dr. Duke finds no objective findings of injury in 263 cases, or approximately 71% of the time.

j. Dr. Duke gives a sprain/strain injury or no injury diagnosis when the treating doctor's diagnosis was injury or more than a sprain/strain injury in approximately 319 cases, or 86% of the time.

k. Dr. Duke agreed with the past treatment rendered by the treating doctor in approximately 15 cases, or 4% of the time, but still often disagreed with part of the physicians treatment or future recommendation.

II. APPLICABLE LAW

A. Law Related to Rule 35 Examinations

NRCP 35(a) allows for "a physical or mental examination by a suitably licensed or certified examiner," when a party's mental or physical condition is "in controversy." Nev. R. Civ. P. 35. This Rule is substantively identical to FRCP 35(a)(1), as well as similar rules or statutes in almost every state. *See, for example*, Ariz. R. Civ. P. 35(a); Cal. Civ. Proc. Code § 2032.020; Ore. R. Civ. P. 44; Tenn. R. Civ. P. 35.01.[1]

The instant action is a case of first impression due to the paucity of Nevada cases pertaining to the application of NRCP 35 to civil cases. Moreover, there are no Nevada cases

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[1] The Nevada Supreme Court has recognized that "federal decisions involving the Federal Rules of Civil Procedure provide persuasive authority when this court examines its rules." *Moseley v. Eighth Judicial Dist. Court ex rel. County of Clark*, 124 Nev. 654, 668, 188 P.3d 1136, 1146 (2008), quoting *Nelson v. Heer*, 121 Nev. 832, 834, 122 P.3d 1252, 1253 (2005). Similarly, the Nevada Supreme Court will "turn to other jurisdictions for guidance" when interpreting similar statutes and rules. *Rubio v. State*, 124 Nev. 1032, 1041, 194 P.3d 1224, 1230 (2008); *Las Vegas Mach. & Eng'g Works v. Roemisch*, 67 Nev. 1, 9-11, 213 P.2d 319, 323-24 (1950).

relating to allegations of bias and/or the validity and reliability of the examination method of a Rule 35 examiner. In light of the foregoing, this Court feels compelled to point out, that while Rules 26, 33 and 34 provide for discovery of material relevant to the subject matter involved in the pending action, Rule 35 contains a stricter requirement. Thus, the moving party must make an affirmative showing that the condition as to which the examination is sought is in controversy and that there is good cause existing for ordering the particular examination. *See Schlagenlauf v. Holder*, 379 U.S. 104, 85 S.Ct. 234, 13 L.Ed. 2d 152 (1964).

Under Rule 35, the mental or physical condition of the plaintiff is always in controversy in personal injury litigation. However, whether good cause is established depends on both relevance and need. *See Sacramona v. Bridgestone/Firestone, Inc.*, 152 F.R.D. 428 (D. Mass. 1993); *Mohamed v. Marriott Int l., Inc.*, 1996 U.S. Dist. Lexis 2788 (S.D.N.Y. Mar. 7, 1996); *Smith v. J.I. Case Corp.*, 163 F.R.D. 229 (E.D. Pa. 1995); *Peters v. Nelson*, 153 F.R.D. 635 (N.D. Iowa 1994); and *Simpson v. University of Colorado*, 220 F.R.D. 354 (D. Colo. 2004). Thus, controversy does not equate to good cause, which mandates a separate and distinct analysis, because good cause may not be found if the mental and physical examination of the plaintiff may be established by prior documentary evidence.

As the United States Supreme Court noted, in determining whether good cause exists for a Rule 35 examination, "[t]he ability of the movant to obtain the desired information from other means is also relevant." *Schlagenhauf, supra*, at 118-119. For example, "[o]ne of the factors which must be considered in determining good cause is whether the defendants have utilized other discovery procedures before seeking the medical examination." *Anson v. Fickel*, 110 F.R.D. 184, 185 (N.D. Ind. 1986). Thus, a plaintiff is not required to submit to a Rule 35 medical examination simply because he or she sustained injury when the defendant had been supplied all of plaintiff s medical records and had deposed the plaintiff. *See Stanislawski v.*

Upper River Serv., 134 F.R.D. 260 (D. Minn. 1991). In light of the good cause requirement, a Rule 35 examination shall only be required if the plaintiff asserts ongoing injury, ongoing injury necessitating surgery or a significant worsening of plaintiff s medical condition. See *Duncan v. Upjohn Co.*, 155 F.R.D. 23 (D.Conn. 1994); *Shapiro v. Win-Sun Ski Corp.*, 95 F.R.D. 38 (W.D. N.Y. 1982); *Ziemann v. Burlington County Bridge Comm n.*, 155 F.R.D. 497 (D.N.J. 1994); and, *Galieti v. State Farm Mut. Auto Ins. Co.*, 154 F.R.D. 262 (D. Colo. 1994).

Even if good cause for ordering the mental or physical examination is established under Rule 35, it is still within the sound discretion of the trial court to order examination of the plaintiff. *See, Ligotti v. Provident Life and Casualty Ins. Co.*, 857 F. Supp. 2d 307 (W.D. N.Y. 2011); and *Curtis v. Express, Inc.*, 868 F. Supp. 467 (N.D.N.Y. 1994). Consequently, a Rule 35 examination of the plaintiff is not granted as a matter of right. *Great West Life Assurance Co. v. Levithan*, 153 F.R.D. 74 (E.D. Pa. 1994).

This Court may also place reasonable limitations on a Rule 35 examination. Nevada Rule of Civil Procedure 26(c) provides, in relevant part, that a court "may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following: ..... (2) that the discovery may be had only on **specified terms and conditions** ... " Nev. R. Civ. P. 26 (emphasis added). Moreover, Nevada Rule of Civil Procedure 35 states in pertinent part:

> The order may be made only on motion for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, **conditions** and scope of the examination and the person or persons by whom it is to be made.

Nev. R. Civ. P. 35 (emphasis added).

Because there is no absolute right for defense counsel to choose a specific physician for the Rule 35 examination, the identity of the examining physician is a "condition" that can also be determined by the Court. *Newton v. Ceasar*, M2000-01117-COAR10CV, 2000 WL

863447, at *2 (Tenn. Ct. App. June 29, 2000), *citing Liechty v. Terrill Trucking Co.*, 53 F.R.D. 590 (E.D.Tenn. 1971); *Stuart v. Burford*, 42 F.R.D. 591 (D.C.Okla. 1967); *Timpte v. District Court*, 421 P.2d 728 (Colo. 1966); *Martin v. Superior Court*, 451 P.2d 597 (Ariz. 1969). Ultimately, "if the court finds that a particular doctor cannot be trusted to make a fair examination, it may refuse the requested order or designate another doctor in whom the court has confidence." *Warrick*, supra. A Nevada federal court has concurred:

> The court nevertheless has the authority to exclude evidence, including expert opinion testimony, that is irrelevant, or whose probative value is substantially outweighed by the danger of unfair prejudice, confusion of issues or of misleading the jury. Fed.R.Evid. 402 and 403. **A physician who engages in a pattern or practice of providing improper, inflammatory opinions may justify an order barring him from performing a medical examination pursuant to Rule 35.**

Pham v. Wal-Mart Stores, Inc., 2:11-CV-01148-KJD-GW, 2012 WL 1957987, at *4 (D. Nev. May 29, 2012)(emphasis added).

Of paramount significance, the trial court in the exercise of its discretion with regard to the requested examination, shall consider if challenged, the scientific validity and reliability of the Rule 35 examiner or examination method. Nevada trial court judges assume the role of a gatekeeper in assessing whether experts satisfy these requirements, and in that capacity have "wide discretion, within the parameters of NRS 50.275, to fulfill their gatekeeping duties." *Higgs v. State*, 222 P.3d 648, 658 (Nev. 2010). As the gatekeeper of evidence in this case, the Court's focus shall be limited to determining whether Dr. Duke's expert opinions will assist the trier of fact in this matter. In doing so, this Court must the follow the mandate of the Nevada Supreme Court in *Hallmark v. Eldridge*, 124 Nev. 492, 189 P.3d 646 (2008). Under *Hallmark*, to testify as an expert witness, the witness must satisfy the following three requirements:

> (1) he or she must be qualified in an area of scientific, technical or other specialized knowledge (the qualification requirement); (2) his or her specialized knowledge must assist the trier of fact to understand the evidence or to

> determine a fact in issue (the assistance requirement); and (3) his or her testimony must be limited to matters within the scope of his or her specialized knowledge (the limited scope requirement).

Id. at 498.

An expert's testimony will assist the trier of fact only when it is (1) relevant and (2) the product of reliable methodology. *Id.* Additionally, when determining whether an expert's methodology is reliable, the court should consider whether the opinion is (1) within a recognized field of expertise; (2) testable and has been tested; (3) published and subject to peer review; (4) generally accepted in the scientific community (not always determinative); and (5) based on particularized facts rather than assumption, conjecture, or generalization. Id. at 498.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Dr. Duke's Reports And Opinions Fail the Assistance Requirement of *Hallmark* and NRS 50.275.

Applying *Hallmark* and NRS 50.275 to the instant action, the court finds as a matter of law that Dr. Duke's medical opinions are personal and his methodology unreliable. The Court further finds that Dr. Duke's medical opinions rely heavily on speculation and other irrelevant factors.

This Court's decision is based on the evaluation of Dr. Duke's methods and practices in conducting a Rule 35 examination, and is also based on, but not limited to, the following factors:

1. Dr. Duke Failed to Demonstrate How He Could Reliably Apply The BPS Model of Healthcare to Forensic/Causation Rule 35 Examinations.

Dr. Duke testified that he utilizes the biopsychosocial model of healthcare ("BPS model") in both his private practice and his Rule 35 examinations. Dr. Duke states that he treats his patients using a "whole body perspective," and that he believes it is important for him to understand how his patient's other health issues and other social factors might be contributing to the patient's condition.

In a Rule 35 examination, Dr. Duke sees a plaintiff one time, for 30-40 minutes. He rarely, if ever, is provided with the plaintiff's entire medical history, and he is not permitted to discuss the plaintiff's condition with his or her treating physicians. As a Rule 35 Examiner, Dr. Duke does not have a physician/patient relationship with the plaintiff, cannot refer the plaintiff for further testing, and cannot devise alternative treatment plans for the plaintiff going forward. Unlike his own patients who see Dr. Duke by choice, a personal injury plaintiff presenting for a Rule 35 exam is ordered by the Court to submit to a physical examination by Dr. Duke – a physician they do not know and did not chose. Dr. Duke testified that he does not permit anyone else (besides his staff) in the examination room. Such conditions could inevitably result in some level of discomfort, distrust, unfamiliarity or apprehension on the part of examinee. During this evidentiary hearing, Dr. Duke failed to articulate precisely how he could reliably apply the BPS model of healthcare to a causation analysis given the constraints and limitations inherent to a Rule 35 examination.

Further, Dr. Duke is not a psychologist and does not administer any psychological testing during his exams. Nonetheless, Dr. Duke ultimately confirmed that he believes a Rule 35 examination is the proper setting for the application of the BPS model of healthcare- despite the fact that clear limitations and restrictions placed on such examinations may impede his assessment of a patient's psychosocial factors and the impact on their pain complaints. The Court notes that Dr. Duke even acknowledged that the limitations of a Rule 35 examination could impede his application of the BPS model. Dr. Duke's attempt to import the BPS model of healthcare into his forensic work results in discussions of "potential" social and psychological factors that could "possibly" be causing or contributing to the patient's pain. Dr. Duke does not actually determine exactly how, *or even if*, such factors are actually relevant or contributing to the patient's complaints in a specific case. Without the appropriate time and information

necessary to fairly address the "whole person," Dr. Duke's examinations result in highly speculative and prejudicial opinions that unfairly cast doubts about the veracity of claims by personal injury plaintiffs without a sufficient foundation for such opinions.

2. Dr. Duke's Reliance on The "AMA Guidelines" in Conducting a Forensic/Causation Rule 35 Examination Results in an Unreliable Methodology.

The Court also finds that Dr. Duke gives great weight to certain AMA Guidelines Newsletters in conducting his forensic injury/causation Rule 35 examinations. Although Defendants produced evidence that the AMA Guides Newsletters were peer reviewed, the Court was not provided any information about what that peer review process entails. Regardless, the Newsletters appear to be largely based upon opinions and testimony by author Robert Barth, PhD. The Court finds these Guidelines to be woefully unreliable, misleading both in law and fact, and not based upon proper scientific methods.

Dr. Duke discussed in great detail the steps set forth in the lengthy May/June 2012 AMA Guides Newsletter authored by Dr. Robert Barth. Dr. Duke testified that the information in the May/June 2012 AMA Guides Newsletter summarizes how he uses the BPS model during his treatment of patients or during Rule 35 exams. Dr. Duke testified the AMA Guidelines were the "gold standard" for determining causation, and are an authoritative source for physicians for understanding how to utilize the AMA *Causation* book in their forensic work. Dr. Duke also touted the author Dr. Barth as "a giant" in the field.[2]

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[2] Plaintiff presented evidence regarding the AMA and its active agenda to promote tort reform on a state and federal level. As part of those efforts the AMA has taken steps to limit non-economic damages, to advocate for screening panels for medical malpractice cases, and to limit the ability of treating physicians to give causation opinions. Accordingly, the AMA is not a "neutral" organization with regard to legislative policies related to litigation affecting the court system.

Dr. Duke's reliance on Dr. Barth's approach on how to utilize the AMA Guides, as reflected in the AMA Guides Newsletter is troubling to the Court because Dr. Barth is not a medical doctor, he does not see patients in a clinical setting, and, like Dr. Duke, he is hired by the defense as an expert in at least 95% of his cases.[3] A close review of the Guides Newsletters authored by Dr. Barth demonstrates a general bias against plaintiffs and the court system in general. Dr. Barth encourages physicians not to cooperate with the court system and to combat what he believes to be the "anti-fact" bias of the court system. Dr. Barth touts the Causation Guides as being "especially notable for the powerful manner in which it directs doctors away from the anti-fact bias that is inherent in court and administrative systems."

For example, Dr. Barth states in his Chapter 16 in *Causation* that he does not believe that a plaintiff claiming a mental illness-related injury will ever be able to establish causation in the legal setting.

> In an effort to leave no ambiguity, this chapter's author and contributors endorse the following statement: All of the issues discussed above have left a very strong impression that the scientific knowledge base is so flawed that it cannot be credibly used to justify any claim of causation for any mental illness.

Causation at p.498.

This is important, because in the May/June 2012 Guides Newsletter authored by Dr. Barth, he encourages physicians to apply his methodology to "All types of Medical-Legal Claims"- not just claims of mental injury to forensic injury/causation Rule 35 examinations. In the 2013 AMA Guides Newsletter, upon which Dr. Duke also relies, Dr. Barth appears to encourage physicians to apply his methodology to establish that it is not possible to determine the cause of chronic pain in the litigation setting (suggested chronic pain should be treated as a

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[3] Dr. Duke testified that he served as defense expert in 95% of his medicolegal work, and that he had made approximately $1 million per year providing expert testimony. See 7/8/16 Hr. Tr. at 187: 3-10; 190:11-21.

purely psychological issue). Given such views, it is unsurprising that other Courts have excluded Dr. Barth as an expert on the grounds that he is not credible and biased against injured claimants.

Based on his testimony, Dr. Duke appears to have adopted Dr. Barth's methodology and that is reflected in his reports which do not establish causation in an overwhelming percentage of cases. Dr. Duke's testimony strongly suggests his resistance to finding causation when he told the Court that "nothing is fully known" with regard to the spine because it is a "gray thing." Finally, when confronted with these criticisms of Dr. Barth, Dr. Duke testified that he still had "no concerns" relying upon Dr. Barth's Methodology,

> So knowing that a court has entered an order [excluding] someone that you considered to be "the giant" in this field of that nature, I'll ask you again: Would you have any concerns about relying on Dr. Barth or authoritative for scientific findings?
>
> A. No.

8/17/16 Tr. at 98:20-25.

Dr. Duke's reliance on the opinions and methodology of Dr. Barth who has been excluded from testifying in multiple trial courts across the country as an expert witness, because of bias and lack of credibility, is not only unreliable, but astonishingly unacceptable.

3. Dr. Duke's Application Of The AMA Guidelines And Methodology Results In The Application Of A Causation Standard In A Forensic Injury/Causation Rule 35 Examination That Exceeds Nevada Law.

The protocol advocated by Dr. Barth in the AMA Guidelines Newsletters, as applied by Dr. Duke in his forensic injury/causation Rule 35 examinations, is also irrelevant and unreliable because it subjects injured plaintiffs to a higher standard of causation than is required under Nevada law. In Nevada, a plaintiff need only prove that his or her injuries were more likely than not caused by the subject incident. By following Dr. Barth's protocol, Dr. Duke appears to be

advocating for a more rigorous causation test that plaintiffs, absent an acute or obvious injury, will rarely be expected to pass. Dr. Duke testified that he applies the methodology set forth in AMA Guidelines Newsletters which requires a "definitive diagnosis" of injury and at times requires "an unusually high rigor of scrutiny." This methodology also assumes that injured plaintiffs give false information in nearly 100% of cases,

> Evaluators should note the scientific findings, which indicated an approximate rate of 100% of examinee-reported histories being false when the examinee was blaming someone else for his or her health complaints."

May/June 2012 AMA Guidelines, *Id* at. p. 9.[4]

Dr. Duke introduced the May/June 2012 AMA Guides Newsletters into this proceeding, and testified that it was "authoritative," and that he followed the described protocol when conducting his Rule 35 examinations. This Newsletter, authored by Dr. Barth, appears to encourage medical legal experts to defy the legal standard of causation and adhere to the medical standard - which Dr. Barth argues will never be satisfied during litigation,

> By using this protocol, evaluators can demonstrate their allegiance to, and adherence to, the scientific tradition of professional health care and **can demonstrate and justify their resistance to the anti-fact bias of the court and administrative systems**.

May/June 2012 Guides Newsletter, at p. 5.

By adopting this methodology, Dr. Duke subjects plaintiffs to a higher causation standard than that required under Nevada law, and the summary of opinions prepared by Plaintiff generally reflects the skewed opinions that result from application of this methodology. Defendants argue that Dr. Duke has found some type of injury in a high percentage of cases, however, with the exception of a handful of acute injury cases, Dr. Duke has consistently found the claimed injury to be nothing more than a soft tissue injury (sprain/strain) even though the

[4] In the Newsletter, Dr. Barth cites to himself for this finding. Id. at fn.8.

claimant and the treating physicians were claiming a more serious injury. As a result of his flawed methodology, Dr. Duke's reports and opinions fail to apply the legal causation standards under Nevada law, and therefore provide no assistance under *Hallmark*.

4. Dr. Duke Does Not Follow the AMA Guidelines Resulting in Opinions that Are Unreliable.

Regardless of whether the AMA Guidelines themselves are biased against personal injury plaintiffs or are otherwise inconsistent with Nevada law related to causation, the manner in which Dr. Duke applies them is unscientific and unreliable.

a. Dr. Duke's Injury/Causation Opinions Are Untestable Because He Fails To Cite to Scientific or Epidemiological Data.

Step two of the Dr. Barth's protocol, as explained in the AMA Guidelines Newsletter, charges evaluators to apply scientific findings and epidemiological data to the case at hand. Indeed, the Chapter on "Report Writing" in the *Causation* Guides even states that,

> "**In the discussion of causation, scientifically referenced reports are preferred. In addition to the contents of the problematic report described above, the evidence-based report will discuss the available medical literature on causation**, the presence or absence of other risk factors or injuries and the mathematical likelihood that the exposure is related to the illness or injury in question.

See *Causation* at p.181 (emphasis added).

The Court notes that Dr. Duke's reports do not contain any references to specific studies, epidemiological data or other scientific findings that he relies upon in support of his opinions. Indeed, throughout the hearing, Dr. Duke was often unable to cite to specific articles or scientific journals to support his opinions – even when asked by the Court. Dr. Duke did not appear to have "working knowledge" of the precise studies or empirical data he relies upon to support his analysis. As a result of Dr. Duke's vague and non-specific references to "scientific literature" the Court at times had difficulty determining whether he was simply unable to provide the source of certain data, or whether such data existed at all. By withholding this information, Dr. Duke

makes it overly burdensome for a plaintiff or plaintiff's expert to evaluate his opinions without the need for further inquiry and clarification.

b. Dr. Duke's Generic Use Of Term "Risk Factors" In His Injury/Causation Rule 35 Expert Reports Creates Confusion, and He Never Clarifies The Important Distinction Between "Ruling Out" Or "Ruling In" The Likely Cause Of Injury.

One of the most troubling parts of Dr. Duke's methodology is his testimony that he engages in a clear analysis of a patient's "risk factors." In the 2012 AMA Newsletter, Dr. Barth states,

> In order for a causation conclusion to be credible, the process of creating that conclusion must have included comprehensive consideration of the epidemiological scientific findings for the definitively established diagnosis, determination of risk factors for the diagnosis (based on scientific findings), determination of which of the risk factors apply to the case at hand (which ones are relevant), and determination of which relevant risk factors are of greatest significance for the diagnosis in general and for this case in particular.

Id. at p. 8.

The Chapter regarding "Report Writing" in *Causation* also states that evaluators should include "the presence or absence of other risk factors or injuries, the mathematical likelihood that the exposure is related to the illness or injury in question." *Causation* at p. 181 (emphasis added). Throughout his testimony, Dr. Duke repeatedly states that his methodology includes an examination of various "risk factors" wherein he analyzes the "dominant risk factor" related to the plaintiff's pain complaints and/or claimed injury. This Court, however, has reviewed nearly 400 reports written by Dr. Duke and notes that Dr. Duke does not appear to use the term "risk factor" or "dominant risk factor" in any of those reports. Further, Dr. Duke did not provide clear testimony during the evidentiary hearing with regard to what a dominant risk factor is, or where someone reading his report can locate his analysis related to any dominant risk factor. He also fails to include any clear analysis of the magnitude of exposure, duration, timing, statistical significance or likelihood that one or more risk factors is specifically impacting the patient at

hand, or to what degree the risk factor is causing or contributing to the patient's claimed injury. When Dr. Duke lists the same "risk factors" over and over in his reports, he never articulates whether such risk factors are actually contributing or causing a patient's condition. Because Dr. Duke does not cite to any scientific literature to support his conclusions, the finder of fact is left not knowing how to apply this information to the case at hand.

Ultimately, Dr. Duke did not present to the Court any reliable or testable methodology that he uses when he decides to include references to certain risk factors besides generically stating that he makes the decision "internally" or based on "training, experience and the facts of that case." See 9/8/16 Hr. Tr. at 67:9-18.

Although Defendants suggest that Dr. Duke's "risk factor" opinions are somehow admissible as other plausible causes under the lower standard discussed in *Williams v. Eighth Judicial Dist. Court of Nev.*, 127 Nev. 518, 262 P.3d 360 (2011), other plausible causes are not even evaluated under *Williams* until such causes satisfy *Hallmark* and are demonstrated to be relevant to the condition of the subject plaintiff. Dr. Duke's opinion is impossible to evaluate because his analysis is not clearly identifiable, and conclusions appear to be based on speculation. As a result of this unscientific and unreliable approach, Dr. Duke's resulting reports often set forth nothing but a general "possibility" that certain risk factors might be impacting pain. Dr. Duke also does not appear to appreciate that his discussions of such possible "risk factors" often cast the plaintiff in a negative light or calls in question the legitimacy of their claimed injury. Such opinions therefore not only fail to assist the Court (or the jury) in analyzing causation, but are more prejudicial than probative.

c. Dr. Duke's Reports and Opinions are Littered With Personal Observations and Imprecise Language.

The Court is further troubled by Dr. Duke's repeated inclusion of his own "observations," "statements," and "considerations" in the same "Discussion" section of his report where he purportedly includes his risk factor analysis.

> **Q. Okay. That's your opinion, right?**
> **A. That's my observation.**
> Q. This is -- these are your words, right?
> A. Yes.
> Q. Your conclusion from your report, correct?
> A. It's in that -- it's in the Discussion section.
> Q. That's where you put your conclusions in your report, isn't it, Doctor?
> A. It's the Discussion Section.
> Q. Every one of your reports, the Discussion section is where you put your opinions, correct?
> A. I'm putting my discussion and observations there and --
> Q. And that's where your opinions are, right, Doctor?
> A. In Observations and --
> Q. And your opinions, correct?
> A. This is my observations.
> **Q. Do you have a separate section that says Conclusions and Opinions in your reports? You don't, do you?**
> **A. There's one section called Discussion.**
> **Q. And it's -- and it gives your opinions and now what you're claiming are observations, right?**
> **A. That's my observation.**

8/9/16 Hr. Tr. at 29:4-30:13 (emphasis added).

> Q. Well, let's look at what you said here. "Opiate dependence is a strong motivator for secondary gain behavior which can occur on either a subconscious or conscious basis and is known to significantly affect one's report of pain complaints."
>
> A. Yes.
>
> Q. And you said that in -- with regard to your opinions in this case about this patient, right?
>
> **A. Well, it's a general statement. It's -- I'm not saying that they're motivating him. No, I'm not saying that.**

Id., at 232:20-233:7.

Because he does not use the term "risk factor" in his analysis, it is often impossible to tell the difference between a "risk factor," "observation," "statement," or "consideration." Further, because such observations are personal to Dr. Duke, they are not subject to medical or scientific evaluation. It is likely for that reason the AMA *Causation* Guides has stated that expert opinions are problematic when based upon "personal experience" or "anecdotes,"

> In the discussion of causation, problematic reports are those that state medical facts (history, exam, and tests), the diagnosis, and the physician's opinion or conclusion, with the conclusion apparently based upon "my years of experience." **This is anecdote**.

Causation at p. 181.

The Court is also perplexed by Dr. Duke's decision to include these personal observations or statements in his report,

> Q. So -- so this is something you consider in your opinions and discussion, what -- when the plaintiff hired an attorney, right?
> A. No.
> Q. Okay.
> THE COURT: Then why is it in the report?
> **THE WITNESS: Well, again, this is just a statement that oftentimes whenever I see this, I -- early referral, I see this pattern of care. That's -- that's all I'm saying is that I've seen this pattern in the past. It didn't -- it didn't affect my opinion as to causation in these cases. Just a pattern that I see oftentimes.**

7/18/16 Hr. Tr. at 64:12-25.

Another reason Dr. Duke's personal observations and considerations are problematic is because he regularly couches them in imprecise terms without providing any consistent context to their meaning. Because Dr. Duke's personal observations are personal to him, they cannot be fully understood, challenged or evaluated. The Court notes that Dr. Duke's reports repeatedly describe the frequency of his experiences with vague terms such as "oftentimes," "time to time" or "quite frequently," without any specific number, percentage, or specific meaning that can be attributed or measured report to report.

Q. If I ask you, Well, what would -- if you did something from time to time out of 371 reports, what would be your estimate of time to time, you would have no estimate; is that correct?
A. It's a vague, you know, measure.
Q. Your statement "time to time" is a vague statement, right?
A. Yeah, that's right. Because I don't have the number.
Q. So when you say "time to time," you really have no idea how many times you've done that out of your reports, right?
A. I don't know a number.

8/8/16 Hr. Tr. at 46:8-20 (emphasis added).

Q. If you had written here "medical providers oftentimes have significant financial incentives to perform these medical services," what do you mean by using the phrase "oftentimes"? Does that mean more than 50 percent of the time? less than 50 percent of the time? two out of ten? eight out of 10? What does that mean to you?
A. It doesn't mean any of those.
Q. It doesn't mean anything to you?
A. No. It means something, but not those things.
Q. Well, what does it mean? Tell me what it means. When you use the phrase "oftentimes," what does that mean to you?
A. I don't have a definition other than oftentimes is what it is.

Id. at 53:11-25 (emphasis added).

Q. How is someone supposed to know what you mean -- when they're reading your report what you mean by "quite frequently"?
A. I assume they know what the English language means. I didn't define the word "and" or "the" for them either.

See 8/8/16 Hr. Tr. at 66:14-19.

Dr. Duke eventually confirmed that the meaning of these words could change from "day to day,"

THE COURT: Doctor, please just try to answer if you can. And listen. I think that's what's what's causing us over talk.

Q. Doctor, if you change your interpretation as you've just told us if you change your interpretation of the definition of words that you use in your reports, frequently, and you change -- and you just tell us well those definition and change from time to time with you, how is someone, whether it's a lawyer, a judge, or a lay person reading your reports have to -- be able to understand what you're saying if your definition in your mind change these words change from day to day how are they supposed to do that?

> A. Definitions -- the definitions don't change. The words that you use to describe them could change. **I could say on one day if you asked me what a word means, a certain set of words, and another day I could say a different set of words.** The concept of what it represents is specific to the setting in which the word was used and- and- and- and so that's very important. But the concept that it relays does in the change.

See 8/9/16 Hr. Tr. at 37:4-38:1. (emphasis added).

Dr. Duke's repeated reliance on personal observations and anecdotes is problematic. Dr. Duke's "observations" and "statements" lack scientific foundation under *Hallmark* because they are not medical opinions, but are merely personal to him and "things he's seen" or "things he heard." Coupled with his use of such imprecise language, the use of such anecdotes create a significant threat of prejudice when considered by a jury. If "many" means anywhere "between 3 or an unlimited number," as Dr. Duke suggested, then different jurors will attach their own definition to the term potentially placing greater import on Dr. Duke's observations than he even intended. Because different people attach vastly different opinions about the meaning of Dr. Duke's words, and because Dr. Duke himself uses different definitions for the words he uses in his reports from one day to the next, such opinions do not assist the trier of fact.

B. <u>Dr. Duke's Methodology Also Fails to Meet the Limited Scope Requirement of *Hallmark*.</u>

1. Dr. Duke Exceeds the Scope of His Qualifications When He Offers Opinions On Malingering, Secondary Gain, Depression and Anxiety Without A Proper Neuropsychological Workup.

The third prong of *Hallmark* requires that the expert's "testimony must be limited to matters within the scope of his or her specialized knowledge." The record in this case also establishes that Dr. Duke repeatedly offers opinions that exceed the scope of his specialized knowledge, and exceed his role as a Rule 35 Examiner.

The BPS model that Dr. Duke adheres to is heavily dependent upon a thorough analysis of psychological factors. It is evident from his testimony and from reviewing his reports, that

Dr. Duke frequently exceeds the scope of his qualifications as a spine surgeon when rendering opinions with regard to psychological issues such as malingering, secondary gain, depression, and anxiety. The Court notes that on the very first day of his testimony, Dr. Duke informed the Court of his ability to diagnose and treat depression and anxiety without the need for neuropsychometric testing, and often merely by talking with them. See 7/8/16 Hr. Tr. at 35:4-36:16.

Dr. Duke is not a psychologist, and he does not use the DSM in his practice. He does not administer neuropsychological testing. Dr. Duke testified that he only includes a diagnosis of anxiety or depression in a medical legal report when another treating physician has already made the diagnosis, however, Dr. Duke's reports and prior deposition testimony demonstrate otherwise. The Court reviewed multiple reports where Dr. Duke relied upon a patient's self-reporting of depression and anxiety, which in some instances occurred a substantial amount of time before the subject incident. In one report Dr. Duke relied solely on the patient's self-reporting of a specific 6 month period of depression (after his father died). Despite having no current diagnosis and no information regarding the prior diagnosis of depression, Dr. Duke report included a current diagnosis of depression in his report, and suggested the plaintiff was depressed from (1) being "misinformed" of his medical condition by his treating physician; and (2) by the mere fact this patient was involved in litigation,

> Q. So you were suggesting here that Dr. Prater's diagnosis is causing this patient's depression?
> A. I -- I can't gather that from -- from this.
> **Q. You are speculating that Dr. Prater's diagnosis could lead to concern by this patient and that such concern could lead to depression, right?**
> **A. Possibly.**
> Q. Okay. But you really don't know either way if Dr. Prater's diagnosis had any psychological impact on this patient at all, right?
> A. Not as I sit here today, no.

9/8/16 at 22:63-23:16, at 25:6-12; see also D-000528 (emphasis added).

In another case, Dr. Duke included a non-accident related diagnosis of "Possible psychological factors affecting his general medical condition" for a plaintiff with no history of mental health issues. Dr. Duke made this conclusion based upon the person's "affect" during the Rule 35 examination. Dr. Duke, however, never even described the affect in the physical examination section of his report. See Report D-001447. Once again, this diagnosis was included without any review of any mental health records or prior diagnoses of anxiety or depression.

Dr. Duke is not qualified to diagnose anxiety or depression, and he should not speculate as to their "possible" impact on a plaintiff's condition. Such opinions lack foundation, are not reliable, and are more prejudicial than probative. Indeed, the frequency of Dr. Duke's improper discussions of psychological issues is reflected by the fact that he includes such discussions in 43.4% percent of his reports. This is despite the fact that Dr. Duke testified that he finds anxiety and depression in only 10% of his own patients - consistent with the general population. See 7/8/16 Hr. Tr. at 61:22-62:1.

2. Dr. Duke Exceeds The Scope of Rule Examiner When He Inquires Into Matters Irrelevant to a Rule 35 Examination.

The record in this case demonstrates that Dr. Duke frequently goes beyond the scope of a Rule 35 Examiner, and the Court finds that there was sufficient evidence produced during the hearing that established that Dr. Duke truly failed to understand his role as a Rule 35 Examiner. Instead of conducting a straight-forward injury/causation analysis, Dr. Duke frequently detoured into the realm of advocacy by conducting "defacto depositions" and discovery.

Based upon evidence produced at the hearing, Dr. Duke attempts to treat patients, openly disagrees with their current treatment plan, and often counsels them regarding what changes he believes should be made to their treatment plan. Dr. Duke testified that he often includes

opinions about "possible" treatment considerations that do not rise to a reasonable degree of medical probability, simply because he wants to educate the examinee's treating physicians or to assist in the examinee's future, unknown treatment plan.

Regardless of whether Dr. Duke is motivated by the best interests of the patient or by some other self-interest, his role as a Rule 35 Examiner is simply to evaluate whether the injury in controversy was related to the subject incident. A Rule 35 Examiner's role is not to insert himself into the patient's ongoing medical treatment, to advise the patient to disregard his or her treating physician's instructions, or to counsel the patient about what he believes is the proper treatment plan.

Dr. Duke also frequently inquires into matters regarding litigation, including when the plaintiff hired an attorney and whether the plaintiff is treating on liens. Dr. Duke should never question an examinee on when he or she retained a lawyer, as such information is not relevant to a forensic injury/causation Rule 35 examination. He certainly should not comment on the ongoing litigation and weigh in on what he believes to be the weaknesses of the plaintiff's case.

The Court is particularly concerned with the audio recording of the Ribera Rule 35 examination. Although Dr. Duke believed the audio to be incomplete, he acknowledged that it was his voice on the recording, and that he had heard the Ribera recording before this hearing. Dr. Duke also testified that he had no reason to believe that his examination of Mr. Ribera deviated from his typical Rule 35 examination. See 7/8/26 Hr. Tr. at 222:17-20. In that exam, Dr. Duke essentially argued with Mr. Ribera, told him that even a 60 mph crash would not cause the need for back surgery, told him that the need for back surgery is known within 10 minutes of an incident, and that 99 percent of people who have back surgery are not in motor vehicle crashes. See Ribera Transcript at 29:1-25.

The Court is concerned that Dr. Duke conducted a "de facto deposition" of Mr. Ribera. This is troubling because plaintiffs ordered to undergo such examinations are allegedly injured, are vulnerable, and are subjecting themselves to a stranger for medical exam under court order. The most troubling thing about this Rule 35 examiner conducting a "de facto deposition," is that it is done with none of the safeguards of an actual deposition. These plaintiffs are forced to appear with no witnesses and no legal representation. There is no court reporter and there is no record of what questions are asked or what the answers were. Discussions such as those on the Ribera recording could also be construed as unauthorized communications with a represented party - which is highly inappropriate. Moreover, Dr. Duke's Report becomes the "record" of what occurred during the examination, and its Dr. Duke's word against the plaintiff's if there is a disagreement as to what actually occurred during the exam. Any such dispute could result in tremendous prejudice to the Plaintiff. As the Court in *White v. State Farm Mut. Auto. Ins.* Co., 680 So. 2d 1 (La.App. 3 Cir. 1996) noted,

> More importantly, in instances where the basis of an expert opinion (whether iterated by a charlatan or a prince) is beyond the common knowledge of the jury, the jury can be deprived of the ability to objectively and rationally evaluate the merit of the expert's opinion. It is precisely in such instances that a retained expert's 'apparent objectivity' can carry 'undue weight' with the jury. (citations omitted).
>
> Thus, precautions must be taken lest a retained expert's testimony, **'dressed up and sanctified as the opinion of an expert,' be permitted to unduly influence the jury.** These precautions include enabling parties litigant to discover an expert's bias by discovery or subpoena, to present evidence of such bias to the trier of fact ***and, in extreme cases, to have the expert's testimony declared inadmissible***

680 So.2d at 13. (emphasis in original)

A look at the entirety of the examination reveals even more evidence that Dr. Duke exceeds the scope of his role as a Rule 35 examiner. Dr. Duke appears to attempt to provide

legal advice to Mr. Ribera by discussing what he views to be "red flags" or problems with Mr. Ribera's lawsuit,

> DR. DUKE: The -- you know, the---I think part of your -- the issue too with your case that's difficult is that -- you know, you were seen for a lifting injury at (unintelligible)---at home, you know, right after the car wreck... you know the history changed, and I think that's what's got a red flag raised on your case. And so---and then to -- you know, it makes it very difficult, you know -- these kinds of things, because it's hard to go back and undo and erase the -- the medical record, which says what is say, you know.

Id. at 21:17-22:11.

Dr. Duke then suggests to Mr. Ribera that he should use his insurance because, presumably, he is going to lose his lawsuit. Id. at 22:12-16.

Although at one point during the hearing Dr. Duke expressed some general regret about his examination of Mr. Ribera, he ultimately refused to indicate exactly what he would change about his examination,

> Q. Well, if you would do it differently, which parts would you do differently?
> A. I don't know.
> Q. Okay. So you think you would do something differently, but you can't tell us what you would do differently; is that correct?
> A. Not as I sit here today.

See 8/17/16 Hr. Tr. at 128:2-8.

Finally, the Court is concerned that Dr. Duke frequently uses his reports to engage in unnecessary attacks against the Rule 35 examinee's treating physicians. In the reports reviewed by the Court, there are various irrelevant opinions regarding local providers, including: (1) that "The reputation of Las Vegas spine surgeons nationally is quite poor," and the treating physician's recommendations "represent ample evidence to support this reputation."; (2) that a treating physician was "blatantly pandering to those seeking to inflate the economic value of litigation."; (3) that local providers purposely "drive up" the economic value of cases; and (4) that local providers were part of a "ring" or engaging in a conspiracy.

Indeed, in one report, Dr. Duke describes a provider as being "overtly unethical" and described his reports as, "lack[ing] professionalism" and being, "without medical basis, unprofessional, and likely serve to damage [Patient] psychologically by indicating to him he has a multitude of injuries and diagnoses that are not present. Presenting this false information to the patient could have very serious negative psychological consequences." After discussing this specific opinion, Dr. Duke confirmed that he found nothing wrong with using this type of language in his reports,

> Q. Okay. All right. So accepting that from the Court as what a Rule 35 examination, do you believe the language you used about Dr. Gross in this report was appropriate for a Rule 35 report?
> A. Yes.

See 8/17/16 Hr. Tr. at 159:15-20.

On at least one occasion, it also appears that Dr. Duke used his position as a Rule 35 Examiner to obtain information used to file a complaint with the National Association of Spine Surgeons (NASS) alleging malpractice against his former business partner. Although this Complaint was later dismissed as lacking merit, a Rule 35 examination should never be used as a vehicle to settle a score with an ex-partner as the record has established in the instant action. Such conduct by Dr. Duke strongly suggests a lack of objectivity in his analysis of an injured claimant, and also evidences an escalation in Dr. Duke's attacks against local physicians who treat personal injury patients.

These types of inflammatory opinions regarding treating physicians, litigation, and personal injury attorneys, are similar to the inflammatory opinions the *White* Court found to evidence "extreme bias." As an experienced medical expert, Dr. Duke should be fully capable of setting forth his medical opinion without the need to hurl insults at providers he disagrees with or dislikes. Dr. Duke appears to lack objectivity when it comes to assessing the diagnoses of other providers if different than his, and the language Dr. Duke uses to discuss treating physicians that

could potentially inflame a jury thereby resulting in undue prejudice against a plaintiff.[5]

C. **Dr. Duke Often Formulates His Medical Conclusions Without A Rule 35 Examination.**

Just as an Alabama Court found with Dr. Barth, Dr. Duke appears to develop his causation opinion without the need to conduct a Rule 35 examination. Dr. Duke appears to make his diagnosis after reviewing the available diagnostic imaging, and then spends the majority of his report discussing speculative and unquantified "potential" risk factors that might (or might not) be causing the patients pain.

Dr. Duke has testified that he can typically tell if an injury was traumatically induced just by looking at an MRI. See 7/8/16 at 46:17-23. He also testified that he sometimes spends only a "couple of minutes" on a physical exam. Id. at 282:8-11. Based on the reports reviewed by the Court, Dr. Duke does not appear to place much reliance on the results of the physical exam, and the physical examination portion of the reports is typically the least detailed, and contains very little commentary beyond scoring range of motion. After a review of nearly 400 reports by Dr. Duke, absent an acute and obvious injury apparent on an MRI, the Rule 35 examination appears to be a mere formality that only provides Dr. Duke with further opportunity to obtain information from plaintiffs, who are present without counsel or witnesses, to provide additional support to his preconceived opinions.

D. **Dr. Duke's Reports Themselves Are Unreliable.**

The Court also finds that the procedures Dr. Duke utilizes in the preparation of his expert reports are unreliable. Dr. Duke's reports are often produced without his review, contain transcription errors, and he fails to follow the safeguards of accuracy required by the AMA

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[5] Although Defendants argued that expert reports are not admissible, and therefore the inflammatory language would likely be excluded from trial, Dr. Duke should not include language in his reports that he should know is improper, and plaintiffs should not have to expend valuable time and resources repeatedly challenging such improper opinions.

Guide to the Evaluation of Disease and Injury Causation (July 26, 2013). Dr. Duke testified as follows,

> Q. Okay. Want to go back a little bit on the record to see the process. When you generate a report, how is that done within your office?
>
> A. I dictate the audio. It's then sent to a transcriptionist. We have several transcriptionists. They then transcribe the report. It's sent to my secretary. And most oftentimes, I tell her to send the reports, to send the report. Sometimes I review the report. And that's how it gets sent out.
>
> Q. Have any of your reports ever been sent out with errors in them?
>
> A. Sure.

See 7/8/16 Hr. Tr. at 74:22-75:9.

Dr. Duke testified that he sends out reports without reading them (and allows his office to stamp his signature) despite the fact that transcription errors could negatively affect or unfairly affect an injured party,

> Q. Okay. That doesn't answer my question. It is important that you read these reports to make sure there are no transcription errors that could negatively affect or unfairly affect an injured party before these reports are sent out, right, Doctor? That's important.
> A. It can be important.
> Q. Okay. And you don't do that, do you?
> A. Not always.
> Q. In fact, you talked to us a week and a half ago when you talked about some of your reports, and you said, Well, that's my -- that's my stamp signature right?
>
> A. Correct.
> Q. So most of the time you don't read these reports before they go out after they've been transcribed. You just have your office stamp your signature, right?
> A. No, I wouldn't say most.
> Q. Many times, right?
> A. I -- you could say many.
> Q. Many. Okay.

Id. at 7/18/16 Hr. Tr. at 53:9-54:15.

The Court also reviewed two audio recordings of claimants who assert that Dr. Duke did not accurately represent what occurred during the examination. On at least one occasion, Dr.

Duke expressed that he was "fortunate" to be able to locate the original audio file of his transcription (which he typically does not save) evidencing that a patient was correct about a major error in a report produced by Dr. Duke. See 9/9/16 Hr. Tr. at 77:2-12. Specifically, Dr. Duke's report stated a patient had reported pain in the years before the accident, when she had said the opposite.

Expert opinions can potentially make the difference as to whether a plaintiff receives compensation for his or her claim. For that reason, NRCP 16.1 (a)(2)(B) requires that an expert report be "prepared and signed" by the witness. Id. Such a rule is designed to ensure the final report is actually reviewed by the physician (who must then sign it) - as opposed to Dr. Duke's practice of allowing his office to stamp his name on a transcription without final review.

Accordingly, and notwithstanding this court's finding that Dr. Duke's Rule 35 examination practices fail to meet the assistance requirement under *Hallmark* and NRS 50.275, the court is concerned that he is not a reliable historian based on evidence establishing that Dr. Duke inaccurately recorded discussions with a Rule 35 examinee. There should never be a factual dispute as to what was discussed between a Rule 35 physician and the examinee. However, when there is a factual dispute regarding what was said during a Rule 35 examination, and because of conflict created by the physician's poor record keeping, whether intentional or not, this results in the expansion of Rule 35 examination beyond injury/causation analysis and it becomes a litigation tool to attack the credibility of the Rule 35 examinee.

This same concern applies to allegations of secondary gain/malingering by Dr. Duke. This is of grave concern to the Court because when physicians testify before a jury they are cloaked with the perception of trustworthiness and believability which is difficult to overcome. This perception is elevated under the backdrop of an independent medical examination and places an additional evidentiary burden on the Rule 35 examinee that is collateral to the salient

facts of the case and contrary to the purpose of a Rule 35 examination - which is to conduct an injury/causation analysis.

The Court is therefore concerned about Dr. Duke's reporting practices because of the potential a jury will be highly likely to believe Dr. Duke, and not the plaintiff, given a disagreement about what actually occurred during the examination. Dr. Duke has demonstrated a lack of care or concern that his reports are complete or even accurate, and he testified that he has no intent to change his practices.

Near the end of the hearing, counsel for Plaintiff gave Dr. Duke a full opportunity to explain anything he might change in the way he conducts his Rule 35 examinations or prepares his reports, and he could not think of anything,

> Q. After going through these numerous days of examination, Doctor, is there anything you would change about the way you conduct your Rule 35 examinations or write your reports?
> A. I can't point to anything specifically, but I'm sure everything in life has some impact on what you do.
> Q. As we sit here today, you cannot tell us that you would in any way change the way you conduct your Rule 35 examinations or the way you write your reports. Is that a fair statement?
> A. Not precisely, but again some language I certainly would probably change. But I can't point to anything specifically.
> Q. As we sit here you can't tell us anything you would change, correct?
> A. Well, not specifically.
> Q. Well, that is the question.
> A. I know. And I'm answering it.
> Q. Okay. Thank you.

See 9/9/16 Hr. Tr. at 137:2-21.

Based on the foregoing, the court hereby affirms the Decision of Discovery Commissioner Bulla. In addition, based on the totality of the evidence produced at the evidentiary hearing, the Court expands the decision to preclude Dr. Duke from performing a Rule 35 examination based on a history of personal bias as to some treating physicians and

extreme bias resulting in prejudice against personal injury plaintiffs.

Lastly, Dr. Duke shall be excluded from conducting a Rule 35 examination in this matter for the failure to meet the assistance requirement under *Hallmark* and NRS 50.275.

IT IS SO ORDERED.

July 13, 2017.

DISTRICT COURT JUDGE

SUBMITTED BY:	APPROVED BY:
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EGLET PRINCE

EXHIBIT "8"

TRANSCRIPT OF MEDICAL EXAMINATION

Transcribed from

DVD provided by

Richard Johnson, Esq.

Transcribed by: Jennifer A. Clark, RDR, CCR #422

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DR. DUKE: What -- what kind of -- how did you get run in -- or what was the mechanism of the action of the accident?
MR. RIBERA: As -- as far as (unintelligible) --
DR. DUKE: What -- what actually happened during the car wreck?
MR. RIBERA: The -- the vehicle got hit from the side by -- from a vehicle that was coming down going eastbound on Charleston right where the Home Depot there is on Hualapai and Charleston. The inlet that --
DR. DUKE: Uh-huh.
MR. RIBERA: Right where you come out of the parking lot.
DR. DUKE: So the other vehicle got hit, pushed into you --
MR. RIBERA: No. He hit us. We were -- he was blindsided from a vehicle that was turning into the Home Depot parking lot. That's why he was never seen. He was behind him, so he wasn't seen until he was coming out further. And he came and hit the -- hit the -- hit the whole quarter panel side and then spun the whole truck around. And then they deemed it -- they totaled it, I guess.

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DR. DUKE: Did you get knocked out?
MR. RIBERA: Did I get knocked out?
DR. DUKE: Yeah.
MR. RIBERA: No, no.
DR. DUKE: Okay. Did you have a seat belt on?
MR. RIBERA: Did I what?
DR. DUKE: Have a seat belt on?
MR. RIBERA: Yes.
DR. DUKE: Okay. These are just standard questions.
MR. RIBERA: No problem.
DR. DUKE: And did you get taken to the hospital or anything like that?
MR. RIBERA: No.
DR. DUKE: When did you first seek medical attention?
MR. RIBERA: It was a few weeks afterwards is when I first sought medical attention. I thought the pain was just going to go away, and it never did, so that's when I decided to go in when I -- when I couldn't take it no longer.
DR. DUKE: Okay. And now let's -- let's go over -- you -- you had -- you went down to Scottsdale --

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MR. RIBERA: Yes.
DR. DUKE: -- to get some laser spine surgery?
MR. RIBERA: Correct.
DR. DUKE: Which -- which never works.
MR. RIBERA: I had Dr. Flangas say the same thing.
DR. DUKE: We thought about -- we were renaming our office. We were going to rename it to the Laser Spine Institution Correction --
MR. RIBERA: Correction facility.
DR. DUKE: Correction Facility, yeah.
MR. RIBERA: So are you getting a lot of patients back from that?
DR. DUKE: Oh, yeah. Tons.
MR. RIBERA: Do you really? You know, it's funny, 'cause the pain was different when I first went in there. It was -- it was more of a -- it was sharper before the surgery. Like, I mean, I -- well, now I can tolerate sitting down. Before the surgery, I couldn't. I mean, I couldn't sit down more than 15, 20 minutes, and I had to get up. I had to be walking around, and that took the pain away.
DR. DUKE: So what -- what pain were you

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looking to get rid of with laser spine surgery?
MR. RIBERA: Kind of what I'm feeling right now. I thought it was going to be gone completely. I mean, that was (unintelligible) --
DR. DUKE: What exactly are you feeling? I don't know that.
MR. RIBERA: It's kind of a numbness and a burning down right at the tailbone, right -- right at the base, like --
DR. DUKE: In the middle?
MR. RIBERA: Right in that area right in there.
DR. DUKE: Okay. So right in the middle.
MR. RIBERA: Like right down below the -- like, almost like the bottom of the -- the bone. You know, 'cause I guess that's the bottom of your spine right down there.
DR. DUKE: Did you have any leg pain before the laser spine surgery?
MR. RIBERA: No.
DR. DUKE: Did you have any after?
MR. RIBERA: It -- the pain came and went. It -- the left -- the pain in my left leg comes and goes. It doesn't -- it's not there every

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day.
DR. DUKE: When did it start?
MR. RIBERA: It's kind of there every day.
Huh?
DR. DUKE: When did it start?
MR. RIBERA: It started sometime after that, you know. I didn't -- I didn't notice it until I just felt a frequent pain. It was not frequent but just pain that was coming in my left leg, and it would be kind of numbing. And it would last for a week -- it would last anywhere from three or four days to a couple of weeks, and then it would go away.
DR. DUKE: Uh-huh.
MR. RIBERA: And then a month later, it would be back. And to -- you know, you couldn't do this, you couldn't do that and get comfortable. You -- you sit on the couch, elevate it, and just whatever you did --
DR. DUKE: Uh-huh.
MR. RIBERA: -- it wouldn't get -- wouldn't be comfortable. And that's --
DR. DUKE: So the -- the -- the symptoms that you had surgery for at the Laser Spine

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Institute was pain and burning at the base of your spine.
MR. RIBERA: Yes. I didn't notice this until after, and if it was there before, I --
DR. DUKE: How long after?
MR. RIBERA: I can't recall. I -- I really don't -- I really don't know, to be honest with you. You know, like I said, it could have been there before it, and it's still there now and I just never noticed it.
You know, I do have very -- I have -- I have a high tolerance for pain, so when I have pain in my body, I'm usually -- it's at the extreme before I go in.
DR. DUKE: What kind of work do you do?
MR. RIBERA: I'm a serviceman for elevators.
DR. DUKE: Okay. Now, in your -- your -- no neck symptoms, no arm symptoms that you're -- that you're treating for right now; correct?
MR. RIBERA: No arms, but I -- I had a bunch of pain in the back of the neck leading up --
DR. DUKE: Are you relating it to the accident or not? Do you think --

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MR. RIBERA: I think it's attributed to but --
DR. DUKE: Did you make a claim for it, though? Have you sued them for neck symptoms?
MR. RIBERA: Oh, well, just the whole back. I mean, that's part of the back, isn't it?
DR. DUKE: Well, usually people, they sue for their lumbar spine or their cervical spine.
MR. RIBERA: Oh, I mean, I didn't realize -- I mean, I -- I get treatments for that. I get massages for that and stuff like that from -- I've had people come to the house and the entire -- you know, other massage therapists.
DR. DUKE: Let's -- let's go over your --
MR. RIBERA: But -- but not necessarily saying, you know, this is, you know --
DR. DUKE: Okay. Let's go over your current symptoms starting with the most severe.
Number one, what's the most severe symptom you have?
MR. RIBERA: It's -- it's the L4-L5-S1 pain.
DR. DUKE: Let me just -- just tell me what the symptoms are. If you use L4-5, that's a

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diagnosis.
MR. RIBERA: Okay. Well, I just thought from what the doctors say, it's just -- the pain level. Lower back? Is that fair enough?
DR. DUKE: So low back pain.
MR. RIBERA: Yes. That's the more severe.
DR. DUKE: So low back pain is number one. It's kind of like right at the belt line; is that right?
MR. RIBERA: Belt line? No, I think it's below the belt line.
DR. DUKE: Below the belt line.
MR. RIBERA: Yeah.
DR. DUKE: Does it go into the buttocks at all?
MR. RIBERA: Vaguely. I mean, even if -- if it does too much, I really don't notice it 'cause of the -- the spot right at the -- at the base of -- that's where the main burden of the pain is at.
DR. DUKE: So really no buttock pain.
MR. RIBERA: Not really, no.
DR. DUKE: And often do you get the leg pain?

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MR. RIBERA: I would say -- I would say I probably get it once every six weeks to two months, and it lasts for a week or two.
DR. DUKE: What part of the leg does it involve?
MR. RIBERA: What -- only this left leg.
DR. DUKE: (Unintelligible.)
MR. RIBERA: Never the right leg.
DR. DUKE: Pardon me?
MR. RIBERA: It's like right in the -- is this the quad?
DR. DUKE: The top of the thigh?
MR. RIBERA: Yeah, quad area and kind of goes through down here. And then with that at times, I'll get this tingling in my -- I know you guys described as something like needles.
DR. DUKE: Uh-huh.
MR. RIBERA: Pins and needles, that's when I get on -- on -- on the left -- on the left foot area. And then but -- but that that doesn't always come with this. Sometimes this pain is here without that pain. As a matter of fact, when I was out in your lobby waiting, I had the left -- I had the tingling in the left foot.
DR. DUKE: Okay.

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MR. RIBERA: Almost like a numbness, like it's -- almost like it's fallen asleep, but I know -- and I thought that -- there's -- there's no pressure on it. It shouldn't be falling asleep. There's nothing --
DR. DUKE: Okay. Number 2?
MR. RIBERA: That kind of feeling.
DR. DUKE: What's the second most problematic thing? We can -- we can call that 2. What would be number 3?
MR. RIBERA: Okay. The mid back.
DR. DUKE: (Unintelligible.)
MR. RIBERA: And -- and like I said, that's being overshadowed by -- by everything that's happened with the lower back.
DR. DUKE: Okay.
MR. RIBERA: And the neck. I would say that those two things --
DR. DUKE: Okay.
MR. RIBERA: I mean, anytime I move my neck, there's -- I mean, there's -- there's -- it just -- it feels like all the muscles are tight in the neck.
DR. DUKE: What are the --
MR. RIBERA: That's kind of what it

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feels like.
DR. DUKE: What are your -- your current medications include morphine?
MR. RIBERA: Yes.
DR. DUKE: Do you take that every three hours?
MR. RIBERA: Every four to six hours.
DR. DUKE: I mean, that's an outrageous amount. Wow. So --
MR. RIBERA: I probably take about a four a day. So I take one -- and I'm just taking the same thing on Percocet.
DR. DUKE: Who's got you on the drugs?
MR. RIBERA: Dr. Erkulwater.
DR. DUKE: Okay. Wow.
MR. RIBERA: Southern Nevada Pain Center.
DR. DUKE: Do you -- do you know that these are highly, highly addictive?
MR. RIBERA: Uh-huh.
DR. DUKE: How long total have you been on the narcotics?
MR. RIBERA: I switched to the morphine on --
DR. DUKE: Just narcotics in general.

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MR. RIBERA: Oh, shit. From the -- I -- I am going to say since May -- I'm going to say about mid May 2007.
DR. DUKE: Had you ever been on narcotics before?
MR. RIBERA: No, never, never.
DR. DUKE: Never (unintelligible) --
MR. RIBERA: Not that I could remember. I mean, I --
DR. DUKE: (Unintelligible) Long-term use.
MR. RIBERA: Yes, yeah. You know, I'm not a -- I might have gone in for something in the past and I had something that I didn't realize was --
DR. DUKE: Any kind of drug use?
MR. RIBERA: No.
DR. DUKE: Have you ever been through any addictions?
MR. RIBERA: No.
DR. DUKE: Programs?
MR. RIBERA: No (unintelligible).
DR. DUKE: Alcoholism? No alcohol addiction?
MR. RIBERA: No.

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DR. DUKE: And then what about have you ever had a -- you know, a worker's comp claim before?
MR. RIBERA: Worker's comp claim? I don't think so, no.
DR. DUKE: Okay. Yeah, this is just standard stuff.
MR. RIBERA: Yeah, no problem.
DR. DUKE: Just standard stuff.
Any other car wrecks?
MR. RIBERA: I did get in a little fender-bender that I ran -- I ran into a guy ahead of me at a stop light that I -- this is after the accident. It's probably about nine months ago, but it was nothing. It was no --
DR. DUKE: There was (unintelligible) --
MR. RIBERA: -- claim, yeah.
DR. DUKE: Did he claim an injury?
MR. RIBERA: No, no. It was just, like, he didn't even -- you know, it was nothing really -- you know, being honest, you know, to tell you about that, it was just something that I just bumped into the guy on. So yeah, no -- no -- no report was done. He didn't ask for any insurance thing to fix his car or whatever so --

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DR. DUKE: Sure, sure.
MR. RIBERA: You know (unintelligible), you look at the (unintelligible), you see the light's green so you start coasting. Oh, shoot.
DR. DUKE: Right, right.
MR. RIBERA: One of those.
DR. DUKE: Now -- okay. How did you get down to the Laser Spine Institute?
MR. RIBERA: How did I get down?
DR. DUKE: Yeah. I mean, did -- was it -- how were you referred down there?
MR. RIBERA: Oh, oh, oh, oh. Well, a lady at -- a friend of ours, my wife and I, at Choice Center of Las Vegas said that she had surgery from Dr. Perry in Scots -- in Tampa, Florida, and she recommended me just to go take a look at it.
So we did. We did some research online, and I called them up, and they sent me some stuff (unintelligible).
I listened to some of the -- you know, the -- the golfers that are on there. They got the one professional golfer saying, yeah, you know, all his pain went away and all that so -- you know, when you're -- when you're in pain, you're -- you're (unintelligible) to anything at that point to get --

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alleviate the pain and -- and --
DR. DUKE: What -- what percentage of your pain went away with surgery?
MR. RIBERA: It changed. It didn't -- it didn't -- I wouldn't say it went away. It just changed to kind of a --
DR. DUKE: So overall --
MR. RIBERA: Yeah, I would say -- I would say -- well, enough that I can sit down in a chair now and take it for at least an hour before I'm -- I'm -- it's driving me nuts.
DR. DUKE: So would you have done it again? Would you do it again?
MR. RIBERA: Would I do it again? Good question. Knowing what I know right now with the -- with the pain still there, I would say -- I would say no.
I had to pay a lot of money out of my pocket too. That was the screwy thing, 'cause they -- you know, you have to get, you know, med -- what do you call it? Med -- Med Choice. Is that what it's called? Yeah.
DR. DUKE: Yeah. And so --
MR. RIBERA: And a lot of people referred you too, and I just took -- I took another

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route because I didn't hear about you until afterwards (unintelligible). That's how that goes.
DR. DUKE: Let me -- let me check your strength now.
Dr. Flangas is excellent.
MR. RIBERA: Is he?
DR. DUKE: Oh, yeah.
MR. RIBERA: Okay.
DR. DUKE: Let's check your strength out here.
MR. RIBERA: All right.
DR. DUKE: Hold your arms like this real stiff, yeah. Hold it there. Now like this and pull and pull. And push towards me, push, and push. Fingers apart, real far apart, real far apart. Good. Fingers up and pull. And pull.
Then raise up your knees straight up. To the side. Leg straight out like this. Pull your toes back. This side straight out. Pull your toes back. Excellent.
So the strength test is good.
So just any other -- the low back pain, that's really the main thing.
MR. RIBERA: Oh, I'd give anything for it.

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DR. DUKE: Yeah. Do you know that -- how hard it is for your body to get rid of back pain when you're on opiates? Did anybody talk to you about that?
MR. RIBERA: No.
DR. DUKE: It's super hard. And -- and there's a lot of studies that show that being on opiates chronically impairs your body's ability to get rid of aches and pains, low back pain. And there's some studies that suggest that it won't -- that it won't go away once it gets started and you start the opiates.
MR. RIBERA: Why would they --
DR. DUKE: 'Cause it down regulates your opiate receptors. It shuts down your endorphin system.
MR. RIBERA: To heal?
DR. DUKE: Correct.
And it hypersensitizes your body to pain. It also blunts and masks some of the protective things that should be done to help it go away, but since you're on the morphine, those get blocked so you do things you shouldn't do, and then you end up just redamaging it. So it's like shooting up your knee with lidocaine in a -- in a

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football player and having him go out and play anyway, and they end up just wrecking their knee.
MR. RIBERA: Because they don't -- because -- right.
DR. DUKE: They don't feel it.
MR. RIBERA: Because they're not (unintelligible) --
DR. DUKE: Yes.
MR. RIBERA: -- major injury because they don't feel it.
DR. DUKE: Correct.
MR. RIBERA: Right.
DR. DUKE: And so you're doing things you probably shouldn't be doing, movements that are exacerbating the pain, hypersensitization to pain. It -- it is a disaster.
MR. RIBERA: Okay.
DR. DUKE: And -- and pretty much use of long-term, high-dose, you know, morphine, it's just been completely abandoned. And it's shocking that -- that you're being managed that way because I can -- I would bet any amount of money that no matter what is done, you will not get better as long as you have the drugs onboard.
MR. RIBERA: So what's the plan of

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attack? I mean, what would you do with me?
DR. DUKE: You get rid of the drugs first, and then you get through that. And you know, on opiates for four years, that's a major problem, 'cause your body gets used to it. You get addicted to it so sometimes you have to see an addiction medicine specialist.
MR. RIBERA: Really? I bet you I could quit tomorrow.
DR. DUKE: Boy, I tell you, that would be the best thing you ever did.
MR. RIBERA: I -- I would just be in pain, and that would be the part that sucks.
DR. DUKE: Yeah. But -- and the pain would be worse than while you were on it too because, you know, you're hypersensitized to pain, so the pain level goes up. It actually takes, like, three months for it to come down again, and pain levels drop. It takes a while and -- it takes about three months for people to say I'm not in any more pain than whenever I was taking the drugs. By month four, about a hundred percent of people are better than they were taking the drugs.
MR. RIBERA: Really?
DR. DUKE: Yeah.

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MR. RIBERA: So now they're just dealing with that -- that little bit of pain without the drugs.
DR. DUKE: Correct. But it's better. It's better. And I've had innumerable patients, I mean, more than I can count that thought they needed surgery, but we got them off the drugs, and in four months, I don't need surgery, you know. They said I -- my pain is so much better. I thought I needed surgery, but I don't.
MR. RIBERA: Huh.
DR. DUKE: So I would -- before I committed myself to having my back sliced open again, that's -- that's the route I would go.
MR. RIBERA: Okay.
DR. DUKE: You know, it's my advice.
The -- you know, the -- I think part of your -- the issue too with your case that's difficult is that -- and I think what's raised red flags is that I -- you know, you were seen for this lifting injury at (unintelligible) -- at home, you know, right after the car wreck. And then you had several notes that said onset of pain, two weeks ago, like, in -- in mid May, you know, a month after the accident.

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You wrote a letter to Blue Cross/Blue Shield saying that I'm not being treated for a car wreck. I had a lifting injury at home. I was lifting cabinetry. And then it was only later that it switched. You know, the history changed, and I think that's what's got a red flag raised on your case. And so -- and then to -- you know, it makes it very difficult, you know, those -- those kind of things, because it's hard to go back and undo and erase the -- the medical record, which says what it says, you know.

Hopefully you have medical insurance and can cover future treatment as you need it.

MR. RIBERA: Uh-huh.

DR. DUKE: Litigating it is going to be very, very difficult. Just -- just --

MR. RIBERA: How else -- won't the attorneys -- won't the attorneys hash that out because that's what they're there for?

DR. DUKE: Absolutely.

MR. RIBERA: I mean, building cabinets, what -- what -- that's what I was doing at the time -- at the time. Then when they asked me, what -- what were you doing at the time of the injury? I was doing cabinets in the garage when my

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son picked me up so -- and then, you know, we'll let them hash that out.

DR. DUKE: Yeah, absolutely.

MR. RIBERA: Yeah, so --

DR. DUKE: So yeah. It is what it is.

MR. RIBERA: Yeah.

DR. DUKE: So anyway, any -- any other -- you mentioned your current symptoms. You mentioned your -- your current medications, your current, you know, exam.

Oh, can I see the incision they did for that surgery that they did at Laser Spine.

MR. RIBERA: I'm going to assume it's back here somewhere.

DR. DUKE: Okay. So you don't really see anything?

MR. RIBERA: (Unintelligible) It's right in, let's say, where I had that patch at. Maybe right in here?

DR. DUKE: Okay. So it's --

MR. RIBERA: It's small. It was only -- I mean, it's --

DR. DUKE: A little dot.

MR. RIBERA: Yeah, yeah.

All I can remember is I remember they --

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they had -- they brought me in and out of the anesthesia. They talked to me. I -- I remember that. And they would say do you feel anything now and -- and -- and I remember swearing and using foul language like a mad man. And then they would -- I was out, and then they kept doing that back and forth. And I could hear the pinging sound, almost like an MRI kind of a sound. And I don't know if that was just the dissect -- discotomy thing that they were doing, cleaning the disc up around the -- around the thing or what but --

DR. DUKE: They did a plasma disc decompression. Did they tell you that's an experimental procedure, nonstandard?

MR. RIBERA: I know we talked. I know we sat and we talked, and we have a counsel thing. You know, you're up there for five days. You went -- you went there and -- and they sent me up for -- for some x-rays up there because mine weren't correct when they shot. The MRIs were good that I sent up. They could use those.

And then the next day was a consultation with the doctor. I think the third day was the surgery. That was on a Friday.

DR. DUKE: Uh-huh.

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MR. RIBERA: I had to stay over the weekend and come back on the Monday and then be seen -- be seen before I got sent home.

DR. DUKE: Okay.

MR. RIBERA: But I don't know. I mean, it's weird, 'cause all the people that -- it's funny 'cause the people that were all coming out of the surgery, all -- all of them felt better when they came out. I mean, you heard all the stories from all the people that were -- you know, people that were there, like, on their fourth day and they said, oh, I feel great right now and all this horse -- you know. Who knows? I mean --

DR. DUKE: So the -- let me see here.

MR. RIBERA: So you would never go that route; right?

DR. DUKE: No.

Now, you'd had some back pain in your life prior; correct.

MR. RIBERA: Yeah, I've had the basic back stuff where, you know, I've gone to the chiropractors before and then done, you know, maintenance adjustments, you know. I was -- I was currently seeing a chiropractor that I went into, like, four times a year every -- you know, every

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three, four -- three, four months, I'd go get an adjustment just to -- just kind of a maintenance thing, you know.

DR. DUKE: Yeah.

MR. RIBERA: It wasn't like I was going to see him every week because I was -- I was -- you know, 'cause I was injured or whatever. Nothing like that. It was just more -- more maintenance more than anything.

DR. DUKE: Has any --

MR. RIBERA: Kind of like changing the oil.

DR. DUKE: Has -- has anybody told you that any of the imaging studies shows evidence of injury to -- from the car wreck -- car wreck?

MR. RIBERA: Well, Flangas -- Flangas had mentioned to me that he thinks I need surgery.

DR. DUKE: But I mean has anybody said this MRI shows damage from your car wreck?

MR. RIBERA: You know, I don't know if I'm allowed to talk about any of that.

DR. DUKE: Oh, yes, you are. I mean, I -- you know, basically --

MR. RIBERA: This is medical. That is an exam that you're giving on me. I mean --

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DR. DUKE: Right, right, right, right. But what I need to know is what your understanding is of what the films showed to you, you know, what -- how it's been represented to you, you know. I mean, that -- I just thought -- has it been represented to you that -- that the films showed damage from the wreck?

MR. RIBERA: No, it -- again, I don't know, you know. I'm going to, you know, leave that one alone.

DR. DUKE: Is it --

MR. RIBERA: Definitely -- definitely it wasn't done building cabinets in my garage that I've been doing for 25 years, building these kind of cheapo lightweight cabinets. I'll tell you that right now. That's just my opinion. You've been a doctor for how many years? I mean, I've been building cabinets since 1979, you know. I'm not no weekend lawyer guy that doesn't know what he's doing in the garage.

DR. DUKE: Yeah.

MR. RIBERA: You know, it's unfortunate the way I wrote up -- I wrote up the thing, you know, but it is what it is on that -- on that record, you know.

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DR. DUKE: And -- and you know there -- there was multiple other records that -- where you were seen after that where you said that the pain had started, you know, almost exactly to the same date that you had the incident in your house, you know; that basically you'd -- you'd seen several physicians, and to none of them did you relate it to the car wreck at all. Why -- why is that?

MR. RIBERA: I don't know, 'cause the car wreck was pretty brutal.

DR. DUKE: Uh-huh.

MR. RIBERA: I don't know. But building cabinets (unintelligible) -- that's what I was doing for, like, a whole month, you know. But you know, it's like that's my -- you know, I had a, you know, cabinet business in the past. I know what I'm doing. And it's like -- you know, and I know that was -- I know I was doing that at the time of the accident. Yes, that's what I was doing was building cabinets. I also was going to work every day and, you know, mowing my lawn every -- once a week and those standard things in life, you know, doing -- doing the honey-dos around the house.

DR. DUKE: Sure.

MR. RIBERA: You know.

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DR. DUKE: And you realize that 99 percent of people that need back surgery aren't in car wrecks. They -- they're doing the normal things. They're -- they're mowing the grass. They're coughing, sneezing, sitting down. The types of things that people have surgery for are not car wrecks.

MR. RIBERA: Not even getting hit at 60 miles an hour?

DR. DUKE: No. That happens -- whenever people need surgery for that, it's usually instantly that they need it, like within ten minutes. They go to the hospital. They have a broken back. They have a surgery. Almost never does it end up resulting in delaying surgery years down the road. Almost never, because the -- it's either going to damage it, or it's not going to damage it.

And what you have -- what you have MRI findings of is degenerative disc disease, which is from age, genetics, building cabinets, walking, blah, blah, blah. You know, it's not due to acute trauma so --

MR. RIBERA: When it happened, it could have been the straw that broke the camel's back, though.

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DR. DUKE: Yeah. Again, if it -- it breaks it instantly, though, you know, if it -- if it does.
MR. RIBERA: Okay.
DR. DUKE: I will -- I will -- and you're -- let's see. I don't think there's anything else. You've had -- you've had only two to three pain injections?
MR. RIBERA: I think I've had more than that. I think I had two or three just from Dr. Lee. He left the -- he left the practice years ago.
DR. DUKE: Well, have any of them helped you?
MR. RIBERA: They seem like they have. They kind of -- they kind of -- they seem like they -- they -- they lessen it some. Like, I probably need to go back and do it again.
DR. DUKE: Briefly, they help?
MR. RIBERA: Yeah, they seem like they're good for, like, three to six months.
What's your opinion on them?
DR. DUKE: It depends on why you're getting them, you know. That's what really makes the difference there.
MR. RIBERA: What's the purpose of them

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that it's supposed to do?
DR. DUKE: Well, in people that have nerve compression and neuropathic pain, like radiating leg pain, that's what it's for. It never works for back pain.
MR. RIBERA: So it -- it would help this?
DR. DUKE: Well, if -- if you had it more frequently, I would say possibly. But you -- you know, you don't have it that often.
MR. RIBERA: 'Cause my understanding with what Dr. Weiss -- Weiss did, whatever his name is, in LSI in Scottsdale, that the nerve was touching, like, the disc and -- and he would clean up around the disc so the nerve -- or use some sort of a laser to keep the nerve from touching the disc so that that would keep the pain from -- I mean, that was my kind of understanding of it. I don't know.
DR. DUKE: All right. Well, very good.
MR. RIBERA: All right, sir.
DR. DUKE: Yeah, I wish you the very best of luck.
MR. RIBERA: All right.
DR. DUKE: Dr. Flangas is an excellent

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doctor.
MR. RIBERA: Oh, okay.
DR. DUKE: I'd let him operate on me any day.
MR. RIBERA: Would you really?
DR. DUKE: Oh, absolutely.
MR. RIBERA: Good.
DR. DUKE: Yeah, he's got great hands. He's got great hands. He really -- he's one of the best in town for sure.
MR. RIBERA: Oh, good, yeah.
DR. DUKE: Okay.
MR. RIBERA: Yeah.
DR. DUKE: So anyway --
MR. RIBERA: Yeah, he mentioned that 30 -- he said something about if I had surgery that, you know, there would be, like, a 30 percent chance of getting better and a 70 percent chance of staying the same or being worse.
DR. DUKE: Yeah.
MR. RIBERA: I mean, those aren't odds I like to hear.
DR. DUKE: No, no.
MR. RIBERA: You know.
DR. DUKE: But he's being truthful.

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MR. RIBERA: Yeah. That's -- that's why I went to him, 'cause I heard he's a straight-up guy.
DR. DUKE: He's straight -- straight-up, honest guy, yeah.
MR. RIBERA: Yeah.
DR. DUKE: Absolutely he is. Well, I'll take care --
MR. RIBERA: Okay, sir. Thank you for your time.
DR. DUKE: You're very welcome and --
MR. RIBERA: Okay. All right.
DR. DUKE: Just go out to the right. They'll take care of all the paperwork for you.
MR. RIBERA: Okay.
DR. DUKE: Appreciate it. Bye-bye. Take care.
(Unintelligible) Down the hall and then take a left.
MR. RIBERA: All the way down?
DR. DUKE: Yeah.
MR. RIBERA: Okay. See you later.
(End of recording.)

CERTIFICATE OF REPORTER

STATE OF NEVADA)
SS:
COUNTY OF CLARK)

I, Jennifer A. Clark, certified court reporter, do hereby certify that the foregoing transcript constitutes a full, true, and accurate record of the disc provided to me by Richard Johnson.

IN WITNESS WHEREOF, I have hereunto affixed my hand this _____ day of _____, 2011.

_____
Jennifer A. Clark, RDR, CRR, CCR 422

EXHIBIT "9"

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DISTRICT COURT

CLARK COUNTY, NEVADA

* * *

Joshua Green, an individual, Plaintiff, vs. **Ferrellgas, Inc.**, a foreign corporation; **Mario S. Gonzales**, an individual; **Carl J. Kleisner**, an individual; Does I through XXX, inclusive and Roes Business Entities I through XXX, inclusive Defendants.	Case No.: A-19-795381-C Dept. No.: XXXI
Mario S. Gonzalez, an individual; Cross–Claimant, vs. **Ferrellgas, Inc.**, a foreign corporation; **Carl J. Kleisner**, an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200; Cross–Defendants.	**Plaintiff, Joshua Green's Initial Designation of Expert Witnesses and Reports**

H&P LAW

Mario S. Gonzalez, an individual;

Third-Party Plaintiff,

vs.

BBQ Guys Manufacturing, LLC dba Blaze Outdoor Products., a foreign corporation; **Home Depot USA, Inc.,** a foreign corporation; **KSUN Manufacturing,** a foreign corporation; Does 200 through 300 inclusive; and ROE Corporation 301 through 400;

Third-Party Defendants.

Ferrellgas, Inc., a foreign corporation;

Counter-Claimant,

vs.

Mario S. Gonzalez, an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200;

Counter-Defendants

Carl J. Kleisner, an individual;

Counter-Claimant,

vs.

Mario S. Gonzalez, an individual; DOES 1 through 100 inclusive; and ROE Corporations 101 through 200;

H&P LAW

Counter-Defendants.

Plaintiff, Joshua Green, through his attorneys of record, Marjorie L. Hauf, Esq. and Matthew G. Pfau, Esq. of H & P LAW, hereby produces the following Initial Expert Disclosures pursuant to N.R.C.P. 26(B). Said witnesses are expected to testify in person at the time of trial of this matter, however, Plaintiff reserves the right to use each of the below-listed experts as well as those previously listed experts' respective depositions.

H&P LAW

I.

Retained Expert Witnesses

1. Scott G. Davis, Ph.D., PE, CFEI
   GEXCON
   4833 Rugby Avenue, Suite 100
   Bethesda, Maryland 20814

Scott G. Davis, Ph.D, PE, CFEI is a Principal Engineer with specialized knowledge in combustion, thermal, and fluid processes. Dr. Davis is expected to offer testimony relevant to his area of expertise, including in investigation and prevention of fires, explosions, and dispersion hazards. Dr. Davis will also rebut any opinions offered by Defendant's expert witness, if any.

Dr. Davis authored a report, attached hereto as Exhibit 1. The exhibits to be used as a summary of support for Dr. Davis' opinions are all deposition testimony in this case, all written discovery responses in this case, all exhibits produced in this case, all expert reports, and the exhibits listed in his report.

In preparation of his report, Dr. Davis reviewed the following records:

1. FG00001-FG000018: Ferrellgas Answer to First Amended Complaint;
2. FG000019-FG000021: 6/16/17 Ferrellgas Correspondence to Mario Gonzalez and Ferrellgas Customer Agreement for Propane Sales & Equipment Rental

3. FG00002–FG000023: 6/4/18 Delivery Ticket
4. FG000024: 7/3/18 Ferrellgas Invoice
5. FG000025–FG000028: Propane Safety Brochure
6. FG000030–FG000039: STS -7.46a System Check Form (SCF)
7. FG000040–FG000083: STS –5.8 Product Installation Review (PIR)
8. FG000084–FG000096: STS -7.40 Appliance Venting – Venting and Vent System Inspection –
9. FG000097–FG000098: STS 7.36 Pilot Lighting-Inspections
10. FG000099–FG000106: STS 1.71 Unsafe Condition Notice (Red Tag)
11. FG000107–FG000111: Order Details for 4/26/18, 5/9/18 and 6/4/18 Orders
12. FG000112–FG000116: Customer Call Information for June 2018
13. FG000684: Exemplar delivery ticket with customer safety information
14. FG000685: Bulk History Report
15. FG000686–FG000687: Billing Statement for May 2019
16. FG000688–FG000689: Billing Statement for June 2019
17. FG000690: Invoice for June 22, 2017
18. FG000691–FG000692: Invoice for August 14, 2017
19. FG000693: Customer Consumption Report
20. FG000694–FG000695: Case details for M. Gonzalez June 13, 2018 call to Ferrellgas
21. FG000696–FG000697: Detailed case list
22. FG000698–FG000699: 360 service order history for all deliveries and leak tests
23. FG000777-FG000791: Transcript of Recorded Statement of Mario Gonzalez taken June 26, 2018
24. FG000792: Audio Recording of Mario Gonzalez Call
25. FG000793-FG000818: Delivery tickets to Mario Gonzalez
26. FG000819-FG000820: Red Tag dated June 18, 2018
27. FG000821–FG000822: June 19, 2018 Ferrellgas email correspondence concerning incident
28. FG000823: June 19, 2018 Sniff test signed by Mario Gonzalez, Jennifer Gonzalez and Robert Vicory
29. FG000824–826: Vicory Certifications Page
30. FG000827–FG000833: Photos from Gonzalez Residence
31. FG000834: Photo of June 18, 2018
32. FG000835: Invoice for February 2, 2020
33. FG000836: Invoice for June 18, 2018
34. FG000837: Invoice for August 14, 2017
35. FG000838–FG000872: Billing Statements
36. FG000873–FG000881: Order Records
37. FG000882–000888: Notice of Inspection of gas hose
38. FG000889–000891: Notice of Entry Upon Land
39. FG000891-FG000895: Electrical Inspection Protocol
40. FG000896: Vicory Corrective Action Written Warning
41. FG000897: Vicory Corrective Action Final Written Warning
42. FG000989–FG000929: PERC Module 6: Leak Check
43. FG000930–FG000981: PERC Module 2: Vapor Distribution Systems
44. FG000982–FG001033: PERC MODULE 6: Installing Lines
45. FG001034–FG001040: Ferrellgas Training Requirements
46. FG001041–FG001306: Photographs from October 25, 2018
47. FG001307–FG001478: Photographs from May 15, 2020 site inspection and lab exam
48. FG001479–FG001519: Blaze Grills Use & Care Guide
49. FG001520–FG001535: Service Center Update – First Quarter 2018
50. FG001536–FG001537: Flashnote on Documentation
51. FG001538–FG001539: Vicory Certifications Page

52. FG001540–FG001541: STS 1.3 – Safety Communications
53. FG001542–FG001752: Safety Technical Handbook
54. FG001753–FG001755: Regional Safety Manager Job Description
55. FG001756–FG001757: Field Install Specialist Job Description for August 2017
56. FG001758–FG001763: STS 7.31 – System Test Requirements
57. FG001764–FG001768: STS 7.33 – System Leak Checking
58. FG001769–FG001826: Skills Assessment Records
59. FG001827–FG001830: Flashnote on Out of Gas Interruption
60. FG001831–FG001835: Flashnote on Customer Warnings Materials
61. FG001836–FG001837: Flashnote on Incomplete Systems
62. FG001838–FG001842: Flashnote on Placing New Systems into Operation
63. FG001843–FG001875: Excerpts from Safety Technical Handbook
64. FG001876–FG001879: Flashnote Attendance Records for Robert Vicory in 2017
65. FG001880–FG001888: Flashnote Attendance Records for Robert Vicory in 2016
66. FG001889–FG001898: Flashnote Attendance Records for Robert Vicory in 2018
67. FG001899: Flashnote Attendance Records for Robert Vicory in 2014
68. FG001900–FG001902: Flashnote Attendance Records for Robert Vicory in 2015
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77. FG002603–FG003078: LV3CETPDVDS Training module
78. FG003079–FG003482: LV3CETPPDVS Training module
79. FG003483–FG003484: Manager of Operations Job Description
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81. GREEN 943–952: Ferrellgas, Inc.'s System Check Form (SCF)
82. GREEN 953–965: Ferrellgas, Inc.'s Appliance Venting and Vent System Inspection policies and procedures
83. GREEN 966–1009: Ferrellgas, Inc.'s Product Installation Review (PIR), outlining inspection policies and procedures at installed gas systems
84. GREEN 1010–1017: Ferrellgas, Inc.'s Unsafe Condition Notice (Red Tag) policies and procedures for customer gas systems
85. GREEN 1018–1018: Ferrellgas, Inc.'s Pilot Lighting Inspection policies and procedures
86. GREEN 1020–1024: Ferrellgas, Inc.'s Order details dated April 26, 2018, May 9, 2018, and June 4, 2018
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88. Deposition transcript of Plaintiff, Joshua Green Vol I
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93. Deposition transcript of Defendant, Carl J. Kleisner Vol I
94. Deposition transcript of Defendant, Carl J. Kleisner Vol II
95. Deposition transcript of Robert Vicory
96. Deposition transcript of Kelly Kite

97. Deposition transcript of Monica Aragon
98. Deposition of Chad Brown
99. Surveillance footage of Subject Explosion
100. October 25, 2018 Inspection of Gonzalez Property
101. May 14, 2020 Inspection of Subject Gas Hose

Dr. Davis is expected to offer the following opinions, as outlined in his report:

1. Inspection of the subject outdoor kitchen revealed a significant leak, e.g., a volumetric flow rate of approximately 44 SCFH (approximately 61 SCFH at 13" w.c.) in the flexible gas line to the Blaze grill. Testing confirmed that this leak was the only viable leak source within the gas system that could have caused this incident. The flexible gas line was also thermally damaged in the vicinity of the gas leak, further confirming a preexisting leak prior to ignition. Testing confirmed that the propane leak from the flexible gas line was the only possible source of propane that could accumulate in the unventilated kitchen island cavity beneath the grill. Additionally, the grill was improperly installed per the manufacturers manual and lacked the required ventilation. The following sections will analyze the cause of the explosion, the inadequate response by Ferrellgas in which it violated its own policies and procedures, and the improper installation of the gas-fired built-in grill and griddle in violation of the manufacturer's installation manual.

2. Inspection of the evidence revealed a significant leak (a volumetric flow rate of approximately 61 SCFH at 13" w.c.) in the flexible gas line to the Blaze grill. Testing confirmed that the propane leak from the flexible gas line was the only viable leak source within the gas system that could have caused propane to accumulate within the unventilated kitchen island cavity beneath the grill and subsequently ignite while cooking on an open flame. The leaking propane could accumulate within the kitchen cavity because the grill and griddle were improperly installed in a manner that violated the manufacturer's installation manual by not providing the proper ventilation to this cavity.

3. Three hypotheses were identified as possible causes of the leak in the flexible gas line and include: (1) an electrical issue, resulting in fault current overheating the

flexible gas line and damaging the flexible outer hose seal; (2) rodents penetrating the flexible outer hose seal; and (3) defective manufacture of the flexible outer hose seal. Based on Mr. Gonzalez's testimony and the Ferrellgas notes regarding the reason for the call, there was a condition that resulted in significant heating of the flexible gas line to the Blaze grill. Not only was there an "overheat" condition, but when the flexible gas line was disconnected the exiting gas was ignited and resulted in a flame "shooting out". Both of these conditions are indicators that an electrical fault condition was present at the grill and that electrical fault current was flowing through the flexible gas line to ground via the underground service line.

4. Testing by Don Gifford also confirmed that fault currents near 20 amps, yet below the threshold necessary to trip the 20-amp breaker, are high enough to heat the flexible gas line to above 300 °F. These temperatures are very hot and can also cause the flexible outer hose seal to degrade and fail, compromising the integrity of the gas line. Once compromised, propane will leak from such a line, similar to the incident gas line to the Blaze grill. The extremely hot gas line and the observation of the flames shooting out when Mr. Gonzalez disconnected the flexible gas line can only be reconciled by an electrical condition that resulted in fault current going through the flexible gas line to ground via the service line. This scenario is also consistent with Mr. Gifford's finding that there was an improper ground for the grill and outdoor kitchen electrical system.

5. The scenarios of: (1) a defectively manufactured flexible gas line and; (2) damage to the flexible gas line by rodents are not consistent with the overheating of the flexible gas line connection nor with ignition of the exiting gas when the gas line was disconnected. In addition, given a complete system check was performed for Mr. Gonzalez's system a year prior to the incident, which included a leak check and that Mr. Gonzalez has used this system without incident approximately 50-100 times, the defective manufacture of the flexible outer hose seal is highly unlikely. While rodents were present in the kitchen cavity at the time of the inspections, such a cause

for the damage cannot explain the observations in the days leading to the accident. In addition, there was no observed evidence to support that rodents had chewed, gnawed or damaged the gas line in any way. Hence both the defective manufacture of the flexible gas line outer seal and damage to the seal due to rodents can be ruled out. The only theory that reconciles the evidence is an electrical condition was present days before the incident, which ultimately overheated and degraded the seal of the flexible gas line.

6. Ferrellgas violated its own policies and procedures in the response to the call from the Gonzalez residence. Mr. Vicory found a serious issue with the system, and since he was not an electrician and did not have experience with electrical issues, he recommended that Mr. Gonzalez hire an electrician to inspect the issue. Mr. Vicory responded to a questionable or unsafe condition in an area outside his area of expertise. Per Ferrellgas's procedures, Mr. Vicory should have red tagged and disabled the system or red tagged and disabled the appliance. Mr. Vicory contacted Mr. Kite for advice on the situation, Mr. Kite advised him of two similar incidents where he red tagged the system until it was fixed.

7. Ferrellgas's disabling of appliances requires actions beyond simply turning the valve to the "off" position and red tagging. Had Ferrellgas disabled the appliance per their own policies and procedures, one or more of the following actions would have been performed: (1) Removing the handle of the manual shutoff valve; (2) Disconnecting and capping or plugging the gas line; and (3) Disconnecting the electrical supply to the appliance or equipment. Similarly the system could have been disabled via: (1) Removing a valve handle, such as the service valve handle (2) Removing a regulator; (3) Using a clamshell, lock, wire, cable tie, plastic or lead seal, or similar device to prevent a valve from being operated without physically removing the securing device; and/or (4) Disconnecting and plugging or capping a line, such as a pigtail or hogtail. Mr. Vicory and Ferrellgas failed to red tag and disable the system or red tag and disable the appliance and removed it from available use. The system

was required to be disabled which would have prevented the grill from being used. Were the system properly disabled per Ferrellgas's procedures then this incident would have been avoided.

8. Mr. Vicory testified that he sprayed down the lines with a leak detector, smelled the lines, and observed no leaks. He failed to follow Ferrellgas's own policies and procedures for leak testing and documentation of the leak test. Mr. Vicory failed to follow any of Ferrellgas's six methods to conduct a leak check, which would have included a pressure decay test. A pressure decay test does not rely on human factors such as sense of smell, visual checks to identify a leak, or where the leak detection solution is applied. Mr. Gonzalez testified that the soap and water was placed only on the tee, which, if true, would not detect a leak in the flexible gas line. In addition, Mr. Vicory did not document any leak testing that was performed which violates Ferrellgas's procedures. This conflicting testimony, along with the lack of documentation and improper procedures, brings question to whether a leak was already present during the initial inspection by Ferrellgas.

9. Whether a leak was present or not at the time of the initial inspection by Ferrellgas, there was a leak observed in the flexible gas line to the grill found during post-incident testing. Mr. Vicory either failed to find a dangerous situation of a gas leak by using an unapproved leak test or failed to red tag and disable the system for a dangerous situation of electrical current flowing through the gas hose. After the incident, current and former Ferrellgas employees, Mr. Vicory, Mr. Kite, and Mr. Barrett all stated that the system should have been red tagged.

10. Mr. Gonzalez testified that sometime in July of 2017 he modified the original installation and installed outdoor cooking equipment after purchasing new equipment in June of 2017. According to his testimony he replaced the appliances and hired a handyman to do some masonry work to fit the new appliances. Listing images from 2015 (Figure 4.1), show appliances in different locations and different countertop and stone exterior.

11. As clearly indicated in Blaze's installation manual, vent panels were required for their gas-fired built-in outdoor cooking equipment. In their manual, Blaze provided many warnings about proper ventilation, explanations on why proper ventilation is important, and even provided multiple examples of vent panel locations. Ventilation in outdoor kitchens is important to reduce the likelihood of flammable gas buildup in the island cavity. Without ventilation, a leak can freely buildup inside the enclosure. Upon finding a competent ignition source, a flame can propagate through accumulated flammable gasses. The incident island cavity had no place to vent the combustion products except for out the access doors.

12. Mr. Gonzalez did not follow the manufacturer's instructions of adding proper ventilation to the enclosure. In addition, the installation was not performed or inspected by a qualified professional installer or service technician. If the installation had been inspected by a qualified professional, the enclosure would not have passed the inspection until the required vent panels were installed. In addition, Ferrellgas failed to notice that the kitchen cavity had no openings for ventilation when taking over the account in their initial inspection, and when they were called to the Gonzalez residence to inspect the outdoor kitchen, which included inspecting the gas piping in the "unventilated" kitchen cavity.

13. As discussed above, post-incident inspections revealed a leak in the flexible gas line supplying propane to the grill. A CFD analysis was performed to evaluate the consequences of this leak in the outdoor kitchen island. More specifically, CFD was performed to determine if the leak could have created a flammable cloud of sufficient size inside the island cavity with and without the required vents installed.

14. The CFD analysis was performed in FLACS, a tool developed by Gexcon in the 1980's to simulate gas dispersion and vapor cloud explosions. FLACS can simulate gas and aerosol releases, dispersion of vapors, ventilation in structures, and the effects of ambient conditions such as wind. In FLACS, the compressible Reynolds-Averaged Navier–Stokes (RANS) equations are solved on a 3D Cartesian grid using a

finite volume method and the k-ε turbulence model. Incorporated in the model are the conservation equations for mass, impulse, enthalpy, turbulence and species, with closure provided by the ideal gas law. The FLACS non-premixed combustion model uses the Eddy Dissipation Concept56 to describe the overall rate of reactivity of turbulent non-premixed reacting flows.

15. FLACS has been extensively validated against numerous gas dispersion, vapor cloud explosion, and jet fire experiments, including large-scale realistic release scenarios and full-scale experiments. Recent validation studies, including blind validation studies (i.e., simulations were performed prior to, or without knowledge of the experimental results), have demonstrated the ability of FLACS to accurately predict gas dispersion and explosion scenarios. Because it has been extensively validated, FLACS is typically required when performing fire and explosion consequence studies for complicated oil and gas offshore platforms.

16. A geometry model was created of the outdoor kitchen island (Figure 4.2). A 61 CFH release of LP gas from the leaking hose was modeled. Figure 4.3 shows how the flammable cloud spreads in the incident outdoor kitchen cavity construction with very little to no ventilation. The CFD simulations show that the leak found after the incident was of sufficient magnitude to not only create a flammable gas cloud in the outdoor grill island, but also reach the grill burners. Per the Blaze installation manual, passive vents were added to the outdoor kitchen cavity model (Figure 4.4) and the effect of ventilation on the flammable gas cloud buildup was evaluated. Simulations show that by adding only 4 vents (1 low and 1 high on each side) to the sides of the outdoor grill island, the flammable layer would be less than 4 inches (see Figure 4.5) and would remain remote from any ignition sources. These simulations assume no external wind and conservatively underpredict the actual ventilation on the day of the incident, which would further dilute the propane in the cavity and reduce size of the flammable gas cloud shown in Figure 4.5.

17. A propane leak and subsequent explosion occurred at the residence of Mr.

Mario Gonzalez on June 18, 2018 in Las Vegas, Nevada. The incident involved an outdoor kitchen equipped with built-in propane-fired appliances.

18. An explosion occurred when Mr. Joshua Green opened the lid of a built-in grill. The explosion engulfed Mr. Green, shook the Gonzalez residence and was loud enough to alert the neighbors that an incident had occurred. Mr. Gonzalez had stepped away and Mr. Joshua Green took over cooking duties per Mr. Gonzalez's request.

19. Post-incident inspection of the subject kitchen island revealed a significant leak, e.g., a volumetric flow rate of approximately 44 SCFH (corrected to 61 SCFH at 13" w.c. propane) in the flexible gas line to the Blaze grill. Testing confirmed that this leak was the only viable leak source within the gas system that could have caused this incident.

20. The grill and griddle in the outdoor kitchen cavity were installed improperly and in a manner that violated the manufacturer's installation manual by not providing the required openings and adequate ventilation to this cavity to prevent propane accumulation in the cavity in the event of a leak.

a. The outdoor kitchen did not include any ventilation openings as stated in several places throughout the manual, including several pages that are dedicated to explicitly warning of the hazards of inadequate ventilation.

b. The manual specifically states, "Failure to adequately vent your outdoor kitchen cavity could result in an explosion or fire."

c. The manual specifically states, "Ensure there is adequate ventilation for both the appliance, grill cart and/or island cavity. This is required not only for proper combustion, but also to prevent gas build up."

21. Propane vapors accumulated within the unventilated outdoor kitchen cavity beneath the grill and griddle, which subsequently ignited while cooking on an open

flame.

22. Testing and modeling confirmed that the propane leak from the flexible gas line was the only viable leak source within the gas system that could have caused propane to accumulate within the unventilated outdoor kitchen cavity beneath the grill and griddle, and subsequently ignite while cooking on an open flame.

23. An electrical fault condition was present at the grill and fault current was flowing through the flexible gas line to ground via the underground service line. This electrical condition was present at least five days before the incident, which ultimately overheated and degraded the seal of the flexible gas line causing it to leak.

a. Both the extremely hot and "overheat" condition of the flexible gas line, and the fact when the flexible gas line was disconnected the exiting gas was ignited and resulted in a flame "shooting out", are indicators that a fault condition was present at the grill and the fault current was flowing through the flexible line

b. Testing showed that fault currents near 20 amps, yet below the threshold necessary to trip the 20- amp breaker, are high enough to heat the flexible gas line to above 300 °F and degrade the line.

c. Inspections revealed that the outdoor kitchen was not properly grounded.

d. Defective manufacture of the flexible line outer seal is not consistent with the facts of this case and can be ruled out as a possible cause.

e. Damage due to rodents is not consistent with the facts of this case and no evidence was found to indicate that rodents had chewed, gnawed or otherwise affected the integrity of the gas line and can be ruled out as a possible cause.

24. On June 13, 2018, five days prior to the incident, Mr. Gonzalez called Ferrellgas's emergency phone number regarding a dangerous condition with the

flexible gas line to the built-in grill

a. When Mr. Gonzalez opened the stainless steel access door below the Blaze Grill he felt a shock from the door.

b. Mr. Gonzalez noted the flexible gas line to the grill was very hot even though the gas valve that serviced the built-in appliances (grill and griddle) was turned off.

c. Mr. Gonzalez stated that he released the quick-connect connections on the gas line and a small flame shot out of it.

25. On June 14, 2018, four days prior to the incident, a Ferrellgas's service technician, Robert Vicory responded to the Gonzalez residence. On June 15, 2018, three days prior to the incident, Mr. Vicory came back out to check the system for a second time and he informed Mr. Gonzalez his grill was safe to use.

26. Ferrellgas violated its own policies procedures in the response to the Gonzalez residence.

a. Ferrellgas failed to document the inspections.

b. Ferrellgas failed to perform a leak check per their own policies and procedures. Using soap solution and sense of smell is not in accordance with Ferrellgas policies and procedures.

27. Mr. Vicory and Ferrellgas recognized an unsafe and hazardous condition at Mr. Gonzalez's residence.

a. The service call indicated a hot gas line connection and flames shooting out when the gas line was disconnected.

b. Mr. Vicory conferred with his general manager at Ferrellgas, Kelly Kite and they determined that the issue was electrical. When Mr. Kite had experienced similar issues previously he red tagged those systems because he was not an electrician.

c. Mr. Vicory recommended further corrective action by an electrician.

28. Mr. Vicory and Ferrellgas violated their own policies and procedures, and failed to red tag and disable the system, or red tag and disable the appliance and remove it from available use. Instead Mr. Vicory allowed an unreasonably dangerous condition to continue to exist and only recommended that the owner find an electrician.

a. Ferrellgas failed to red tag a questionable or unsafe condition despite unsafe and hazardous condition being present in the gas system.

b. Ferrellgas did not:

i. remove the handle of the manual shutoff valve

ii. disconnect and cap or plug the gas line

iii. disconnect the electrical energy to the appliance or equipment.

29. On June 15, 2018, Mr. Vicory and Ferrellgas went back out to check the system for a second time. Despite not verifying the condition of the system was repaired, Ferrellgas service technician informed Mr. Gonzalez his grill was safe to use. Again, Mr. Vicory and Ferrellgas failed to red tag the system, leaving an unsafe and unreasonably dangerous condition to continue to exist.

30. Had Ferrellgas followed their own procedures and red tagged the unsafe and hazardous condition in either of their inspections of the gas system, this incident would have been avoided.

a. Multiple employees of Ferrellgas, including the technician who allowed the unsafe and unreasonably hazardous condition to continue to exist, testified that the system should have been red tagged and taken out of service.

31. In July of 2017, after recently switching to Ferrellgas as a propane supplier, Mr. Gonzalez renovated his outdoor kitchen which included replacing gas-fired appliances and masonry work. Mr. Gonzalez's installation was not performed or

inspected by a qualified professional installer or service technician.

32. In violation of the manufacturer's installation manual, Mr. Gonzalez's created an unreasonably dangerous condition by improperly installing the Blaze grill and griddle in the outdoor kitchen, whereby he did not provide the required openings and proper ventilation to the kitchen cavity to prevent propane accumulation in the cavity in the event of a leak. In fact, the kitchen cavity had no openings for ventilations.

33. Modeling demonstrated that had the outdoor kitchen island included adequate ventilation per the Blaze manual, propane vapor would have escaped through the vents and would not have accumulated to significant quantities in the cavity nor reached the burners and ignited. In fact, had ventilation been provided per the Blaze manual, the gas would have remained within inches of the ground and very remote from grill burners.

34. Ferrellgas failed to notice that the kitchen cavity had no openings for ventilation during their initial inspection when they took over the account and when they were called to the Gonzalez residence to inspect the issue with the outdoor kitchen.

35. Had Mr. Gonzalez properly installed ventilation in the outdoor kitchen cavity, this incident would have been avoided.

Dr. Davis' testimony will be consistent with GREEN 1272-1317 and the documents provided in Dropbox as Exhibits 5 and 6.

2. Don L. Gifford
GIFFORD CONSULTING GROUP, LLC
4405 East Post Road, Suite A
Las Vegas, Nevada 89120

Don L. Gifford is a licensed contractor, electrical contractor, and construction expert. Mr. Gifford is expected to offer testimony relevant to his area of expertise, including in construction, contracting, and design, general engineering, and forensics in analysis of fires, explosions, fire causation and fire propagation. Mr. Gifford will

also rebut any opinions offered by Defendant's expert witness, if any.

Mr. Gifford authored a report, attached hereto as Exhibit 7. The exhibits to be used as a summary of support for Mr. Gifford's opinions are all deposition testimony in this case, all written discovery responses in this case, all exhibits produced in this case, all expert reports, and the exhibits listed in his report.

In preparation of his report, Mr. Gifford reviewed the following records:

1. FG00001-FG000018: Ferrellgas Answer to First Amended Complaint;
2. FG000019-FG000021: 6/16/17 Ferrellgas Correspondence to Mario Gonzalez and Ferrellgas Customer Agreement for Propane Sales & Equipment Rental
3. FG00002-FG000023: 6/4/18 Delivery Ticket
4. FG000024: 7/3/18 Ferrellgas Invoice
5. FG000025-FG000028: Propane Safety Brochure
6. FG000030-FG000039: STS -7.46a System Check Form (SCF)
7. FG000040-FG000083: STS -5.8 Product Installation Review (PIR)
8. FG000084-FG000096: STS -7.40 Appliance Venting - Venting and Vent System Inspection -
9. FG000097-FG000098: STS 7.36 Pilot Lighting-Inspections
10. FG000099-FG000106: STS 1.71 Unsafe Condition Notice (Red Tag)
11. FG000107-FG000111: Order Details for 4/26/18, 5/9/18 and 6/4/18 Orders
12. FG000112-FG000116: Customer Call Information for June 2018
13. FG000684: Exemplar delivery ticket with customer safety information
14. FG000685: Bulk History Report
15. FG000686-FG000687: Billing Statement for May 2019
16. FG000688-FG000689: Billing Statement for June 2019
17. FG000690: Invoice for June 22, 2017
18. FG000691-FG000692: Invoice for August 14, 2017
19. FG000693: Customer Consumption Report
20. FG000694-FG000695: Case details for M. Gonzalez June 13, 2018 call to Ferrellgas
21. FG000696-FG000697: Detailed case list
22. FG000698-FG000699: 360 service order history for all deliveries and leak tests
23. FG000777-FG000791: Transcript of Recorded Statement of Mario Gonzalez taken June 26, 2018
24. FG000792: Audio Recording of Mario Gonzalez Call
25. FG000793-FG000818: Delivery tickets to Mario Gonzalez
26. FG000819-FG000820: Red Tag dated June 18, 2018
27. FG000821-FG000822: June 19, 2018 Ferrellgas email correspondence concerning incident
28. FG000823: June 19, 2018 Sniff test signed by Mario Gonzalez, Jennifer Gonzalez and Robert Vicory
29. FG000824-826: Vicory Certifications Page
30. FG000827-FG000833: Photos from Gonzalez Residence
31. FG000834: Photo of June 18, 2018
32. FG000835: Invoice for February 2, 2020
33. FG000836: Invoice for June 18, 2018
34. FG000837: Invoice for August 14, 2017
35. FG000838-FG000872: Billing Statements
36. FG000873-FG000881: Order Records

37. FG000882-000888: Notice of Inspection of gas hose
38. FG000889-000891: Notice of Entry Upon Land
39. FG000891-FG000895: Electrical Inspection Protocol
40. FG000896: Vicory Corrective Action Written Warning
41. FG000897: Vicory Corrective Action Final Written Warning
42. FG000989-FG000929: PERC Module 6: Leak Check
43. FG000930-FG000981: PERC Module 2: Vapor Distribution Systems
44. FG000982-FG001033: PERC MODULE 6: Installing Lines
45. FG001034-FG001040: Ferrellgas Training Requirements
46. FG001041-FG001306: Photographs from October 25, 2018
47. FG001307-FG001478: Photographs from May 15, 2020 site inspection and lab exam
48. FG001479-FG001519: Blaze Grills Use & Care Guide
49. FG001520-FG001535: Service Center Update – First Quarter 2018
50. FG001536-FG001537: Flashnote on Documentation
51. FG001538-FG001539: Vicory Certifications Page
52. FG001540-FG001541: STS 1.3 – Safety Communications
53. FG001542-FG001752: Safety Technical Handbook
54. FG001753-FG001755: Regional Safety Manager Job Description
55. FG001756-FG001757: Field Install Specialist Job Description for August 2017
56. FG001758-FG001763: STS 7.31 – System Test Requirements
57. FG001764-FG001768: STS 7.33 – System Leak Checking
58. FG001769-FG001826: Skills Assessment Records
59. FG001827-FG001830: Flashnote on Out of Gas Interruption
60. FG001831-FG001835: Flashnote on Customer Warnings Materials
61. FG001836-FG001837: Flashnote on Incomplete Systems
62. FG001838-FG001842: Flashnote on Placing New Systems into Operation
63. FG001843-FG001875: Excerpts from Safety Technical Handbook
64. FG001876-FG001879: Flashnote Attendance Records for Robert Vicory in 2017
65. FG001880-FG001888: Flashnote Attendance Records for Robert Vicory in 2016
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96. Deposition transcript of Kelly Kite
97. Deposition transcript of Monica Aragon
98. Deposition of Chad Brown
99. Surveillance footage of Subject Explosion
100. October 25, 2018 Inspection of Gonzalez Property
101. May 14, 2020 Inspection of Subject Gas Hose

Mr. Gifford is expected to offer the following opinions, as outlined in his report:

1. GCG will show, substantively, that the circumstances and conditions which created and/or led to the Subject Incident were a consequence of the decisions and actions of the Defendants referenced within this report.

2. We have seen no evidence to support any theory purporting Mr. Green's prior knowledge of dangerous or non-code compliant conditions, either related to the electrical system or gas supply system pertaining to the barbeque island and its appurtenances, or that he had any control over the events that resulted in the Subject Incident and resulting injury.

3. We will provide substance in support of our determination that Ferrellgas and Mr. Gonzales each bore principal duties respective to their various roles with regard to the events and conditions which allowed for the Subject Incident, and that each of them failed to execute those duties so as to provide for the safety, well-being, and welfare of Mr. Green and others, as mandated by the Clark County Building and Administrative Codes, the County adopted technical codes, and the standard of care.

4. It is our opinion that the Subject Incident was the consequence of overheating, melting, and failure of a Ksun flexible gas hose ("Subject Hose") feeding the island

barbeque appliance, in that the hose was subjected to current flow due to an electrical fault at the barbeque island.

5. The Subject Incident, in all probability, was preventable but for the actions/inactions on the part of Defendants Ferrellgas and Mr. Gonzales, in that (a) Ferrellgas failed to Red Tag the primary gas delivery valve to the home or, at least, the gas supply line to the barbeque and (b) the failure on the part of Mr. Gonzales to (i) comply with the barbeque appliance manufacturer's (Blaze) instructions for installation and use, (ii) adhere to the terms of his agreement with Ferrellgas, (iii) obtain the services of a properly qualified service company and/or licensed electrical contractor to troubleshoot and correct electrical anomalies manifest at the barbeque area.

6. Mr. Kleisner, an electrician who provided unlicensed services and recommended the implementation of non-code complaint electrical scopes, was also contributory to the Incident.

7. The gas appliance which is a seminal point of discussion in this report is a stainless steel barbeque unit marketed by Blaze, who provides, by virtue of their distribution of the manufacturer's installation, use, and maintenance instructions. The unit is 40" wide, designed for an application, such as that utilized by Mr. Gonzales' barbeque island, and appears to be (or similar to) a Summerset Sizzler Pro, 40", 5 burner unit.

8. The deposition of Mr. Gonzales provides insights with regard to his (a) purchasing and installing the grill, (b) connecting the unit to the gas tee/valve assembly by Ksun flex hoses which he also purchased, (c) maintaining and using the appliance, e.g., his habit of turning the gas off at the valve below the barbeque appliance during the majority of those times when he was done using it – and turning it back on at the valve at each time of use.

9. Hence, based on evidence and testimony, Mr. Gonzales turned on the gas valve, lit the barbeque grill, placed the steaks on the grill, after which time Mr. Green

showed up.

10. The photo insertions below show the disposition of the Blaze grill in relation to the barbeque island as well as the location of the riser and tee/valve assembly below the grill.

11. The under-counter space of the barbeque island was observed to have been without proper venting, and thus, is not in compliance with Blaze's instructions. The interior space beneath the grill is continuously open from east to west and from north to south, thus allowing for the accumulation of leaking gas not only under the barbeque grill, but under the griddle and other areas as well. Thus, when Mr. Green opened the barbeque lid, he was unwittingly subjected to a gas explosion as the result of a good volume of propane gas that appears to have suddenly ignited once the grill cover was lifted, providing ventilation.

12. Based on my examination of the property and artifacts, the explosion showed fire scorch on the Subject Hose and, of course, to the clothing of Mr. Green. The explosion also moved the griddle directly out from it's snug resting position, resulting in a significant gap (askew) between the back of the griddle and the counter backsplash area.

13. The Subject Incident was, in my opinion, dependent upon and the result of various critical factors, including, without limitation: (1) the pressurized gas supply line which runs underground from the 2nd stage at the south side of the house to the gas tee under the barbeque appliance; (2) the damaged and leaking coiled Ksun gas hose extending to the barbeque appliance from the tee; (3) a known electrical issue of unknown character prior to the Incident; (4) failure on the part of Ferrellgas, at some point prior to the Subject Incident, to (a) Red Tag the system or the barbeque gas valve and (b) perform the additional steps as prescribed by Ferrellgas, such as removing the handle from the gas valve and/or disconnecting the electrical power source; (5) failure of Mr. Gonzales to hire the services of an electrical contractor to troubleshoot and resolve the electrical issue, including the deteriorated and unsafe

electrical conditions at the barbeque; (6) failure on the part of Mr. Kleisner, who prescribed non-code complaint and unsafe electrical procedures.

14. As noted in the inspection notes further above, the electrical fault may have been intermittent at times both prior to and after the Subject Incident. This is a plausible explanation with regard to inability of the experts to re-establish the pre-existing continuity between the electrical grounding conductor of the barbeque island branch circuit and the gas riser/tee assembly. This would also explain the lack of measurable fault current (and implicitly the pathway for the same) to the gas riser/tee assembly.

15. I have seen no statement or testimony by anyone, wherein it was reported or where there was evidence showing that the overheated gas riser and gas hose under the barbeque appliance (a principal point of discussion with regard to this matter) was a function of some other heat generating mechanism prior to or at the time of the Subject Incident. By way of illustration and not of limitation, Mr. Gonzales testified with regard to the overheated gas line: "Q...'[t]hat was even though it was turned off.' A. Yes, which was really freaking me out...so it didn't have huge a gas leak as far as you could tell? A. No. Q. But you had a very hot line?...A. Yes" (Gonzales, p. 129).

16. Inasmuch as the barbeque appliance is electrically powered, the housing of the appliance was, and is, per the NEC, required to be grounded. Moreover, the manufacturer's instruction also calls for grounding of the appliance. Notwithstanding that grounding of an appliance is often achieved by means of a pigtail 120-volt power cord connection: (a) Blaze's instructions point to a more robust electrical bond and (b) the NEC, by virtue of Article 110.3, inherently requires conformity with the manufacturer's instructions.

17. In the event the barbeque had been properly grounded, it is possible that the flexible gas hoses, notwithstanding their introduction of a certain level of electrical resistance to electrical current, would have allowed for sufficient current to flow back

to the grounded neutral source at the panel, thus tripping the overcurrent device (20-amp circuit breaker) and defeating the catalyst to the overheated flex line and rise/tee assembly. Conversely, the lack of proper grounding of the appliance, in conjunction with the electrical issues noted at the barbeque island, allowed for the very conditions that resulted in the Subject Incident.

18. I see no evidence that the electrical wiring and any electronic controls within the barbeque appliance itself were capable of sustaining the level of fault current so as to allow the overheating of the riser/tee assembly and melting of the gas hose (as a function of time) feeding the appliance.

19. Our testing of the exemplar Ksun gas hoses (results are provided in Table 1 and narrative following Table 1) provide evidence or show, as follows:

1) The PVC covering of the Ksun gas hose distorts, melts, and opens at temperatures that are not greater than 300□F, allowing for the emission of gaseous vapor from a pressurized gas line into the surrounding atmosphere.
2) In the absence of other identifiable potential contributors to the Subject Incident, based provisions expressed within NFPA 921, Section 18, (a) the electrical phenomena reported by Mr. Brown and Mr. Gonzales (acknowledged by both Ferrellgas and Mr. Kleisner) and (b) the conditions found during site investigations, testing, and examination of evidence, combined to provide for the accumulation of gasses at the undercabinet area of the barbeque island.
3) The failure temperature of the Ksun hose is easily achieved within relatively brief periods of time when the hose is subjected to fault-currents easily derived from household 20-amp branch circuitry.

20. Mr. Gonzales testified that he observed a flame appear and extinguish as he removed the quick connect coupling between the riser tee and the appliance gas hose. As I discussed in Note (d) of Table 1, this ignition would have been, in all

probability, attributable to an electrical arc, resulting from the electrical anomaly described by the deponents.

21. Based on evidence and belief, the Subject Hose, to a reasonable degree of probability, was damaged by virtue of electrical current flow (over time) passing through its metallic jacketing, which occurred prior to the brief timeframe during which the appliance was put into use on the evening of the Incident. It is implausible that the Subject Hose jacketing melted and emitted gaseous vapor all within the brief segment of time beginning at the point in time where Mr. Gonzales lit the barbeque grill, and ending with the point in time at which the explosion and resulting injury of Mr. Green occurred.

22. Our testing confirms the propensity of a 3/8" Ksun gas hose to heat up due to the flow of electrical current through the length of the hose, and that the resistance is sufficient (as a function of current and time) to bring the flex hose to failure, thus releasing nominally pressurized gas into the surrounding atmosphere. Moreover, our testing shows that electrical fault currents from 20-amp household circuitry are capable, when passing through the length of hose, of compromising the integrity of a 3/8" Ksun flexible gas hose.

23. Ferrellgas was in violation of company policy and County codes, principally as the result of the actions and non-actions taken by Mr. Vicory prior to the Incident. Most notably, based on several substantive evidences, Mr. Vicory did not carry out the company required red tag procedure. Among other things, Ferrellgas failed to ascertain the credentials of Mr. Kleisner and/or Mr. Gonzales with regard to the electrical steps that were taken in efforts to resolve the catalyst to acknowledged overheating and shocking events. Rather, he simply relied on notice from Mr. Kleisner or Mr. Gonzales or both that the electrical anomaly had been resolved.

24. Ferrellgas failed to take seriously two known electrical phenomena, whether understood by Ferrellgas or not, e.g., overheating of the flexible gas hose, overheating of the gas supply tee assembly, electrical shocks experienced and

expressed by more than one person, and an open flame generated by the incidence of an electrical arc, which, under the circumstances, based on the laws of physics, was an expected phenomenon.

25. Based on testimony, Mr. Gonzales relied on the work of an unlicensed and (by Mr. Kleisner's admission) unqualified individual to perform the work which he, Mr. Gonzales, had expressed as a life-safety concern. Mr. Kleisner made it clear, several times, that Mr. Gonzales should contact a qualified electrician/company to investigate and resolve the electrical phenomena manifest prior to the Incident. Based on evidence and belief, this was never done.

26. Mr. Gonzales failed to comply with each of the following obligations which rested with him as both the owner of the property and the installer/user of the subject barbeque appliance: (i) he failed to comply with the County Building Code and applicable County technical codes, which could have been achieved by obtaining the services of a licensed contractor or service company (whom, by virtue of their licensing, would have been duty bound to understand and comply with applicable electrical codes); (ii) he failed to adhere to NRS requirements with regard to the use of unlicensed persons; (iii) he was wisely advised by others to obtain the services of such an authorized contractor in the interest of resolving unknown electrical anomalies (discussed at length within this report), and failed to do so; (iv) he failed to conform to the agreement he made with Ferrellgas with regard to the safe use of his gas appliance; (v) he failed to comply with the instructions and/or provisions set forth by Blaze.

27. It is my opinion that the actions of both Ferrellgas and Mr. Gonzales, and to a lesser degree the actions of Mr. Kleisner, are directly contributory to, and a proximate cause of, the Subject Incident. Accordingly, but for the actions and inactions of the Defendants, the Subject Incident would have been prevented.

Mr. Gifford's testimony will be consistent with GREEN 1318–1396.

3. Ruth Brubaker Rimmer, Ph.D, CLCP
CARE PLANS FOR LIFE
2145 East Glencove Street
Mesa, Arizona 85213

Ruth Brubaker Rimmer, Ph.D, CLP is a psychologist and certified life care planner. Dr. Rimmer will provide testimony regarding the past medical treatment provided for Joshua Green, the future medical treatment needed, the amount, necessity, and reasonableness of the charges for past and future treatment, and that the charges for the past and future medical treatment are within the usual and customary charges in the community. Dr. Rimmer will also rebut any opinions offered by Defendant's expert witness, if any.

Dr. Rimmer authored a report, attached hereto as Exhibit 11. The exhibits to be used as a summary of support for Dr. Rimmer's opinions are Joshua Green's medical records, billing, radiographic studies, films, and reports, deposition testimony, her individual interview with Joshua Green, and the exhibits listed in her report.

In preparation of her report, Dr. Rimmer reviewed the following records:

1. GREEN 01–85: Medica and billing records from Spring Valley Hospital
2. GREEN 86–97: Medical and billing records from UNLV Medicine
3. GREEN 98–186: Medical and billing records from Enrico Fazzini, Ph.D
4. GREEN 187: Billing records from Shadow Emergency Physicians
5. GREEN 251–273: Medical and billing records from Interventional Pain & Spine Institute
6. GREEN 188: Medical and billing records from American Medical Response
7. GREEN 370–73: Co-Pay Receipts to University Medical Center
8. GREEN 345–346: Medical records from Las Vegas Neurosurgical Institute
9. GREEN 374–845: 9. Medical and billing records from University Medical Center
10. GREEN 846: Photograph of Josh Green's palms from burns
11. GREEN 847–48: Medical and billing records from Henderson Dermatology
12. GREEN 849–888: Color photographs of Josh Green's burns taken at University Medical Center
13. GREEN 1075–1094: Medical and billing records from Michael Elliott and Associates
14. GREEN 1239–1248: Supplemental medical and billing records from Michael Elliott and Associates
15. GREEN 1249–1271: Photos that depict scars on Josh's arms, abdomen, and hands
16. Deposition transcript of Plaintiff, Joshua Green
17. Individualized interview with Joshua Green

Dr. Rimmer is expected to offer the following opinions, as outlined in her report:

1. The physical complications of burn injuries are significant. Serious burn injuries are complex and place a major stress on all the body's major organs in the acute care phase. The skin is the largest organ of the body, and when it has been damaged by deep 2nd degree burn injuries like Joshua's, it can cause serious physiologic and metabolic disruption to the entire system. Burn injuries have been noted to be the most injurious insult the human body can sustain. Burns are always unexpected, and therefore when they occur, a crisis is created. This unanticipated crisis causes the burn victim and their family to experience significant physical, emotional and psychological distress.

2. The skin is the largest organ of the body and provides several critical functions: protection, sensation, thermoregulation, excretion, absorption, metabolism, and non-verbal communication. Any compromise of the skin integrity can lead to the interruption of these vital functions and results in pain, discomfort, and possible infection.

3. Allostasis is the term used to define the adaptation that the body makes in response to stressful events. "The process involves activation of several physiologic systems, including the immune system, and is essentially the body's ability to maintain "stability through change." The body is able to cope effectively with these stressors when adaptations are activated infrequently; however, there is the potential for the system to become overloaded." (Askay & Patterson, 2008).

4. Joshua suffered severe pain from his burn injuries. With second degree burns, there is damage to the dermis, but the nerve endings are still intact. This makes them very painful. There appears to be a relationship between poor acute pain management such as Joshua's and later distress that might be manifested by issues such as depression and/or PTSD (post-traumatic stress system). He has worked as a chef for many years and shared that the burns to his hands has made his job quite difficult. He can no longer tolerate the long hours he put in pre-injury and finds that

the pain in his hands compromises his ability to do his job.

5. Life expectancy according to the Vital Statistics of the United States 2017 Life Tables indicated that a 39-year-old American male would live, on average, to the age of 78.7 years.

6. Dr. Kevin N. Foster conducted a Zoom evaluation with Joshua Green on November 25, 2020. He had reviewed his medical records and after the evaluation he then discussed Joshua's future care needs with this life care planner.

7. Joshua shared that he had followed up at the Las Vegas Burn Center and then was sent to another physician and dermatologist for his ongoing issues, which include chronic pain and skin sensitivity that is triggered with changes in temperature, such as stepping out of the shower into a cool bathroom. He stated that his hands become so painful when there are fluctuations in temperature that he must wrap them in blankets to warm them in order to relieve the stinging and painful sensation. He also reported ongoing itching on both arms and hands.

8. Joshua has a fear of grilling post-injury with flashbacks that occur when he tries to use a grill with a flame. He stated "I don't work as much as I used to and had to cut my hours drastically. I get really tired when using my hands as a chef." Chronic neuropathic pain and itch are commonly reported following burn injury. In one sample of burn survivors, over half of them reported having continuous pain despite being, on average, 10 years post-injury (Dauber, et al. 2002). Laser surgery can help to alleviate these issues. Additional treatment involves massage therapy as well as the use of moisturizers and lotions (Anthonissen, et. al., 2016).

9. Dr. Foster opined that Joshua will benefit from laser surgery for improved skin tone, pain and itching reduction, and improved cosmesis. The integrity of his burn-injured skin will never be the same as it was pre-injury. Dr. Foster also recommends pain management, medication, massage and psychological interventions which has been endorsed by his treating psychologist, Michael Elliott, PhD. The cost of future care is outlined in the life care plan tables.

10. A visit should take place, annually, over the next 5 years until such time as Joshua's burn-related issues will likely be resolved.

11. A visit every year should occur every 2 years through age 55 and then, annually, through life expectancy due to his heightened potential for skin cancer and other dermal problems. All burned areas and donor sites are more prone to sunburn and skin cancer and must be protected by sunscreen daily. Sun protective clothing is also recommended.

12. Joshua will benefit from monthly massage for the next 2 years for scar management, relaxation, and anxiety reduction.

13. Pain and itch are inevitable after laser procedures. Joshua will be prescribed Ibuprofen 800mg post-laser surgery and will be able to take over the counter medications such as Tylenol and Ibuprofen for his chronic pain. At age 50 he will likely have increased pain issues in his hands, so Naproxen has been recommended.

14. Joshua will need to keep his skin hydrated and protected from the sun through life expectancy. The recommended supplies are sunscreen and moisturizers. He should also always wear sun protective clothing when he is outdoors.

15. Dr. Foster has recommended six - CO2 and six - Pulse Dye laser sessions for Joshua. These surgical interventions will address the itching, pain and skin integrity on his bilateral arms and hands. The closest burn center that performs surgical laser procedures is the Arizona Burn Center in Phoenix, Arizona. Included in the cost projection are round trip flights from Las Vegas to Phoenix with an overnight stay in a hotel each time because Joshua will receive general anesthesia for the procedure and will need to remain close to physician access in case of complications.

16. Dr. Michael Elliott is Joshua's current, injury-related, mental health provider. Dr. Elliott has provided recommendations for necessary psychological treatment associated with the burn event and his subsequent burn injuries. He opined that Joshua's symptoms will likely worsen unless his physical, cognitive, and psychological problems are treated aggressively. Joshua's post-injury memory deficits, sleep

troubles, high levels of stress, and overall quality of life put him at significant risk. His stress coping skills are challenged, and he needs several strategies for stress management. As such, a normal course of recovery is threatened without treatment for his physical and mental conditions. The longer he suffers with his current levels of stress, anxiety, and depression, the more likely his mood and cognitive deficits will worsen.

17. Dr. Elliott recommends 6 months of weekly Cognitive Behavioral Therapy (24 sessions) with an additional 6 months of weekly Biofeedback and Mindfulness Training. Cognitive Behavioral Therapy will help to nurture Joshua 's awareness of and responsiveness to his emotional struggles with anxiety, whereby he can more effectively manage his emotions, so they do not negatively impact his planning and follow through. This includes an 8-week course of graduated cognitive therapy that requires a weekly session with specific homework assignments for completion between sessions. An additional six months of biofeedback and mindfulness training are necessary to manage anxiety. This will include a Biofeedback/Heartmath Heart Rate Variability (HRV) program. This program offers highly effective and practical solutions for reducing stress, anxiety, depression, and sleeplessness.

18. Due to his symptoms associated with PTSD, Joshua should also participate in Eye Movement Desensitization & Reprocessing (EMDR) therapy. EMDR is a treatment designed to alleviate distress associated with traumatic memories. Data from meta-analyses and Randomized-Controlled Trials included in this review evidence the efficacy of EMDR therapy as a treatment for PTSD. Specifically, EMDR therapy improved PTSD diagnosis, reduced PTSD symptoms, and reduced other trauma-related symptoms. EMDR therapy was evidenced as being more effective than other trauma treatments and was shown to be an effective therapy when delivered with different cultures (Shalev AY., 2009).

19. Careful consideration has been given to Joshua's future medical and psychological needs which have resulted from his burn injuries. He has survived

deep 2nd degree burns to both arms, hands, and his abdominal area as the result of the accident, with the most significant damage occurring to his hands. Pain is one of the biggest problems that burn victims experience. The recovery phase of a burn primarily involves tissue growth which causes pain, itchiness, numbness and tingling. Some burn patients experience nerve damage which results in longer lasting chronic pain. In addition, being on fire is a very traumatic event and the psychological damage can be as significant as the physical injury. Studies have found that survivors of fire related injury can experience symptoms of major depression and anxiety, as well as an uptick in symptoms associated with Post Traumatic Stress Disorder.

20.The goal of this Life Care Plan is to provide reasonable and medically necessary care that will maintain/increase Joshua Green's medical stability and quality of life, and to anticipate and prevent potential complications. The plan provides for medical and surgical care, evaluations, therapies, medications, supplies, transportation needs, in order to promote and maintain his independence and prevent complications. This plan should be re-evaluated/modified if complications develop and/or as progressive aging alters Joshua's medical condition and functional status. The recommendations are outlined in specifics within the Life Care Plan Tables, which are attached as Appendix A.

Dr. Rimmer's testimony will be consistent with GREEN 1397–1474.

4. Kevin N. Foster, MD, MBA, FACS
The Arizona Burn Center, Valleywise Health
Phoenix, Arizona 85008

Kevin N. Foster, MD, MBA, FACS is a burn surgeon and medical provider. Dr. Foster will provide testimony regarding the past medical treatment provided for Joshua Green, the future medical treatment needed, the amount, necessity, and reasonableness of the charges for past and future treatment, and that the charges for the past and future medical treatment are within the usual and customary charges in the community. Dr. Foster will also rebut any opinions offered by Defendant's expert witness, if any.

Dr. Foster authored a report, attached hereto as Exhibit 1474. The exhibits to be used as a summary of support for Dr. Foster's opinions are Joshua Green's medical records, billing, radiographic studies, films, and reports, deposition testimony, Dr. Rimmer's lifecare plan, and the exhibits listed in his report.

In preparation of his report, Dr. Foster reviewed the following records:

1. GREEN 01–85: Medica and billing records from Spring Valley Hospital
2. GREEN 86–97: Medical and billing records from UNLV Medicine
3. GREEN 98–186: Medical and billing records from Enrico Fazzini, Ph.D
4. GREEN 187: Billing records from Shadow Emergency Physicians
5. GREEN 251–273: Medical and billing records from Interventional Pain & Spine Institute
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13. GREEN 1075–1094: Medical and billing records from Michael Elliott and Associates
14. GREEN 1239–1248: Supplemental medical and billing records from Michael Elliott and Associates
15. GREEN 1249–1271: Photos that depict scars on Josh's arms, abdomen, and hands
16. Deposition transcript of Plaintiff, Joshua Green
17. Individualized interview with Joshua Green

Dr. Foster is expected to offer the following opinions, as outlined in his report:

1. Joshua green suffered an 8% total body surface area thermal burn injury on June 18t, 2018 as the result of a propane grill explosion. He was 36 years old at the time of his injury. He was cared for in the Las Vegas burn center for seven days. He received daily dressing changes, pain control, nutritional support, physical and occupational therapy, and all of the other resources of this tertiary care burn center. He was discharged home in good condition and has been followed by the burn center as an outpatient since that time.

2. I have reviewed the medical records for Mr. Green, the photographs of his

injuries and subsequent scars, the life care plan prepared for him by Dr. Rimmer and myself, and various other documentation related to his injury and hospitalizations. I have also interviewed and examined Mr. Green via telemedicine. I agree with the future needs and care projected and outlined in Mr. Green's life care plan. I consider these projections and needs to be medically likely, fair and reasonable. Thank you.

3. Dr. Foster has recommended six - CO2 and six - Pulse Dye laser sessions for Joshua. These surgical interventions will address the itching, pain and skin integrity on his bilateral arms and hands. The closest burn center that performs surgical laser procedures is the Arizona Burn Center in Phoenix, Arizona. Included in the cost projection are round trip flights from Las Vegas to Phoenix with an overnight stay in a hotel each time because Joshua will receive general anesthesia for the procedure and will need to remain close to physician access in case of complications.

Dr. Foster's testimony will be consistent with GREEN 1397–1474 and GREEN 1475–1518.

II.

Treating Physicians

The following non-retained physicians and witnesses are expected to give opinions regarding the treatment of Joshua Green at their respective facilities, the authenticity of the records for said treatment, the necessity of treatment rendered, the causation of the necessity for the medical treatment rendered and any treatment they have recommended. Their opinions shall include the cost of past medical care, diagnostic testing, surgery and medication; the cost of future medical care medical care, diagnostic testing, surgery and medication; and whether those past and future medical costs fall within the ordinary and customary charges in the community for similar medical care and treatment. They are expected to also review documents outside their report(s) for the purpose of providing and defending those opinions:

1. Elad Bicer, MD
Spring Valley Hospital Medical Center
5400 South Rainbow Boulevard
Las Vegas, Nevada 89118
T: 702-853-3000

2. Elizabeth Sodomin, MD
UNLV Medicine
2040 West Charleston Boulevard, 3rd Floor
Las Vegas, Nevada 89102
T: 702-895-4928

3. Jon Petrick, DC
Las Vegas Pain Relief Center
2779 West Horizon Ridge Parkway, Suite 210
Henderson, Nevada 89052
T: 702-948-2520

4. Elizabeth Sodomin, MD
5. Paul J. Chestovich, MD
6. Amy Urban, MD
University Medical Center -
5400 South Rainbow Boulevard
Las Vegas, Nevada 89118
T: 702-853-3000

7. Cyril Joseph, PA-C
Henderson Dermatology and Skin Center
2960 Saint Rose Parkway, Suite 120
Henderson, Nevada 89052
T: 702-558-5100

8. Michael Elliott, Ph.D
Michael Elliott and Associates
1661 West Horizon Ridge Parkway, Suite 280
Henderson, Nevada 89012
T: 702-307-0133

III.

Documents

1. Scott G. Davis, Ph.D, P.E., CFEI's Expert Report and Opinions (GREEN 1272–1299), as Exhibit 1.

2. Scott G. Davis, Ph.D, P.E., CFEI's Curriculum Vitae (GREEN 1300–1314), as Exhibit 2.

3. Scott G. Davis, Ph.D, P.E., CFEI's expert fee schedule (GREEN 1315), as Exhibit 3.

4. Scott G. Davis, Ph.D, P.E., testimony history (GREEN 1316–1317), as Exhibit 4.

5. GEXCON Green v. Gonzalez Simulations Presentation (provided in Dropbox), as Exhibit 5.

6. GEXCON Simulation of explosion (provided in Dropbox), as Exhibit 6.

7. Don L. Gifford's Expert Report of Findings (GREEN 1318–1349), as Exhibit 7.

8. Don. L Gifford's Curriculum Vitae, testimony history and expert fee schedule (GREEN 1350–1374), as Exhibit 8.

9. Reference Material for Don L. Gifford's Expert Report of Findings (GREEN 1375–1395), as Exhibit 9.

10. GCG Gas Hose Testing (GREEN 1396 and provided in Dropbox), as Exhibit 10.

11. Ruth B. Rimmer, Ph.D, CLCP's Life Care Plan (GREEN 1397–1474), as Exhibit 11.

12. Ruth B. Rimmer, Ph.D, CLCP's Curriculum Vitae (GREEN 1455–1474), as Exhibit 12.

13. Ruth B. Rimmer, Ph.D, CLCP's expert fee schedule (GREEN 1473), as Exhibit 13.

14. Kevin N. Foster, MD, MBA, FACS's Letter Regarding Record Review and Life Care Plan (GREEN 1474), as Exhibit 14.

15. Kevin N. Foster, MD, MBA, FACS's Curriculum Vitae (GREEN 1475–1513), as Exhibit 15.

16. Kevin N. Foster, MD, MBA, FACS expert fee schedule (GREEN 1514), as Exhibit 16.

17. Kevin N. Foster, MD, MBA, FACS's testimony history (GREEN 1515–1518), as Exhibit 17.

18. Michael A. Elliott, Ph.D's Curriculum Vitae (GREEN 1519–1523), as Exhibit 18.

19. Michael A. Elliott's expert fee schedule (GREEN 1524), as Exhibit 19.

20. Jon S. Petrick, DC's Curriculum Vitae (GREEN 1525–1526), as Exhibit 20.

21. Paul J. Chestovich, MD, FACS's Curriculum Vitae (GREEN 1527–1543), as Exhibit 21.

DATED this 29th day of January 2021.

H & P LAW

Marjorie Hauf, Esq.
Nevada Bar No.: 8111
Matthew G. Pfau, Esq.
Nevada Bar No.: 11439

Attorneys for Plaintiff,
Joshua Green

H&P LAW

Certificate of Service

I hereby certify that on the 29th day of January 2021, service of the foregoing **Plaintiff, Joshua Green's Initial Designation of Expert Witnesses and Reports** was made by required electronic service to the following individuals:

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Attorneys for Defendant,
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An Employee of H & P LAW

H&P LAW

EXHIBIT "10"

In the Matter Of:

A-19-795381-C

GREEN

vs

FERRELLGAS, INC. et al.

Videotaped Deposition Of:

JOSHUA GREEN, VOLUME II

June 29, 2020

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envision
legal solutions

702-805-4800
scheduling@envision.legal

DISTRICT COURT

CLARK COUNTY, NEVADA

JOSHUA GREEN, an individual, Plaintiff, vs. FERRELLGAS, INC., a foreign corporation; MARIO S. GONZALEZ, an individual; CARL J. KLEISNER, an individual; DOES I through XXX, inclusive, and ROES BUSINESS ENTITIES I through XXX, inclusive, Defendants. AND ALL RELATED ACTIONS.	Case No.: A-19-795381-C Dept. No.: C

VOLUME II

VIDEOTAPED DEPOSITION OF JOSHUA GREEN

LAS VEGAS, NEVADA

MONDAY, JUNE 29, 2020

Reported by: Monice K. Campbell, NV CCR No. 312

Job No.: 4472

VIDEOTAPED DEPOSITION OF JOSHUA GREEN, held at Envision Legal Solutions, located at 700 South 3rd Street, Las Vegas, Nevada, on Monday, June 29, 2020, at 8:38 a.m., before Monice K. Campbell, Certified Court Reporter, in and for the State of Nevada.

APPEARANCES:

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Also Present:
JORDAN LEEDS, VIDEOGRAPHER

I N D E X

* * * * *

LAS VEGAS, NEVADA; MONDAY, JUNE 29, 2020
8:38 A.M.

* * * * *

THE VIDEOGRAPHER: This begins the video-recorded deposition of Josh Green, Volume II, in the matter entitled Green v. Ferrellgas, Incorporated, et al., Case Number A-19-795381-C.

We're at 700 South 3rd Street, Las Vegas, Nevada. Today's date is Monday, June 29th of 2020, and the time is approximately 8:38 a.m.

I am the videographer, Jordan Leeds. The court reporter is Monice Campbell with Envision.

Will counsel please identify yourselves and then the reporter will administer the oath.

MR. McMULLEN: Mike McMullen for Defendant Ferrellgas.

MS. WINSPEAR: Gina Winspear for Defendant Carl Kleisner.

MR. WALKER: Mike Walker for third-party Defendant Home Depot.

MR. GOLDSTEIN: Steve Goldstein for Defendant Mario Gonzalez.

MR. PFAU: Matt Pfau for Plaintiff, Josh Green.

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Whereupon,

JOSHUA GREEN,

having been sworn to testify to the truth, the whole truth, and nothing but the truth, was examined and testified under oath as follows:

EXAMINATION

BY MR. McMULLEN:

Q. Good morning.

A. Good morning.

Q. How are you, Josh?

A. Good.

Q. How are you feeling today?

A. Good. Itchy hands, but good.

Q. Do you feel like you can complete your deposition today? And by that I mean, is there anything that might interfere with your ability to do so?

A. No.

Q. So you do feel like you can continue?

A. Yes. I can continue.

Q. All right. Thanks.

I just have a few things and then I'm going to pass the witness to other counsel.

Last time we talked about your work

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issues, and you testified that long before this grill accident, you had epileptic seizures. I think you said those began when you were working at SkinnyFATS; is that right?

A. It began before that, but yes.

Q. And you testified at least initially that the seizures reduced your work hours, correct?

A. Yes.

Q. And then if I understand, once you treated those seizures with medical marijuana, it has been several years since you've had any seizures; is that true?

A. Yes.

Q. So am I correct that you no longer have any reduction in your work hours due to seizures?

A. Yes.

Q. You also testified about at a very young age, at least at that time, a learning disability; is that right?

A. Yes.

Q. Are there any current continuing issues that you relate to that learning disability that interfere with your work?

A. No.

Q. So there's no reduction in work hours due

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to any learning disability problems?

A. No.

Q. You testified that the first six months after the accident that your mother helped with you with daily activities such as eating, bathing, and driving while your hands and arms were healing; is that true?

A. Yes.

Q. You testified by October '18 -- sorry, by October of 2018, that by then you were able to return to work full time as a chef cooking in the kitchen; is that right?

A. Yes.

Q. And did that include using gas grills in the kitchen?

A. I haven't used a gas grill or a propane grill since the accident.

Q. You've not used any gas grill at all since the time of the accident?

A. No.

Q. And that gets into psychological issues where you are fearful of using a gas grill; is that right?

A. Yes. It happened once. It can happen again.

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Q. Other than the psychological issue which I'll get into in a moment, according to your prior testimony, the only remaining problem that you're facing that you relate to the accident is temperature extremes on your hands; is that true?

A. Yes.

Q. So let's talk about the psychological issue briefly.

You testified last time that -- that was May 18, I believe, that the Friday before we started your deposition, which would be May 15, that you saw a -- is it psychologist or psychiatrist?

A. Psychologist.

Q. Is that Michael Elliott?

A. Yes.

Q. You saw psychologist Michael Elliott for an evaluation on May 15?

A. Yes.

Q. Have you heard from him on the results of his evaluation?

A. Yes. I have another appointment with him on July 1st.

Q. Can you tell us what results he reported to you from his evaluation?

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A. We didn't really go into too much of it. They said we were going to go over stuff on the 1st. Just told me that I had -- from his findings, that I -- that I have PTSD on the situation, and that, you know, me working on grills or anything that has to do with potential fire, it definitely has a play on it.

And, I mean, his whole thing is that he definitely thinks that there's trauma due to the incident.

Q. Did he specifically diagnose you with PTSD as a result of this grill accident?

A. I mean, he told me that he feels that it can and then that's why they're doing more tests and they're doing more -- that's why we're having more meetings and more sessions.

Q. So if I understand, is his evaluation continuing or has he completed his --

A. No. It's continuing.

Q. So at this point he said it's a possibility that you have PTSD from this accident but that more evaluation is needed; is that true?

A. Yes, and going more into a detailed psychological session, and that's what we're going on July 1st.

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Q. Did you do any testing on May 15 with Michael Elliott?

A. Yes.

Q. What kind of testing?

A. I went in front of a computer and answered a bunch of questions.

Q. Do you happen to know the name of that test, what it's called?

A. No. I think it was like a Pearson's test or some straightforward test.

Q. Do you recall how many questions were involved?

A. Like 200. I don't even -- it was a lot.

Q. How long did it take?

A. Like two and a half hours, two hours.

Q. Was it a multiple choice or an essay type?

A. Multiple choice.

Q. So you're given a question and then you have, what, three or four possible answers and you pick one of those?

A. Yes.

Q. Do you recall any other type of testing that you took on May 15 when you saw Michael Elliott for psychological evaluation?

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A. No.

Q. Do you know what future tests he has in mind?

A. No.

Q. But some kind of testing you understand is slated for the next visit?

A. Yes.

Q. And that's on July 1?

A. Yes.

Q. Did you get any paperwork from him, any kind of report or test results from when you saw him on May 15?

A. I believe everything was given to my lawyer.

Q. Okay. Have you seen it?

A. No.

Q. Forgive me if I covered this before.

Had you ever been diagnosed with PTSD before this accident?

A. No.

Q. Have you ever had any traumatic event before this accident that required any kind of professional care?

A. No. I mean, I had a bad car accident, but I never had -- you know, I never had anything

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from it.

Q. You were seeing Lauren Unger, a shaman in Miami?

A. Mm-hmm.

Q. And what specifically were you seeing her for?

A. I was seeing her for -- I've had a lot of businesses and I was, you know, taken advantage of in a couple ways. And I saw her because I was super negative in my life and saw a lot of things going in a negative spiral. So I went to her to fix -- to fix things and going into a better direction, positive and -- you know, kind of fix my life in different ways.

Q. And that had to do in part, I think, from what you testified before, with what happened with Green Gourmet and SkinnyFATS?

A. Yes.

Q. That was a negative impact?

A. Yes.

Q. Psychologically?

A. Yes. I mean, everything.

Q. Right.

Do you feel that you had recovered from that negative psychological impact, what happened

with those businesses, before this accident happened?

A. Yes. Because I -- I mean, after going to her, I felt that I was a different -- I was a different person, and I just felt in a more positive attitude towards things and not as negative.

Q. By the way, I'm sure I'm mistaken, but Lauren Unger is not now your wife? Is it a different Lauren?

A. Yes.

Q. Lauren Unger is still in Miami somewhere?

A. Yes. I still talk to her.

Q. How often do you talk to her?

A. Whenever I need to, but usually like once -- I touch base once every two weeks.

Q. What do you talk about generally?

A. Just what's going on, my well-being, how I'm doing, how, you know, my path is going.

Q. Do you talk to Lauren Unger specifically about your psychological issues from this accident?

A. I mean, we've had discussions about it, yes.

Q. Is she someone that provides therapy for you on that?

A. I mean, she gives me the advice from her -- from her side, and, you know, it's not really -- I wouldn't say "therapy," but it's more of talks and conversations of making myself better.

Q. Is that the main reason you still have contact with her, or are you mainly talking about other things?

A. I mean, we talk about everything. I mean, we have conversations about this accident, about everything.

Q. You talk to her about your general well-being?

A. Yes.

Q. Has she given you any advice regarding your psychological issues from this accident?

MR. PFAU: I'm going to object to the question as it calls for privileged communications. He can answer as long as it's not related to anything she may have said to him.

MR. McMULLEN: I'm not sure I understand the nature of the privilege. He's put his psychological condition at issue, so if he's getting any kind of professional care, that's now become relevant.

MR. PFAU: It's not that it's not

relevant. It is relevant. It's privileged because it is a treating person, a person providing medical treatment or psychological treatment. So for that reason, it is subject to the patient privilege.

MR. McMULLEN: In Nevada is the privilege not waived once the plaintiff puts the condition in issue? That's been my experience.

MR. PFAU: No, it's not waived. It's not waived as it relates to communications.

MR. McMULLEN: So if I had medical records or some notes that she made when she provides therapy to him, clearly those would be discoverable and I could ask him about those.

MR. PFAU: Certainly.

MR. McMULLEN: And that's along the lines what I'm asking now, whether she's provided him any assistance or help, advice, with his psychological issues.

MR. PFAU: Okay. That's fine.

BY MR. McMULLEN:

Q. Has Lauren Unger provided you with any care, therapy-type care, in relation to this accident?

A. Just like I said before, just normal -- just conversations and we talk about -- we do talk

about the incident. We talk about what happened, how I'm doing, and you know, the situation -- how I'm handling it, how I'm going through it. And that's really the basis of it.

Q. In the course of the care or therapy that Lauren Unger has provided you, has she given you any specific advice to help with your psychological issues?

A. No. She just said to go to a more detailed psychological treatment and that's why I went to Michael Elliott.

Q. I see.

A. The conversations that we have are more of a -- about my attitude, my ways of how I'm dealing with all the situations that come into my life, and how I'm making my life better.

Q. How is your attitude and outlook now? How would you describe your psychological state?

A. I mean, everything -- it's been good, but, I mean, a lot of -- like I said before, a lot of this incident just made me -- hindered a lot of things that I would have done before.

I was -- I never was ever in fear of equipment. Now I have fear of equipment. I have fear of grills. I mean, I -- you know, I do cook

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on a normal basis, but it's always like -- I used to work 16-, 17-hour days. I don't do that anymore.

I probably work -- I mean, right now I work at a pizza place. It's called Fries N' Pies. I work there four or five hours a day and that's it. And then I go do a personal chef thing for a couple hours. It's very minimal work in the kitchen.

When I used to work at SkinnyFATS, I worked 16 hours a day. So it's a totally different situation.

Q. Are you saying you work fewer hours because you're afraid of being in a cooking environment?

A. Yeah. That and -- I mean, I've got real bad sensitivity on my hands. My hands have been itching in the past two -- two months, month. I mean, I get out of the shower and if it's cold outside, like, I have to be extremely dry in the shower, because if I go out and it's cold, my hands get extremely sensitive.

I have been having issues of itching on my hands. Maybe that's the healing process or whatever. But my hands are extremely tight. The

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skin is extremely tight. I get cuts all the time. You can see blisters from cuts. I mean, it's blisters.

I mean, it's crazy. And it's on a continuous basis.

MR. McMULLEN: Would you be okay if he holds his hands up for the video so we can see his hands?

MR. PFAU: Sure.

BY MR. McMULLEN:

Q. Show us, if you would, where the blisters and the itching occur.

A. Blister here, blister here (indicating).

Q. Go like this so they can see.

Thank you.

A. Blister here. Scar here. Or like my palms get scraped very easily. I got a blister here. And it's just a continual basis of...

Q. So specifically regarding your hands, I'm understanding that you have itching, you have blisters, and you have scrapes?

A. Yeah, and sensitivity issues.

Q. And sensitivity.

What are you doing to treat those problems, if anything?

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A. I mean, every doctor I have been to just says put cream and kind of wait it out and see if it's going to get better. They all tell me it's going to get better and it's just a waiting process.

Q. Is it getting any better?

A. I mean, like I didn't have itching issues until, you know, the past two months. And that's just -- maybe that -- like I said, maybe that's the healing process or maybe it's just a sensitivity issue, but that's...

Q. Have you talked to any medical person about these issues?

A. I did go to a skin, and they tell me the same -- you know, they tell me the same things, put lotion, keep an eye on it, make sure, you know, if you have any other issues, come back and see us.

And that's really it.

Q. Was this a dermatologist in Henderson you told me about last time?

A. It was that one and then there was another one.

Q. When was the last time you talked to any professional about this?

A. I don't really have exact memory, but I

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could say March or April, in those months.

Q. Who was that, if you remember?

A. I don't. I don't remember the name. I know where it was, but I don't remember the name.

Q. And you got the advice about using lotion?

A. Yes.

Q. Do you use lotion?

A. Yes.

Q. What kind of lotion is it?

A. It's a -- a derma -- a derma -- I don't know exactly what it's called.

Q. Is it over the counter or prescription?

A. Prescription.

Q. Who prescribed it?

A. Every dermatologist that I went to prescribed the same thing, and it's $75 bottle of cream that --

Q. Does it help?

A. No.

Q. Have you told your health care people this lotion isn't helping?

A. Yes.

Q. Do they have any advice?

A. Same thing when I went to the person I

said, I use this already, and they said just keep using it. That's really it.

And then they say that it's going to -- you know, the sensitivity issues should go away and it hasn't. And to be honest with you, I don't think it will because it just gets worse. Me grabbing something from the freezer, me grabbing a hot cup of coffee -- you know, like I said last time, if I grab a hot cup of coffee without a jacket on it, you know, it burns.

Q. So I appreciate your patience with my detailed questions. I'm trying to get a very thorough understanding of the issues you still have from this accident.

I understand physically, with regard to your hands, you told me about sensitivity to temperature, itching, blisters, scrapes, and then you've told me psychologically you have a fear of using grills.

A. Mm-hmm.

Q. Is there anything else that's continuing from this accident that you claim today?

A. I mean, I have headaches on a continual basis. I mean, that is -- I believe it's from the blow and like it just -- it's never stopped since

that accident. I've always had continuous headaches. That's one of the reasons why I smoke weed, is because of that.

And the headaches get so painful, sometimes I -- you know, if you do look at my medical record, I had a problem with headaches and then it kind of got resolved, and then after this accident I've had massive headaches all the time.

Q. I asked you last time -- and maybe I misunderstood or maybe the answer has changed -- if any healthcare professional has told you that your headaches today are likely the result of this accident. And I thought you said no one has, but is that mistaken?

A. No. Like I said, I said that I get headaches and I believe that it's from that. I haven't been to a -- I mean, I went to, you know, the specific individuals that I went to, but no one has said exactly from the accident.

But I -- you know, like I said before, I went through treatment for the headaches, everything was good, and then after this accident had numerous amounts of more headaches.

Q. Are you getting any treatment today for your headaches other than over-the-counter Tylenol

I think you told me before --

A. Yeah, Tylenol, like I said, and CBD and marijuana.

Q. Anything else?

A. No, not right now.

Q. Have you spoken to any healthcare professional and said, Hey, I need to do something more, or are those things working?

A. They work. I mean, it hasn't got to a point where it's not working, so I just keep on -- on that system.

Q. A little bit more about the PTSD. The symptoms of your PTSD you've told me are fear of using grills, fear of other equipment.

What other equipment besides grills are you fearful of using because you relate that to this accident?

A. Any -- you know, like I told you last time, I do catering. So with catering, you hook up ovens. You hook up different things that have propane. So I don't really use -- I haven't used any propane since this accident and I don't think I ever will.

I mean, that's the thing of it. The propane, the explosion was so traumatic to the

point where it's like, you know, it blew me back and I -- you know, if I didn't jump in the sprinkler, I might have had a lot more, you know, damages. But because of my, you know, ability of reacting, I put myself in water, you know, in a sprinkler, and put out the fire.

And then as soon as I -- as soon as the fire went out, I looked at my hands and I said "I'm never going to be able to cook again." So --

Q. Do you have any PTSD symptoms, in your opinion, other than what you've told me? Are you fearful of using propane?

A. Yep. I mean, I'm fearful of using propane. I'm fearful of using grills. I'm afraid of fire. I mean, I went to O, a show at the Bellagio, with my boss, and I was sitting there and there was a guy on fire and I was like, "Oh, look. It's me." You know, anything that I see that has to do with a guy on fire or, you know, any of that, it brings back the memories.

And that's the biggest thing, is that it's always -- I'm always being -- you know, I'm always remembering the situation because it was so dramatic and the fact where I was in the hospital a while. I was in a lot of treatment with them

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ripping off my bandages and just like the whole process was extremely emotional and devastating to everything that I've done after the accident.

Q. So if you see fire, that brings back these bad memories?

A. Yes.

Q. Anything else regarding PTSD?

A. I mean, the biggest thing is that, like I said before -- and I don't really -- you know, if this does pertain to PTSD, it's just the fact where before I was able to do a lot more things in the kitchen, a lot more things at work, a lot more things in my life, and now it's hindered a lot of things, to make me think about doing things either differently or things that I, you know, react.

I react kind of just -- I think about things before I do it, where before I would just, oh, turn on a grill and I wouldn't even think about it, or I would -- you know. So a lot of that stuff has to do with the posttraumatic syndrome of having to deal with -- you know, of what happened.

Q. So you told me before that you're less social, you're more withdrawn?

A. Yeah.

Q. With regard to working in the kitchen,

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you do still cook in the kitchen, true?

A. Yes, but very little.

Q. So what equipment do you use now that you didn't use before?

A. I mean, I use a flat top grill, which is a controlled gas grill, you know, that -- you know, yes, anything can happen, but it's pretty controlled. So, you know, if there's -- if there's a gas problem, I'm going to smell it or I'm going to know about it before it goes into the grill.

And then I use fryers on a daily basis.

Q. So the gas equipment that you use would be a flat top or a fryer, but am I correct that it's not propane that you're using?

A. No.

Q. It's natural gas?

A. Yes. I will never use propane again. I mean, that's just -- and that's, you know, part of the PTSD. That's part of a lot of, you know, the thinking process of using propane after this incident -- accident.

Q. Anything else you can think of that you can't do or you don't do like you did before or other symptoms you relate to PTSD, or have we covered it?

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A. I mean, I think we've covered most of it. I just, you know -- yeah.

Q. All right. So I wanted to ask you briefly about Green's Gourmet and SkinnyFATS. You testified before that Green's Gourmet -- which, by the way, is that greens like we eat greens or is that you, Green?

A. Me.

Q. So it's Josh Green's Gourmet?

A. Yes.

Q. That was a personal chef catering business that you with started with someone named Demetri and an investor, correct?

A. Yes.

Q. What's Demetri's last name?

A. Townsend.

Q. I'm sorry?

A. Townsend. T-o-w-n-s-e-n-d, I believe.

Q. And who was the investor?

A. Tony Clark.

Q. Is Green's Gourmet still in business?

A. No.

Q. Where is Demetri Townsend today, if you know?

A. I don't know.

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Q. The last time you knew where he was, where was he?

A. Las Vegas. But I haven't talked to him since.

Q. How about Tony Clark?

A. No.

Q. You did testify -- the words you used were that they sideswiped you, that they, quote, "pushed you out of the company."

What happened?

A. I went to work for a big fighter in Miami and LA, and while I was doing that, they were doing things behind my back in the business.

And when I came back, we were -- we were having a talk, and they said that because I was doing personal chef stuff and other things, that they didn't think I was, you know, putting all the -- and I started the business. So they were -- I wasn't putting as much effort or they were running the business while I was doing this other stuff. And it just led to problems.

And then they tried to start the aviation company without me and they went -- and they were done in three months.

Q. Were you an investor yourself? Did you

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have an ownership interest in Green's Gourmet?
A. I was the owner. I was the sole owner. I've, you know, dealt with a lot of issues behind it. I was very young and I learned a lot of lessons from it. That's really what it comes down to.
Q. So legally, if you were the sole owner of Green's Gourmet, how were they able to push you out?
A. Because -- so -- I mean, I was the owner and I gave Demetri -- I gave him ownership. And then when I brought in the other investor, he brought in the accountants, he brought in everything, brought in the business aspects of it, and they used that talent to -- you know, in his business ways, to take control and force me out. I mean, that's really what it comes down to.
Q. Was there a lawsuit over this?
A. No.
Q. Did they threaten to sue you?
A. No. I mean, not to sue me, no.
Q. Did you think about hiring a lawyer and --
A. I didn't have the money to fight it. That's the same reason why SkinnyFATS -- I didn't

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have money to fight it. I mean, that guy from SkinnyFATS would have eaten me alive because he would have spent as much money as possible. And that's exactly what happened.
Q. So when we talk about SkinnyFATS, is that Reed Slobusky?
A. Yep.
Q. You said he was your best friend at one time?
A. He was.
Q. And he was your financing partner for SkinnyFATS?
A. He was.
Q. SkinnyFATS is still in operation?
A. Yes.
Q. Do they have more than one location?
A. Yep.
Q. Where do those --
A. Eight locations.
Q. Where was the original location?
A. Dean Martin.
Q. Is that Dean Martin Drive or Avenue?
A. Dean Martin Drive, I believe.
Q. Here in Las Vegas?
A. Yep.

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Q. And that was back in 2013 or 2014?
A. 2013.
Q. So you testified before that you had a falling out with Mr. Slobusky, that you had disagreements and you parted ways.
What was the disagreement --
A. I had a seizure, actually. I had a seizure on the line and I was in the hospital for a month after that. The doctor told him that I could not work on the line due to that.
He said that I didn't -- I wasn't following my contractual obligations. And that's where he said he doesn't need me anymore, and if I wanted to take it up with anybody, that I could take it up with a lawyer.
I spoke to a lawyer and, you know, we had a conversation, and he said that I could do it, but it's going to -- you know, it's the same thing I just told you. He would have eaten me alive.
Q. Did you have an ownership interest in SkinnyFATS?
A. That's part of the issue. I was supposed to. I was supposed to have 25 percent. I was supposed -- and then I had a contract for 10 percent, signed it, and he never gave it to the

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lawyer.
And that's the whole thing. He was supposed to be my business advocate. He was supposed to be my confidant. And he got greedy and started doing things to get me out of it.
Q. So originally you were supposed to have 25 percent, but somehow that got negotiated down to a contract for 10 percent?
A. Well, it was -- it was 10 percent and then it was, you know, after a certain time it would evolve into more, and --
Q. So like Green's Gourmet, you felt like you had been wronged but you didn't have the legal -- you didn't have the resources to fight it?
A. Yep.
Q. Did you talk to any lawyer about this?
A. I mean, I spoke to friends that are lawyers, but, you know, just to get advice.
Q. Did you talk to a lawyer about taking this on on a contingency so the expenses would be fronted by them and you can go forward?
A. I mean, nobody that I talked or nobody that I -- you know, was willing to do it.
Q. So you did talk to some lawyers, but they weren't willing to take it?

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A. Yeah.
Q. So today --
A. Because he had the paperwork.
Q. I'm sorry?
A. Because he had the paperwork. He knew what he was doing.
Q. "He" being Slobusky?
A. Yes.
Q. So today you're working at Fries N' Pies?
A. Yes.
Q. And as a personal chef for someone?
A. Yes.
Q. What are your hours at Fries N' Pies?
A. 10:00 to 3:00.
Q. And I know you told me this.
Is there more than one location?
A. No.
Q. Where is Fries N' Pies located?
A. 4503 Paradise Road.
Q. Some of your time when you're working there from 10:00 to 3:00 is cooking?
A. Yes.
Q. Is that primarily what you do?
A. I mean, I'm a manager. I'm an operating manager. So I operate the store and make sure the

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store's opened and following the proper code of setting up the restaurant.
Q. And you cook as well?
A. Yes.
Q. How much time do you spend cooking at Fries N' Pies?
A. I mean, actual cooking, probably two to three -- two hours a day, two to three hours a day.
Q. What do you cook?
A. I just cook on a flat top and make french fries.
Q. Well, that's what it is, right, it's pizza and french fries?
A. Yeah.
Q. How is that business going?
A. It's good. I mean, it's getting better now. We cut the menu down, so...
Q. How many employees do you have?
A. Seven.
Q. Full time?
A. Yes.
Q. Making a profit?
A. Starting to, yes.
Q. Your other job is a personal chef to someone, and I forgot who someone is.

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A. Scott Sibley.
Q. Who is he?
A. He's a prominent man in Las Vegas. I mean, he has a bunch of businesses. And he got my name through someone that -- he was trying to lose weight, and he said, "I need the best personal chef in town," and somebody that I know referred him. And that's how it happened.
Q. How long have you been doing that?
A. About five months.
Q. What kind of hours do you work as a personal chef for Mr. Sibley?
A. About 4:00 to 8:00 every day.
Q. Seven days a week?
A. Yes.
Q. Sounds like you're cooking all of his evening meals, anyway.
A. Yep. I do his dinner.
Q. Do you do other meals too?
A. I leave a lunch for him in like a container.
Q. I know you're skilled at cooking a wide variety of things, but give me an idea. What do you cook for him?
A. I mean, everything. I mean, it's -- it

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can be tacos to pasta to -- I mean, anything and everything.
Q. Do you use any gas-fueled equipment to cook for Mr. Sibley?
A. I use -- I mean, I use a stove and an oven, and that's really it.
Q. Those are indoor appliances?
A. Yep. I mean, we have -- he's asked me to grill a bunch of times and I tell him no and I tell him I can't. And then about three months ago, he asked me to grill and there was another person there, one of his friends, who said that he would grill instead, so I didn't have to.
Q. What kind of income are you making working for Mr. Sibley?
A. I make $4,000 a month. And that's what keeps me afloat. So that's why I had to take that job. Because I do not get paid at Fries N' Pies because I own 45 percent of it.
Q. That's a long-term business venture?
A. Yes.
Q. Who owns the rest of Fries N' Pies today?
A. Adam Sadie.
Q. The two of you are the owners; no one else?

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A. Yes -- oh, no. There is one 10 percent investor, one of -- a friend of his.
Q. Who is that?
A. Sherman -- I forget his last name. Yu, actually, Y-u. Sherman Yu.
Q. As manager of Fries N' Pies, which I understand has been in operation since July of 2018?
A. Yes.
Q. Continuously?
A. Yes. Besides the past -- we closed in March and reopened two weeks ago.
Q. Because of COVID-19?
A. Yes.
Q. But now you're back open?
A. Yes.
Q. Including dine-in?
A. Yes.
Q. As manager of Fries N' Pies, do you have a projection or expectation as to how that business may grow or how it will work out in the future?
A. I mean -- maybe I don't understand your question.
Q. Sure.
Do you have a business plan for Fries N'

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Pies?
A. I mean, we -- I mean, we developed it based on -- I was actually going to put in a healthy concept. The guy wanted a pizza concept; then Adam and I developed it.
Q. Can you do healthy pizza?
A. We do. It's cauliflower crust and broccoli crust.
Q. So that concept does survive in some way?
A. Yes.
Q. I'm not -- do you have a written business plan?
A. For Fries N' Pies, no.
Q. Do you have a business plan in your head, as it were, as to what you want to --
A. Actually, Adam might have one. He might have something then.
Well, our whole goal of it is to -- I mean, the reason I opened it was because I had the experience -- our whole reason of opening it was to franchise it. So that's where I'm going with it. I'm trying to take it to the next level and franchise it.
Q. So that's the main goal of the business plan, is to grow and have other locations?

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A. Yes.
Q. Do you have a timetable for that?
A. In the next year or two, open another store, and then keep growing it after that.
Q. Open another store in Las Vegas?
A. Yes.
Q. How many stores ultimately do you think you might open with Fries N' Pies?
A. I mean, the goal is 100-plus.
Q. One hundred plus?
A. Yes.
Q. Do you have any expectation as to how long that will take?
A. I mean, I think I could start selling franchises in the next two to three years, and history will be then.
Q. Perhaps outside Las Vegas or no?
A. Yeah. I mean, that's my goal. My goal is to get it nationwide. Because it is easy to duplicate. No need to -- I don't need a big storefront. I don't need a big area. So it's pretty easy to plug and play.
Q. Do you have some idea what the gross sales or income currently is for Fries N' Pies?
A. The first year we were open, we made

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$760,000.
Q. When you say you "made," is that net or gross?
A. That was gross.
Q. Total?
A. Yes.
Q. 760,000?
A. Yes.
Q. And that was July of '18 to July of '19?
A. Yes.
Q. How about July 19 to the present; do you know?
A. Right now I don't, but, I mean, you know, due to COVID -- you know, now we -- to make a profit, we need to make $100 an hour and we're doing that, so...
Q. So you're in the black?
A. Yeah, now we are.
Q. Even with COVID?
A. Well, I mean, we're starting to, yes.
Q. Okay. Have you worked out or do you have some idea of what your financial benefit would be as you grow? With each franchise location that opens, how does that impact you personally, financially? Do you have an idea?

A. I mean, once we start, you know, making profit, you know, we break it up into 45 percent Adam, 45 percent me, 10 percent to the other guy.

And then the same with the franchise -- the building of the franchise would be the same way.

Q. For each franchise location, the same percentages?

A. Yes.

Q. Mr. Green, you've been very courteous and patient. Thank you.

Is there anything about your testimony as we sit here that you think you need to change or add?

A. No. I mean, I just -- I just want you to know that, you know, after the -- after the fire, you know, like I said, you know, like I've been stating, it's changed my life in many ways.

And now I'm just handling it in the fact with -- like I was never a practicing Jew before, and now, because of the accident, like I said, like I stated last time, the rabbi came and sat with me for two hours and opened my world to religion. And, you know, now I talk to a rabbi every single day.

So, you know, there's a lot of things that have changed, you know, like I said, with my thinking, my way of life, because of the accident. That's really what it comes down to.

Q. When you talk to the rabbi, are you talking specifically about this accident or about your path forward?

A. We talk about everything. Everything.

Q. It's been a positive thing?

A. Yeah. I mean, you know, it's helped me get through -- I mean, the biggest thing with this is having -- is being able to turn to people and having people that, you know, understand.

You know, I speak to a very, very small group of this incident. I don't talk to my friends about it. I don't talk to anyone about it. I talk to my parents. I talk to my rabbi. I talk to Lauren. I talk to my wife. And that's it.

It's very -- I don't talk to -- you know, Mario is good friend of mine. I don't talk to him about this incident at all. We don't have a conversation about it because I know he's emotional about the situation, and I don't -- you know, me and him have a friendship, and I don't want to ruin the friendship, so I separate it.

And that's how I've done this whole incident. I haven't really communicated with a lot of different people about it, but I speak to a certain group of people, you know.

Q. Do you feel that your businesses are going well?

A. Yeah.

Q. You got married middle of May?

A. Yeah.

Q. Are you happily married?

A. I am.

MR. McMULLEN: Those are all my questions. Thank you.

EXAMINATION

BY MS. WINSPEAR:

Q. I think I'm probably next in order. My name is Gina Winspear and I represent Defendant Carl Kleisner.

Have you ever met Mr. Kleisner?

A. I haven't.

Q. Did you have any knowledge of Mr. Kleisner or had you ever heard his name prior to the incident back in June of 2018?

A. No.

Q. Since the incident in June of 2018, have you had any conversations with Mario Gonzalez about Mr. Kleisner?

A. No.

Q. Have you obtained a disability rating from any governmental body or disability insurer?

A. No.

Q. Have you applied for any disability insurance since this incident in June of 2018?

A. I haven't.

Q. Prior to the incident in June of 2018, did you have any knowledge that Mario was having electrical problems with his koi pond?

A. No.

Q. In your lawsuit you allege that Carl Kleisner owed a duty to Mario Gonzalez and all of his guests to ensure that all electrical lines to the home were in working order.

Were you aware that's one of your allegations in this lawsuit?

A. Yes.

Q. What information or knowledge do you have that the electrical lines in the home were not in working order?

A. I mean, I believe they were. That's the

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whole thing.
Q. You believe they were or they were not?
A. I didn't know anything about the electrical problems.
Q. So as you sit here today, is that still your position, you don't know one way or another about any electrical problems?
MR. GOLDSTEIN: I want to raise an objection. Vague.
Go ahead.
BY MS. WINSPEAR:
Q. Do you understand my question? Let me restate it so I make sure our record is really clear.
A. Yeah.
Q. In your lawsuit you allege that Carl Kleisner owed a duty to Mario Gonzalez and all his guests on Mario's premises to ensure that all electrical lines to the home were in working order.
As you sit here today, do you have any knowledge or information that the electrical lines were not in working order?
MR. PFAU: Objection that this calls for an expert opinion and calls for a legal conclusion.
/ / /

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BY MS. WINSPEAR:
Q. You can still answer.
A. So do I know -- maybe say it again.
Q. Do you have any knowledge or information that the electrical lines at Mario Gonzalez's home were not in working order?
A. No.
MR. PFAU: Same objections.
THE WITNESS: I thought they were.
BY MS. WINSPEAR:
Q. So nothing has been communicated to you by Mario indicating that the electrical lines were not in working order.
Is that a fair statement?
A. Yes.
Q. And you never independently did any inspection or investigation of the electrical lines at Mario's home either inside or in the barbecue area. Is that also a fair statement?
A. Yes.
Q. In your -- well, let me ask this question.
Do you have any -- do you personally have any knowledge or information that Carl Kleisner installed electrical lines in Mario's home or in his backyard?
A. I don't know.
Q. You don't personally have any of that information, fair?
A. Yep.
Q. Do you personally have any information that Carl Kleisner maintained or repaired any electrical lines inside Mario Gonzalez's home or in his backyard in the barbecue area?
A. No, I don't.
Q. And I believe -- and I just want to clarify from your earlier testimony. What I wrote down that you said weeks ago when we were in your original deposition is that you didn't know anything about an electrician until after the incident.
Is that a fair statement?
A. Yes.
Q. You now know the name of an electrician to be Carl Kleisner, but that's -- is that from information Mario provided to you or information you learned in the course of this lawsuit?
A. I mean, both. But I just heard the name from Mario, but that was -- that was it.
Q. Okay. You didn't -- other than hearing a

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name, what other information did Mario give you about Carl Kleisner?
A. Nothing.
MS. WINSPEAR: Okay. That's all the questions that I have. Thank you very much.
MR. WALKER: I have no questions.
MR. GOLDSTEIN: I'm Steve Goldstein. I represent Mario. I won't have too many questions because everything's been thorough thus far. I just have a few follow-up questions.

EXAMINATION

BY MR. GOLDSTEIN:
Q. The cream that you use -- I don't know. Do you still use it today?
MR. PFAU: Asked and answered.
BY MR. GOLDSTEIN:
Q. Forgive me. I'm just laying a foundation here.
A. Yes. I have a cream and I do use it.
Q. How long does it take you to go through a bottle of cream or a tube of cream?
A. I mean, I've had the same bottle for a while. So --
Q. A month, two months?

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A. Couple months.
Q. Okay. Do you apply it every day?
A. I apply it when needed or when I -- but, I mean, I have a lotion that I use every day, yes.
Q. Okay. Is the lotion over the counter?
A. Yes.
Q. What kind of lotion is it?
A. I mean, it's non-medicated.
Q. Brand?
A. Yes. It's like Aveeno. But I also use the other lotion that I was given by the doctors.
Q. And I don't believe you remember that name?
A. No, I don't.
Q. Let me ask you about your relationship with Mario a little bit.
A. Yes.
Q. And forgive me if we go over a little bit of what was discussed last time.
You -- how long have you known Mario?
A. I know Mario probably for five years.
Q. Okay. Before this incident, have you ever been a business partner with him at all?
A. No.
Q. At the time of this incident, were you

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all discussing business options and things to make money together?
A. I mean, we always talk about business, but nothing to the fact -- no, we weren't doing anything.
Q. There wasn't a gummy bear CBD --
A. Oh, we were talking about that, but that wasn't -- he was just trying to see if he could buy a product for me because I have a white label company for my edibles.
Q. What does that mean?
A. I have an edible company that I'm a partner with in San Diego that I try to get contacts for, and because he's in the CBD business, I told him about that I had this connection and we were talking about it, but nothing came from it.
Q. Would you classify your friendship with Mario to be good?
A. Yeah, very good.
Q. Today even?
A. Yes.
Q. I know you mentioned one other fellow that you worked with that started SkinnyFATS as your best friend. Where does Mario rate in the whole pantheon of friends that you have?

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A. I mean, he is one of my best friends at this time.
Q. Okay.
A. And that's why we don't talk about this case. We don't communicate about it. We don't say nothing.
Q. When was the last time you communicated about this case?
A. We don't -- I mean, honestly, we don't have a -- we don't.
Q. Well, I imagine during your healing period you guys talked about things, right?
A. Yeah. But I don't -- I don't have an exact date.
Q. I'm not asking for an exact date. But was the last time you talked to him about this incident before you filed a lawsuit against him?
A. Yeah. I mean --
Q. Have you been over to his house since the last time -- since you filed a lawsuit against him?
A. Yes.
Q. Approximately how many times have you been over?
A. I mean, I honestly can't tell you. I don't know. Four or five, six. I don't know. We

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hang out. I mean, like I said, he's one of my best friends. This didn't hinder anything because we don't talk about it.
Q. But you do realize you are suing him, right?
A. Yes. But, I mean, my whole thing was -- yes, I'm suing him, but, you know, the insurance company, and at the end of the day, you know, my friendship -- that's the whole reason we don't -- we don't talk about it. You know, we don't have a conversation about it because we don't -- you know, it keeps our friendship the way it should be.
Q. Do you know why you're suing him?
A. I mean, yeah, because he was negligent and he had the -- you know, it was his grill. It was his place. And, you know, if that incident didn't happen, then my life would be different right now.
Q. So if I understand you correctly, the reason why you're suing him is because he owned the grill and he had the house?
A. Yeah. I -- because I was at his house working on something that should have been handled and fixed and -- you know.
Q. But he was -- if I understand correctly,

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he was told by Ferrellgas that the grill was inspected and fixed and everything was fine?
A. And that's how he told me, and then that's why we used it. And look what happened.
Q. Okay. So with that being said, then, you still think that he's negligent when Ferrellgas is the one that told him?
A. I think everyone in the situation is negligent to the fact where -- they all had a place in this incident, and if everyone handled it to the way that they should have, it wouldn't have happened.
Q. Okay. Do you believe it is reasonable for Mario to trust what the representative for Ferrellgas told him?
A. Yes.
And that's the thing. When I asked Mario if it was fixed, he said that he had the okay from Ferrellgas and obviously it wasn't.
Q. The grill, you mean?
A. Yes. What did I say?
Q. Well --
A. Yeah, the grill.
Q. I just wanted to clarify what the okay was that was okay.

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A. The grill was okay to use.
Q. That's what was told to Mario?
A. Yes.
Q. We all know that you used the grill before.
A. Yes. I've used numerous grills before. I never had an issue.
Q. And you've used that particular grill before without any issue?
A. Yes.
Q. After the incident, and I'm talking directly after the incident, when you were taken to the hospital, Mario took you, right?
A. Yes.
Q. Do you know that Mario set up a GoFundMe page for you?
A. I do.
Q. And do you remember how much money Mario raised for you?
A. I don't remember exactly. I think it was like anywhere from $1,700 to $2,300, something in that range.
Q. And he gave you all that money; is that right?
A. Yeah.

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Q. And that was to go for your health expenses?
A. Yes, which is not even one percent of it.
Q. Understood. Understood. It was a drop in the bucket, let's say.
A. Mm-hmm.
Q. But what did you think of that -- him setting up that GoFundMe page for you?
A. I mean, it was very -- it was nice and generous and...
Q. All right. You had mentioned that -- Mario gets -- you hadn't talked to him because he gets emotional.
What do you mean by that?
A. I mean, just in the situation -- I mean, when you talk about this incident -- and this is like a long, long time ago. When you talk about the incident, he just gets -- he gets choked up. So I leave it alone.
Q. So he gets choked up in a way that is sorrowful or somber?
A. Yeah. I mean, I think that -- you know, he's --
Q. He's not angry about it is what I'm trying --

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A. No, I don't think he's angry. I just think he's frustrated that it happened. He trusted someone -- you know, he trusted someone from a gas company and now we're dealing with this issue.
Q. Understood.
Has any doctor told you that you can't work to your full potential?
A. I mean, directly, no, but indirectly, yes.
Q. What do you mean?
A. I mean, every doctor that I've spoken to that I've had a conversation about my work, they tell me to not work as much and they tell me to limit what I do in certain areas, you know.
And like I said before, I used to work 16-, 17-hour days. There would be no way I could do that right now.
Q. But formally, there has been nothing on paper or anything saying you can't do what it is you do, which is be a chef?
A. I mean, you could take that two different ways: Me being a chef and being able to use every piece of equipment that I'm able to use? I am not able to use everything, so yes, it hinders me.
And the ability of grabbing hot stuff. I

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mean, like before, I used to grab -- I mean, I used to work at a restaurant which had a thousand covers. I used to grab steaks off the grill, like, with my hands. And now I can't even touch something hot.

Q. I think that is, you know, an incredible feat. I just want to put that on the record. He could take something hot before and flip it?

A. I mean, yeah. As a chef, and every chef will tell you, that when you build -- you build your tolerance.

Q. Right.

In your business, in your line of work, do you ever use oven mitts?

A. I use towels, which is like an oven mitt.

Q. Kind of like that, yeah.

Now --

A. But now, anything that I grab -- like before, I used to grab stuff with either a damp towel or whatever, just grab it. And now it's like I have to make sure everything's dry, or like if I grab something -- the other day I grabbed something out of the oven that was sitting out for probably 25, 30 minutes, out of the oven, I grabbed the pan and I dropped it right away because it was hotter

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than I can handle.

Q. You work for this Scott Sibley person. How long have you worked for him now?

A. Five months.

Q. Five months.

And did you know him before?

A. Before the incident?

Q. No. Before working for him.

A. No.

Q. And you work about four hours a day for him?

A. Yep.

Q. Do you have any assistants help you?

A. No.

Q. Now, Lauren Unger, do you know if she has any kind of certifications, professional certifications?

A. I believe so, yeah.

Q. Have you seen them or -- do you know?

A. No. I believe so. I said -- that's all. She's -- from my understanding, she's a certified healer and shaman, whatever you want to call it.

Q. All right. You have lived with her for a little bit of time, right?

A. Yes.

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Q. Did you see any kind of certifications hanging on the wall in her -- in her house at all?

A. I mean, no, but I, you know, I know she went through a lot of training and, you know, I definitely -- before it wasn't just the blind thing. Like I knew that she's worked with people and helped people.

Q. Does she have an office or does she work out of her house?

A. She works out of her house.

Q. Does she see other -- does she have other clients that you know of?

A. Yes.

Q. I just want to follow up on your itchy hands.

You said that they have been itchy for approximately about two months?

A. Yep.

Q. Does that mean they were not itchy before this incident?

A. They were. Not to the point where I got to scratch them every couple hours or whatever. They just itch more than frequently, more than they did.

Q. Do you have any allergies?

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A. I do.

Q. What?

A. Demerol, codeine, and shellfish.

Q. Have you had in the last two months any of those?

A. No.

Q. Or before that?

A. No.

Q. All types of shellfish or just --

A. Red shellfish, crab, lobster, shrimp.

Q. All the good stuff.

A. Yes.

Q. That us nice Jewish boys should be eating.

So with the psychologist, Michael Elliott, you've seen him one time, right?

A. Yes.

Q. How many minutes or hours did you spend with him on that first visit?

A. I mean, I just did a testing visit with him. It was like two and a half hours.

Q. And it was you filling out forms?

A. Me going through questions and -- yeah.

Q. Did he tell you the questions and you provided answers or did you fill out --

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A. No. I sat a computer and filled it out.
Q. So he wasn't like providing you with any guidance at that time?
A. Not yet, no. That's why we're having another meeting on the 1st.
Q. I'm just going through my notes from the last time.
A. And the biggest thing is I had no fear of using anything before. Like never had a fear of drills, equipment. And now, you know, I have a fear, a fear of a lot of different things.
Q. In your mind, do you know if there's a difference between natural gas and propane?
A. Yeah, there's a difference.
Q. Because you mentioned earlier that you won't use propane, but the other grills at your work are natural gas.
A. Yes. But they're not open flame -- I won't use an open flame grill at all, ever. Even if it's a gas grill, I won't use it. I'm afraid of flames. I'm afraid of the idea of fire.
Like -- I mean, like I said to -- Mr. McMullen, is it?
MR. McMULLEN: Yes.
THE WITNESS: Like I said to him, it

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was -- I mean, I saw the show, and when I saw the show, when I see anything on fire, it brings me back to that day and it's -- you know, it's traumatic.
BY MR. GOLDSTEIN:
Q. So your grills at work aren't -- don't have open flame?
A. No.
Q. The grills at -- or the stove at Scott Sibley's, does it have open flame?
A. It does, but it's -- you know, it's on -- it's controlled by a burner, so the flame is controlled. It's not super high. And there's always something covering it. You know, I always have a pan covering it or...
Q. And do you ever use charcoal or wood-pellet grills?
A. No.
Q. Why not?
A. I won't use -- I will not use a grill ever since this accident. Like, I don't care what it is. My father uses charcoal grills. I went to his house. He -- and I stayed inside when he, you know, dealt with the grill.
Like I don't go near grills. I don't

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deal with grills.
Q. Anything about grills you don't do?
A. No. It's like an ex-girlfriend. Stay away from it.
Q. So how often do you get blisters on your hand?
A. I mean, not -- it can happen -- I mean, it happens on a continuous basis. I don't know exactly.
Q. Well --
A. I mean, I had this blister -- I had this blister the other day. I have -- you know, I have blisters that come and go all the time.
Q. Is that because you're dealing with heat?
A. Yeah. Heat. Yeah.
Q. So it comes on when perhaps maybe you're taking a -- something you're cooking and you're flipping it?
A. Well, I don't use my bare hands anymore. It's just anything. I mean, I can touch something that is like a little hot and it will create a blister.
Q. Let me ask you about the PTSD you mentioned earlier. If you're not thinking about or not having something like an open flame that you

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see or somebody on fire, do you think about, you know, the incident?
A. I think about the incident all the time. Yeah. It changed my life, drastically, in everything that I do and everything that I -- I mean...
Q. But up until May --
A. I used to be a very active person and always outside and always doing things, and like this hindered me -- I mean, for the whole month that I was, you know -- or, I mean, from the time since the accident, in the first year I didn't go in the sun at all. You know, there's a lot of things that I didn't do because of the accident.
Q. I believe Mario told us about you playing hockey.
A. Playing hockey?
Q. Yeah, or being a good ice skater, ice hockey?
A. Okay. Yeah.
Q. Can you tell us how long you have been --
A. I played hockey for 22 years. I was supposed to -- I chose to go to a cooking school or UNLV rather than going to a school for hockey. I ended up playing at UNLV after four or five years,

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when they started opening a team. But, I mean, I have skated my whole life.
Q. Okay.
A. His son was skating, so I started teaching him how to skate, but I never -- it was always -- I never used a stick or, you know, used anything. I would just skate with him.
Q. With Mario's son?
A. Yes.
Q. Okay. But you used -- you played hockey -- was this on a formal UNLV team --
A. Yes.
Q. -- when you were a student there?
A. Yes. I actually haven't played -- I used to play roller hockey all the time. I haven't played hockey since this accident.
Q. You said roller hockey?
A. Yeah. I used to play on Sahara and Maryland at a facility, and I haven't played since this accident.
Q. Has anybody said that you can't play or is it just that you don't want to play?
A. No. I just haven't.
Q. And the ice skating, when did you tutor Mario's son?

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A. I mean, in the past -- it was only a couple -- it was only like four or five times.
Q. Was it before the incident or after?
A. I'm not sure exactly. I think it was a little before, a little after. I'm not sure.
Q. Have you been on the ice since tutoring Mario's son?
A. No.
Q. Is it because you don't want to or you just haven't had the opportunity?
A. I just haven't.
Q. Okay. When you get a blister, how long does it take for them to heal?
A. Four or five days.
Q. Do you put anything on the blisters?
A. Just cream.
Q. Just cream.
You don't put a Band-Aid on?
A. No. I mean, unless it needs a Band-Aid, if it's open.
Q. Do they ever bleed?
A. I mean, it depends. It depends on the blister, you know. If you pick a blister sooner than normal, then it's going to -- I don't usually pick them either.

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Q. Since our last meeting, have you seen any medical professionals regarding this incident?
A. No.
Q. So just Michael Elliott?
A. Mm-hmm.
Q. And then you're waiting until July 1st to have a follow-up visit?
A. Yes. And that was because I had -- you know, after talking to my rabbi and Lauren Unger and specific people, I felt that it was time to get some more doctor help.
Q. And the rabbi you talked to, he's associated with Chabad, right?
A. Yes.
Q. Which Chabad?
A. The one on Arville.
Q. What was his name again?
A. Rabbi Motti Harlig. M-o-t-t-i, H-a-r-l-i-g.
Q. The grills at Fries N' Pies, there's no open flame, right?
A. No.
Q. So it doesn't have the same look as like Scott Sibley's that has, you know, a flame that comes up from the stove?

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A. Well, it's a stove that I use at Scott's, and this one is a flat top grill that it's under the --
Q. Understood.
So there's a flame under the grill.
A. Yeah. The grill's a metal or steel plate, and then the heat rises and you cook on it.
Q. The pizzas that you-all make there, is it an oven that's --
A. No flame. Gas.
Q. It's a gas oven?
A. Brick gas oven.
Q. So there's no -- it's like not one that's coal-fired?
A. No.
Q. I call those the new fancy -- new way of doing things because they heat up to like 800 or so degrees.
A. Mm-hmm.
Q. What does your pizza oven heat up to?
A. We keep it at 550.
Q. 550?
A. Or 555.
MR. GOLDSTEIN: All right. I don't have any further questions for you.

Thank you very much.
MR. PFAU: I don't have any questions. Are we all done?
MR. McMULLEN: I think so.
MR. PFAU: Okay.
MR. McMULLEN: Do we have the usual stipulations? What do you want to do?
MR. PFAU: To read and sign, you mean?
MR. McMULLEN: Right.
MR. PFAU: Yeah. We can waive the read and sign for Josh.
MR. McMULLEN: Very good. Thank you.
MR. PFAU: Thanks.
THE VIDEOGRAPHER: This concludes today's deposition of Joshua Green. The time is approximately 9:54 a.m. We're off the record.
(Whereupon, the deposition was concluded at 9:54 a.m. this date.)
* * * * *

CERTIFICATE OF REPORTER

STATE OF NEVADA)
) SS:
COUNTY OF CLARK)

I, Monice K. Campbell, a duly commissioned and licensed court reporter, Clark County, State of Nevada, do hereby certify: That I reported the taking of the deposition of the witness, JOSHUA GREEN, commencing on MONDAY, JUNE 29, 2020, at 8:38 a.m.;

That prior to being examined, the witness was, by me, duly sworn to testify to the truth. That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true, and accurate transcription of said shorthand notes.

I further certify that I am not a relative or employee of an attorney or counsel or any of the parties, nor a relative or employee of an attorney or counsel involved in said action, nor a person financially interested in the action; that a request ([X] has not) been made to review the transcript.

IN WITNESS THEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 12th day of July, 2020.

Monice K. Campbell, CCR No. 312

EXHIBIT "11"

Michael Elliott and Associates

Patient: Joshua Green | **DOB:** 02/12/1982 | **Sex:** M

Provider: Dr. Michael Elliott | **Visit:** 12/16/2020 10:30AM | **Chart:** GRJO000002

Office: Henderson | **Address:** 1661 W Horizon Ridge Parkway Suite 280, Henderson, NV, 89012

Primary Payer ID: | **Secondary Payer ID:**

Chief Complaint: Personal Injury

Subjective:

Client celebrated progress and news in his work life including a new opportunity with a company that he has wanted to work for. He reflected on how his mood was more distress at previous session, and how this experience reaffirmed his faith in the process of life. Client explored holiday season and noted that he'd been intentional in getting Hanukkah gifts for his wife this year.

Objective:

Client presents with casual dress, and normal grooming. His attitude was cooperative throughout session. His speech was rapid but WNL. His affect was mood congruent, although typically flat. His mood was excited and anxious at points. His thought process was goal directed. His concentration wad distractible at points.. No perceptual disturbances observed. He appeared oriented x4. Insight was fair.

Assessment:

Client presents with moderate anxiety, demonstrating increased ability to prioritize his health and wellbeing compared with previous sessions.

Type	Code	Description
ICD-10-CM Condition	F06.4	Anxiety disorder due to known physiological condition
ICD-10-CM Condition	F41.1	Generalized anxiety disorder
ICD-10-CM Condition	Z13.850	Encounter for screening for traumatic brain injury
ICD-10-CM Condition	F43.9	Reaction to severe stress, unspecified
ICD-10-CM Condition	F41.9	Anxiety disorder, unspecified

Problems:

Description	ICD Ver.	ICD Dx Code	Snomed	Status	Diagnosed
Anxiety disorder due to known physiological condition	10	F06.4		active	Oct. 7, 2020, 10 a.m.
Generalized anxiety disorder	10	F41.1		active	Oct. 7, 2020, 10 a.m.
Encounter for screening for traumatic brain injury	10	Z13.850		active	Oct. 7, 2020, 10 a.m.
Anxiety disorder, unspecified	10	F41.9		active	Sept. 1, 2020, noon
Unspecified symptoms and signs involving cognitive functions and awareness	10	R41.9		active	Sept. 1, 2020, noon
Reaction to severe stress, unspecified	10	F43.9		active	July 1, 2020, 9 a.m.

Plan:

Continue with therapeutic coaching sessions to help meet recovery goals. Discussed decreasing frequency of session to see how client maintains wellbeing and copes independently between sessions.

E-signed by Jacqueline Robinson on 12/16/2020 11:54AM PST

This page was generated at 12/16/2020 11:54AM PST

Michael Elliott and Associates

Patient: Joshua Green
DOB: 02/12/1982
Sex: M
Provider: Dr. Michael Elliott
Visit: 12/16/2020 10:30AM
Chart: GRJO000002
Office: Henderson
Address: 1661 W Horizon Ridge Parkway Suite 280, Henderson, NV, 89012

Primary Payer ID:
Secondary Payer ID:

Type	Code	Modifiers	Quantity	Description
CUSTOM	00004		1.00 UN	Coaching

E-signed by Jacqueline Robinson on 12/16/2020 11:54AM PST
This page was generated at 12/16/2020 11:54AM PST

Michael Elliott and Associates

Patient: Joshua Green | **DOB:** 02/12/1982 | **Sex:** M
Provider: Dr. Michael Elliott | **Visit:** 01/13/2021 3:30PM | **Chart:** GRJO000002
Office: Henderson | **Address:** 1661 W Horizon Ridge Parkway Suite 280, Henderson, NV, 89012
Primary Payer ID: | **Secondary Payer ID:**

Chief Complaint: Personal Injury

Subjective:

Client explored disappointment about lack of follow through from his peers on offers for new business. Explored goals of recovery including increased self-awareness and coping skills.

Objective:

Client presents with casual dress, and normal grooming. His attitude was cooperative throughout session. His speech was rapid but WNL. His affect was mood congruent, although typically flat. His mood was euthymic. His thought process was goal directed. His concentration wad distractible at points.. No perceptual disturbances observed. He appeared oriented x4. Insight was fair.

Assessment:

Client presents with moderate anxiety, demonstrating increased ability to prioritize his health and wellbeing compared with previous sessions.

Type	Code	Description
ICD-10-CM Condition	F06.4	Anxiety disorder due to known physiological condition
ICD-10-CM Condition	F41.1	Generalized anxiety disorder
ICD-10-CM Condition	Z13.850	Encounter for screening for traumatic brain injury
ICD-10-CM Condition	F43.9	Reaction to severe stress, unspecified
ICD-10-CM Condition	F41.9	Anxiety disorder, unspecified

Problems:

Description	ICD Ver.	ICD Dx Code	Snomed	Status	Diagnosed
Anxiety disorder due to known physiological condition	10	F06.4		active	Oct. 7, 2020, 10 a.m.
Generalized anxiety disorder	10	F41.1		active	Oct. 7, 2020, 10 a.m.
Encounter for screening for traumatic brain injury	10	Z13.850		active	Oct. 7, 2020, 10 a.m.
Anxiety disorder, unspecified	10	F41.9		active	Sept. 1, 2020, noon
Unspecified symptoms and signs involving cognitive functions and awareness	10	R41.9		active	Sept. 1, 2020, noon
Reaction to severe stress, unspecified	10	F43.9		active	July 1, 2020, 9 a.m.

Plan:

Continue with therapeutic coaching sessions to help meet recovery goals.

Type	Code	Modifiers	Quantity	Description
CUSTOM	00004		1.00 UN	Coaching

E-signed by Jacqueline Robinson on 01/13/2021 4:09PM PST
This page was generated at 01/13/2021 4:09PM PST

EXHIBIT "12"

Professional Psychology: Research and Practice
2016, Vol. 47, No. 1, 66–76

0735-7028/16/$12.00 http://dx.doi.org/10.1037/a0040063

Patient Comfort With Audio or Video Recording of Their Psychotherapy Sessions: Relation to Symptomatology, Treatment Refusal, Duration, and Outcome

Alexis M. Briggie, Mark J. Hilsenroth, Francine Conway, J. Christopher Muran, and Jonathan M. Jackson
Derner Institute of Advanced Psychological Studies, Adelphi University

Despite the widespread use of audio or video recording in psychotherapy training and research, there has been surprisingly little exploration of patient reactions to the use of recordings in psychotherapy, and there is even less written about patient factors that influence their willingness to consent to recording practices or the impact of such a request on treatment. The present study examined the relationship between pretreatment patient symptomatology and patient attitudes toward the audio or video recording of psychotherapy sessions. Treatment refusal, duration, and outcome were also examined as they related to patient comfort with recording. A total of 390 participants completed an initial intake in a university-based community outpatient clinic. Pretreatment patient symptomatology was measured at the initial intake evaluation using the Brief Symptom Inventory (Derogatis, 1993), and patient attitudes toward audio or video recording were measured using an audio/videotape comfort form. The majority of patients expressed no or slight concerns (52%), and almost three quarters (71%) were willing to consider audio or video recording. It was found that higher levels of pretreatment interpersonal sensitivity and paranoia have a significant negative relationship to recording comfort (i.e., greater pathology related to lower comfort). However, treatment refusal, duration, and outcome were not significantly related to patient comfort with recording. Significant intake clinician effects were observed in regard to patient-rated comfort regarding audio or video recordings, indicating a relationship between patients' intake clinician and their level of comfort. Therapist effects were examined with regard to treatment refusal, duration, and outcome, and all results remained nonsignificant. This research has implications for and supports the implementation of audio- or video-recording practices in clinical training, research, and practice.

Keywords: training, audiotape, videotape, patient factors, therapist factors

Those interested in psychotherapy have long attempted to understand the complexities and nuances of that process. Different methodologies have been employed over time in an effort to objectively capture the content and process of psychotherapy sessions. Early methods included the use of one-way mirrors and live supervision; more recently audio or video recordings have been

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Mark J. Hilsenroth received his PhD in clinical psychology from the University of Tennessee and completed his clinical internship at The Cambridge Hospital/Harvard Medical School. He is a professor of psychology at the Derner Institute of Advanced Psychological Studies at Adelphi University and the primary investigator of the Adelphi University Psychotherapy Project. In addition, he is currently editor of the American Psychological Association Division 29 journal *Psychotherapy*. His areas of professional interest include personality assessment, training/supervision, psychotherapy process and treatment outcomes.

Francine Conway received her PhD in clinical psychology from Adelphi University's Derner Institute of Advanced Psychological Studies, where she is currently professor and chair of psychology. Her clinical psychology practice intersects with her research interests largely focusing on psychodynamic psychotherapy of children, as well as socioemotional factors contributing to physical and psychological health among adults and children.

J. Christopher Muran is associate dean and professor at the Derner Institute of Advanced Psychological Studies, Adelphi University. He also serves as director of the Psychotherapy Research Program at Mount Sinai Beth Israel. He received his doctoral degree from a combined professional-scientific program at Hofstra University and completed a postdoctoral fellowship in cognitive-behavioral therapy at the Clarke Institute of Psychiatry, University of Toronto, Toronto, Ontario, Canada, and psychoanalytic training in the New York University Postdoctoral Program. His areas of interest include the therapeutic relationship and alliance, therapist position and experience, and treatment impasse and failure.

Jonathan M. Jackson received his PhD in clinical psychology from New York University. He is currently director of the Psychological Services Center and training director of the affiliated internship at the Derner Institute of Advanced Psychological Studies, Adelphi University. His professional interests include training clinical psychologists, suicide prevention, and ethical practices.

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used. Audio and video recording have provided a partial solution to the desire for an objective record of the psychotherapy process in that they provide permanent, undistorted, unbiased accounts of therapy sessions. Recording allows therapists to focus entirely on the patient and remain fully present in the room without having to worry about taking notes or memorizing the interaction. It also eliminates concerns about the unreliability of memory, perception, and thought (Schacter, 1999) that are inevitable when obtaining data from human memory.

In addition to audiotaping, videotaping opened up the capacity to study nonverbal behavior, such as gestures, body language, and postural configurations in the therapy room. Nonverbal behavior has long been recognized as a source of valuable information and can serve many important functions, including expressing emotions, communicating interpersonal attitudes, as well as accompanying as well as supporting speech (Argyle, 2013). Video recording enables the documentation of a more complete communication, that is, both verbal and nonverbal. On the other hand, despite its many advantages, video recording introduced a new dimension to the potential anxieties of therapists and patients surrounding evaluation and performance. Some of the first anecdotal reports of recording sessions stated that therapists were self-conscious about their voices and physical image being recorded (Redlich, Dollard, & Newman, 1950). Concerns about privacy and ethics were also a factor in some therapists' hesitancy to use the new technology. Schneider (1977) argued that observation constitutes an attack on privacy, and some early opponents of the technology suggested that the threat to privacy might even alter the psychotherapy process itself.

The majority of the early literature on recording of sessions was based on clinical anecdotes and opinion. Therefore, the conclusions drawn are open to the critique that they may be biased or subjective. Audio or video recording was first documented in the psychiatric literature in 1942 by Covner, who found that therapists with more experience were less disturbed by recording when compared with therapists with less experience (Covner, 1942). Harper and Hudson (1952) found that negative effects on patients were undetectable, and Lamb and Mahl (1956) found that therapists who were more disturbed by recording felt it affected them and their patients more. Roberts and Renzaglia (1965) found that patients made more positive self-references in the recording condition and more negative self-references in the no-recording condition. Overall, the anecdotal studies drew largely positive conclusions regarding the effects of recording on patients and therapists.

The empirical findings on the effects of audio or video recording on therapists have been mixed and often contradictory. Although much of the research on this subject is outdated or used a less-sophisticated methodology than would be employed in the present day, it does provide foundational knowledge that can inform current research and provide direction for future investigation. Some early empirical research on recording that has found negative effects on therapists included increased anxiety (Yenawine & Arbuckle, 1971), increased negative feelings (Poling, 1968a; Friedman, Yamamoto, Wolkon, & David, 1978), increased negative self-ratings of performance and decreased positive self-ratings of performance (Niland, Duling, Allen, & Panther, 1971), and increased heart rate (Roulx, 1969). Alternately, other early empirical studies found either neutral or positive effects of recording on therapists. Ellis, Krengel, and Beck (2002) reported that recording was not significantly associated with either anxiety or performance, and other researchers found that recording improved perception of self and others, with more positive ratings reported in the video-recording condition (Star, 1977). One study also reported greater perception congruence between therapists and their supervisors, meaning that therapist self-ratings were more similar to their supervisor's ratings of their performance after reviewing their recordings (Poling, 1968b). Different therapist variables have been found to mediate the effects of recording on therapists. Therapists who were below group mean on level of self-acceptance or acceptance of others used more negative terms to describe the recording experience (Walz & Johnston, 1963), and less-experienced therapists had more negative reactions (Covner, 1942). Therefore, an examination of therapist effects on patient attitudes regarding audio or video recording seems warranted.

In terms of empirical research regarding the effects of recording on patients, results were also found to be mixed and contradictory, including negative, neutral, and positive effects. Some research has found that recording increased inhibition (Gelso, 1973; Tanney & Gelso, 1972; Van Atta, 1969) and decreased satisfaction (Gelso, 1973) with therapy. On the other hand, other research has found that recording had no effect on anxiety (Bush, Bittner, & Brooks, 1972; Wiemann, 1981) and that patients reported positive reactions to the experience (Barnes & Pilowsky, 1969). It was also found that patients rated the impact of research overall to be positive and higher than did therapists (Marshall et al., 2001). Variables that were found to mediate the effects of recording on patients include (a) the nature of the presenting problem (patients anticipated that personal problems would be more inhibiting than would work or school problems, whereas the opposite pattern was actually found; Van Atta, 1969), (b) gender (females anticipated being more inhibited than did males; cf. Gelso, 1974), and (c) personality variables (more inhibited patients had higher levels of self-control, endurance, order, abasement, deference, and counseling readiness; Gelso & Tanney, 1972).

Although there has been some prior empirical research related to the effects of recording on therapists and patients, there is even less contemporary literature that addresses the factors that impact consent to audio- or video-recording mental health sessions. In a comprehensive review of the literature regarding factors influencing consent to having videotaped mental or medical health sessions, Ko and Goebert (2011) found only four studies that examined consent for videotaping within the field of mental health, and they elected to expand their review to include medical studies for this reason. In their review, two of the ways in which they classified study outcomes were by consent rate and consent factors. They found that none of the mental health studies examined consent factors, and only one study qualitatively looked at consent rate. In terms of patient feelings and behaviors, they reported that "most patients reported feeling comfortable being taped" (p. 200). They concluded (mainly on the basis of medical research) that the data are mixed about whether videotaping is inhibiting for psychiatric patients but were unable to draw any conclusions about any of the factors that influenced consent and indicated that further research is necessary to empirically determine the effects of recording on treatment, outcome, and factors impacting patients' willingness to consent to recording. The current study seeks to fill the gap in empirical findings related to consent to audio- or video-recording mental health sessions and the associated out-

come. This is the first study that quantitatively examines these factors in the mental health field, and it is our hope that it will provide the groundwork for further empirical exploration into a topic that has wide-reaching implications for psychotherapy training, research, and practice.

In the current study, we evaluated patient attitudes toward the audio or video recording of psychotherapy sessions and sought to investigate these in relation to several different research questions. First, are there different levels of patient comfort with audio- or video-recording sessions? Do all patients feel the same way about having their psychotherapy audio- or videotaped, or is there some variation in their attitudes? Second, does pretreatment symptomatology have a relationship to patient comfort with audio- or video-recording sessions? Are there certain symptom clusters or characteristics that are associated with attitudes about treatment being recorded? Third, do different levels of patient comfort with audio- or video-recording sessions have a relationship to entering into treatment and its duration? Would patients who are highly opposed to the idea of audio- or videotaping psychotherapy sessions be repelled by even the inquiry, and might this impact whether or not they return for treatment? Fourth, do different levels of patient comfort with audio- or video-recording sessions have a relationship to treatment outcomes? Related to our third question, if patients who are highly opposed to the idea of audio- or videotaping psychotherapy sessions did enter treatment, would asking them about their comfort around this issue impact their subsequent therapy outcomes negatively? Fifth, is patient comfort with audio- or video-recording sessions effected by the clinician they are working with? That is, does a particular clinician's style, training, experience, ability, or skill in discussing the issues related with audio- or video-recording sessions have an impact on patient-reported comfort level? On the basis of the prior research reviewed, we hypothesized that that patients who have stronger concerns about being audio- or video-recorded would exhibit higher levels of pretreatment global pathology. We also hypothesized that patients with stronger concerns about audio or video recording would exhibit higher levels of treatment refusal, shorter duration, and less-effective treatment outcome compared with patients who are less concerned with audio or video recording. Finally, given the literature on therapist effects (Adelson & Owen, 2012; Baldwin & Imel, 2013; Owen, Drinane, Idigo, & Valentine, 2015), we expected that there would be significant clinician effects present in regard to patient-rated comfort regarding audio or video recordings.

Method

Participants

Participants were 390 individuals who received services from a university-based Center for Psychological Services (CPS) between June 2000 and June 2011. CPS is a university-based, community mental health clinic that serves as a training site for the doctoral program in clinical psychology at Adelphi University. The clinic is staffed by doctoral students supervised by the program's faculty, as well as adjunct PhD-level clinical psychologists. All patient data was deidentified prior to archival data collection. Study methods were approved by the university's Institutional Review Board.

Demographics were consistent with populations typically seen at university-based outpatient clinics and are displayed in Table 1. Seventy-nine percent of patients were female, and the average age of patients at intake in the center was 29.02 years (SD = 10.73). The average number of sessions in the clinic per patient was 25.64. Of the patients included in the database, 72% were Caucasian, 11% were African American, 8% were Hispanic, 3% were Asian patients, and 4% of patients identified as "other." The majority of patients in the sample (74%) were single, 10% were married, 7% were divorced or widowed, 6% were living with a partner, and 3% were separated. Fifty-seven percent of participants were current undergraduate or graduate students. The average number of years' education completed was 15.54 (SD = 2.06). The most common primary diagnoses included mood disorder (35%) and anxiety disorder (23%), and Axis II disorders according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) were present in 23% of patients in the sample. Diagnoses were determined by the clinician conducting the intake interview and were based on a semistructured interview. In the sample, there were 168 intake clinicians and 152 treating therapists. Out of the totals, 103 intake clinicians and 100 treating therapists conducted one or more sessions with more than one patient.

Table 1
Demographic Information of the Patient Sample (N = 390)

Variable	%	n	M	SD
Gender				
Male	21	82		
Female	79	308		
Marital status				
Single	74	290		
Married	10	40		
Cohabitating	6	23		
Divorced/widowed	7	26		
Separated	3	11		
Primary Axis I diagnosis				
Adjustment disorder	7	27		
Anxiety disorder	23	91		
Eating disorder	4	15		
Mood disorder	35	137		
Substance-related disorder	2	9		
Other	28	70		
None	10	40		
Axis II diagnosis				
Present	23	88		
Absent	77	302		
Age			29.02	10.73
Years of education			15.54	2.06
Number of sessions			25.64	29.31
Psychiatric severity BSI–GSI (at intake)			1.08	0.63

Note. BSI–GSI = global severity index of the Brief Symptom Inventory.

Measures

Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI was used to assess pretreatment patient symptomatology at intake session and treatment outcome measured at termination. The BSI is a 53-item self-report measure that reflects psychological symptom patterns, and it consists of nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and three global indices of distress (global severity index, positive symptom distress index, and positive symptom

total). The BSI has been shown to have high test–retest reliability and internal consistency reliability (α = .71–.85; Derogatis, 1993) as well as convergent, discriminant, and construct validity. In the present study, treatment severity was measured using the global severity index (GSI). The mean nonclinical GSI score as provided by Derogatis (1993) is .30 (SD = .31), and test–retest reliability utilizing an outpatient sample was .90. The mean pretreatment GSI for the current sample was 1.08 (SD = .63).

Audio/videotape comfort form. Patient attitudes toward audio/videotaping were measured using the audio/videotape comfort form, developed specifically for this purpose at the training clinic described earlier (see Appendix for full text of the form). The questionnaire provides an explanation of potential audio or video recording, including how it will be used, who will have access to it, and how it will be stored. The form included the open-ended statement "In considering how I might respond to being asked for permission to make audio and/or video recordings of the services I receive for training/educational purposes only . . .," for which there were five response options. The five options rated participants' degree of comfort with videotape on a 5-point scale ranging from 5 (*no serious objections*) to 1 (*vehement objections*; α = .70, N = 390).

Procedure

Participants voluntarily sought and were accepted for individual psychotherapy at the clinic. Certain exclusion criteria were applied, including acute suicidality, psychosis, or other severe mental illness requiring significant psychopharmacology (in which case an outside referral was made).

Intake interviews were conducted by doctoral-level graduate students under the supervision of licensed clinical psychologists. At the beginning of the intake interview, all patients received written information regarding privacy policies and a clinic fact sheet that included details about staffing, fees, psychotherapy research, diagnostic testing, and confidentiality. At the conclusion of the intake interview, patients were asked to complete two forms: (1) an initial Brief Symptom Inventory (BSI) and (2) the audio/videotape comfort form. When patients were given these forms, they were verbally informed by the intake therapist that audio or video recording of sessions is not a requirement for treatment at this clinic. It should be noted that patients who completed the audio/videotape comfort form did not necessarily undergo recording procedures. That is, not all patients who expressed comfort with audio or video recordings were asked to do so by their therapist. Thus, the current study assessed patient *comfort* with recording, which was measured (a) prior to beginning any treatment and (b) with the knowledge that recording was not a requirement of the clinic. Therefore, this study offers a better assessment of patient attitudes toward this procedure than does one at a clinic where treatment is predicated on informed consent for actual recordings that are required in order to receive services (i.e., potential bias or coercion that may increase acquiescence). After the intake procedure, if patients did not meet the previously mentioned exclusion criteria for treatment at the clinic, they were assigned a therapist on the basis of schedule and availability. Treatment provided was under the supervision of licensed psychologists and was primarily psychodynamic in orientation.

Treatment refusal and duration. Treatment refusal and duration data were collected from the number of attended sessions recorded in the patient chart. The data was examined in two ways. First, treatment refusers attended only the initial intake interview but did not attend any psychotherapy sessions (i.e., number of sessions attended = 0). Treatment duration was defined as the number of psychotherapy sessions attended beyond the initial intake interview.

Collection of archival data. This study analyzed archival data collected between June 2000 and June 2011. All 390 patients included in the analysis completed an intake evaluation at the clinic, audio/videotape comfort form, and Brief Symptom Inventory (BSI) as part of the intake process. The forms were returned to the graduate clinicians conducting the intake interview. Responses on both forms were then entered into the clinic database by an advanced doctoral student who was neither the treating therapist nor the intake interviewer. Information pertaining to session number was obtained by a retrospective chart review of attendance and billing records.

Data Analyses

Bivariate Pearson r correlations were used to determine whether pretreatment symptom dimensions of the BSI were significantly related ($p < .05$; two-tailed) to comfort with audio or video recording. According to Cohen (1988), effect sizes for Pearson correlations are categorized as small if $r \geq .10$, medium if $r \geq .30$, and large if $r \geq .50$. In addition, for within-group pre–post comparisons, effect size (d) using pooled standard deviation weighted for n was calculated for each comparison. According to (Cohen, 1988), effect sizes for d are categorized as small if $d \geq 0.20$, moderate if $d \geq 0.50$, and large if $d \geq 0.80$. Effect size and clinical significance were obtained and are displayed in terms of overall sample and according to comfort with audio or video recording.

In relation to the calculation of clinical significance, the reliable change index (RCI) for the BSI–GSI was determined using the method outlined in Jacobson and Truax (1991) and in Jacobson, Roberts, Berns, and McGlinchey (1999):

$$\text{RCI} = \frac{X_1 - X_2}{Sdiff},$$

where X_1 = pretest score; X_2 = posttest score; $Sdiff = \sqrt{2(SE^2)}$; $SE = s1\sqrt{(1 - rxx)}$; $s1$ = the standard deviation of control group, normal population, or pretreatment group; and rxx = the test–retest reliability. If RCI $\geq$ 1.96, then it is likely that the change was reliable ($p < .05$). RCI was employed for the BSI–GSI and adjusted in order to control for regression to mean and measurement error (Speer, 1992). We favored this approach because this parameter is a more-conservative value of change than is simply comparing pre- and posttreatment scores. Reliable change (RC) and clinically significant change (CSC) was determined using methodology by Jacobson and Truax (1991) by a two-stage process in which (a) the change must be proven to be statistically reliable (RCI; see earlier formula) and (b) the individual must pass from the dysfunctional to the functional distribution.

Because multiple participants were administered the audio/videotape comfort form and pretreatment BSI forms by the same clinician, and because multiple participants were treated by the same therapist, we utilized multilevel models for several different

analyses. That is, we examined the variation in the effectiveness of clinicians and the nonindependence of patients seen by the same clinician (i.e., patients nested within clinician). The variance explained due to each clinician's cases within the entire sample was controlled for. This approach addresses the hierarchical structure of psychotherapy data by accounting for the lack of independence in patients' scores (Adelson & Owen, 2012; Raudenbush & Bryk, 2002). All statistical analyses were conducted using Hierarchical Linear and Nonlinear Modeling, Version 6 (HLM6) (Raudenbush, Bryk, Cheong, & Congdon, 2005).

To test for therapist effects (i.e., to examine variance accounted for by intake clinicians or therapists in videotape comfort and outcome ratings), we constructed seven baseline models (e.g., a model where the criterion variable was entered with no predictor variables). These models quantify the variability due to intake clinicians or therapists in terms of audio- or video-recording comfort, treatment refusal, number of sessions attended, RC of the BSI–GSI, and CSC. These baseline models allowed for the calculation of the residual intraclass correlation (ICC), which determined whether intake clinicians or therapists differed in their patients' average ratings of audio- or video-recording comfort, GSI scores, and withdrawal rates.

To examine our analyses in a multivariate context, we conducted six fixed effects multilevel models where audio- or video-recording comfort was the predictor variable at Level 1 (grand-mean-centered) and BSI–GSI, treatment refusal, treatment duration, RC, CSC, and number of sessions were the respective criterion variables.

Results

Are There Different Levels of Patient Comfort With Recording Sessions?

In the overall sample ($N = 390$), 33% ($n = 130$) of participants reported having no objections to audio or video recording on the audio/videotape comfort form, 19% ($n = 73$) had slight concerns, 19% ($n = 75$) had moderate concerns, 13% ($n = 51$) had strong concerns, and 16% ($n = 61$) had vehement objections. Therefore, a range of different patient comfort levels with audio or video recording of sessions was observed. In sum, the majority of patients expressed no or slight concerns (52%), and almost three quarters (71%) were willing to consider audio or video recording after discussion with their therapist.

Does Pretreatment Symptomatology Have a Relationship to Patient Comfort With Recording Sessions?

Pretreatment symptom dimensions of the BSI were examined in relation to patient ratings of comfort with audio or video recording (see Table 2). Two of the symptom dimensions, interpersonal sensitivity and paranoid ideation, were found to be significantly negatively correlated with comfort with audio or video recording ($p = .002$; $p = .033$, respectively), meaning that higher levels of interpersonal sensitivity and higher levels of paranoid ideation were associated with lower levels of comfort with audio or video recording. However, the effects of these relationships were relatively small (i.e., $r = -.15$ and $r = -.11$, respectively), and their clinical utility seems quite limited. None of the other symptom dimensions (somatization, obsessive–compulsive, depression, anxiety, hostility, phobic anxiety, psychoticism) were significantly correlated with audio- or video-recording comfort and all showed negligible effects.

Table 2
Relationship Between Pretreatment Patient Symptomatology and Audio/Videotape Comfort ($N = 390$)

	Pretreatment		Audio/videotape comfort	
Pretreatment symptomatology	*M*	*SD*	*r*	*p*
Somatization	0.630	0.643	−.090	.076
Obsessive compulsive	1.500	0.943	−.048	.345
Interpersonal sensitivity	1.416	1.052	−.154	.002*
Depression	1.380	0.936	−.044	.391
Anxiety	1.209	0.879	−.080	.116
Hostility	0.957	0.830	−.041	.418
Phobic anxiety	0.544	0.709	−.097	.056
Paranoid ideation	1.025	0.826	−.108	.033*
Psychoticism	1.006	0.783	−.085	.093
Positive symptom total	28.356	11.378	−.065	.203
Positive symptom distress index	1.871	0.556	−.068	.179
Global severity index	1.077	0.637	−.090	.076

Note. Negative correlation represents greater psychopathology with lower audio/videotape comfort scores.
* $p < .05$.

Do Different Levels of Patient Comfort With Recording Sessions Have a Relationship to Entering Into Treatment and Its Duration?

Rates were determined for treatment refusers (i.e., individuals who completed the initial intake session only and did not return for psychotherapy treatment; $n = 61$, 16%) and compared with treatment acceptors (i.e., those who started treatment and attended at least one session; $n = 329$, 84%) in the overall sample ($N = 390$). Rates were then compared for treatment refusers and treatment acceptors according to audio- or video-recording comfort endorsement rating. Of the 61 treatment refusers, 33% ($n = 20$) reported no objections to audio or video recording, 13% ($n = 8$) reported slight concerns, 18% ($n = 11$) reported moderate concerns, 13% ($n = 8$) reported strong concerns, and 23% ($n = 14$) reported vehement objections. For the 329 treatment acceptors, 33% ($n = 110$) reported no objections, 20% ($n = 65$) reported slight concerns, 19% ($n = 64$) reported moderate concerns, 13% ($n = 43$) reported strong concerns, and 14% ($n = 47$) reported vehement objections. A 5 × 2 chi-square comparing treatment refusers versus treatment acceptors across the five levels of audio- or video-recording comfort was not significant, $\chi^2(4) = 3.74$, $p = .442$, $N = 390$; $\phi = 0.10$, reflecting very similar rates of treatment refusal across the five levels of audio- or video-recording comfort for both groups. In addition, number of sessions attended was not significantly correlated with audio- or video-recording comfort ($r = .06$, $p = .23$), indicating no meaningful relationship between audio- or video-recording comfort reported by patients and the eventual number of sessions they attended in treatment.

Do Different Levels of Patient Comfort With Recording Sessions Have a Relationship to Treatment Outcomes?

Mean intake and posttreatment GSI clinical scores were compared for the participants who completed both the intake and final BSI (i.e., the treatment sample) for each of the five audio- or video-recording comfort endorsement groups and corresponding effect sizes (see Table 3). In order to be most conservative with regard to outcome, we included last observation carried forward of any follow-up patient BSI in our outcome analyses. Patients in all groups showed significant change, with the overall treatment sample improving significantly between pre- and posttreatment scores overall, with a moderate effect size suggesting meaningful psychotherapeutic benefit. Paired t tests for each of the levels of audio/video-recording comfort confirmed significant differences between all of the pre- to posttreatment mean GSI scores, and moderate effect sizes were observed for all groups (range: d = 0.43–0.63; r = .21–.30).

A one-way analysis of variance (ANOVA) comparing the pretreatment means across the five groups was not significant, $F(4, 238) = 0.89$, $p = .473$, indicating that all groups began treatment with equivalent levels of disturbance (i.e., level of pretreatment pathology did not vary according to level of comfort with audio or video recording). The posttreatment mean GSI scores across the five groups were also compared using a one-way ANOVA, and no statistically significant differences were found, $F(4, 238) = 0.774$, $p = .543$, between the groups of varying audio- or video-recording comfort endorsement, indicating that level of pathology posttreatment also did not differ according to audio- or video-recording comfort.

Table 4 shows the number and percentage of patients both overall and at each of the five levels of patient audio- or video-recording comfort endorsement who (a) achieved reliable change (RC; amount of reliable change accounting for measurement error and regression to the mean), (b) returned to the normal distribution, (c) achieved clinically significant change (CSC; positive for both prior conditions *a* and *b*), and (d) showed deterioration (RCI < -1.96). In the overall sample, 30% achieved reliable change, 69% returned to the normal distribution, 23% achieved clinically significant change, and 5% showed deterioration. A 5 × 4 chi-square was performed, comparing clinical significance across the five levels of audio- or video-recording comfort. Differences in RC, return to normal distribution, CSC, and deterioration across levels of comfort were found to be not significant, $\chi^2(12) = 2.93$, $p = .996$, $n = 243$; $\phi = 0.06$, reflecting similar rates of clinical significance across levels of audio- or video-recording comfort.

Number of sessions attended by patients was found to have a nonsignificant relationship with the BSI–GSI reliable change index (RCI; $r = .12$, $p = .07$), albeit a small effect relation between length of attendance in psychotherapy and benefit from treatment. In addition, the dimensional relationship between audio- or video-recording comfort with BSI–GSI RCI was also nonsignificant ($r = .02$, $p = .77$), indicating no meaningful relationship between audio- or video-recording comfort reported by patients and the eventual gains they achieved in treatment.

Is Patients' Comfort With Recording Sessions Affected by the Clinician They Are Working With?

To test for clinician effects (i.e., to examine variance accounted for by clinicians in audio/video-recording comfort and outcome ratings), seven baseline models (e.g., a model where the criterion variable was entered with no predictor variables) were constructed (see Table 5). These models quantify the variability due to clinicians in terms of audio- or video-recording comfort, treatment refusal (calculated for intake clinicians), treatment duration (calculated for treating therapists), BSI–GSI–RCI scores (the amount of reliable change observed over the course of treatment on the global severity index of the Brief Symptom Inventory accounting for measurement error and regression to the mean), patient achievement of reliable change (RC), and clinically significant change (CSC). These baseline models allowed for the calculation of the residual intraclass correlation (ICC), which determined whether clinicians differed in their patients' average ratings on each of the seven criterion variables: audio- or video-recording comfort, treatment refusal, treatment withdrawal, number of sessions attended, BSI–GSI–RCI scores, patient achievement of RC, and CSC. The $ICC_{(therapist)}$ for these seven models were audio- or video-recording comfort (0.146, $p = .002$), treatment refusal (0.06, $p = .42$), number of sessions (0.003, $p = .372$), BSI–GSI–RCI (0.017, $p > .50$), RC (0.001, $p > .50$), and CSC (0.0002, $p > .50$). These findings suggest that intake clinicians accounted for a significant proportion of the variance (15%) in relation to patient ratings of audio- or video-recording comfort. However, subsequently the intake clinicians and therapists did not account for a significant portion of the

Table 3
Treatment Outcome for Sample and Effect Size by Patient Audio/Videotape Comfort Endorsement

Variable	Pretreatment GSI: *M* (*SD*)	Posttreatment GSI: *M* (*SD*)	Pre- to posttreatment paired *t* test		Pre- to posttreatment effect size	
			t	*p*	*d* [CI]	*r* [CI]
Overall $n = 243$	1.07 (0.61)	0.76 (0.59)	−8.31	<.0001	.52 [0.46, 0.57]	.25 [0.20, 0.30]
Audio/videotape comfort						
No objection $n = 80$	1.03 (0.59)	0.75 (0.59)	−4.98	<.0001	.48 [0.39, 0.57]	.23 [0.14, 0.32]
Slight concerns $n = 46$	0.96 (0.54)	0.67 (0.69)	−3.11	.003	.47 [0.35, 0.60]	.23 [0.10, 0.35]
Moderate concerns $n = 50$	1.09 (0.59)	0.74 (0.54)	−4.98	<.0001	.63 [0.52, 0.74]	.30 [0.19, 0.41]
Strong concerns $n = 32$	1.13 (0.70)	0.88 (0.46)	−2.03	.05	.43 [0.29, 0.57]	.21 [0.06, 0.35]
Vehement objections $n = 35$	1.19 (0.68)	0.84 (0.63)	−3.39	.002	.54 [0.39, 0.69]	.26 [0.11, 0.41]

Note. GSI = global severity index; d = standardized mean difference using pooled standard deviation (Cohen, 1988); CI = confidence interval.

Table 4
Treatment Outcome for Sample in Terms of Clinical Significance and by Patient Audio/Videotape Comfort Endorsement

Variable	Reliable change	Return to normal distribution	Clinically significant change	Deterioration
Overall n = 243	30 (74)	69 (168)	23 (57)	5 (12)
Audio/videotape comfort				
No objection n = 80	30 (24)	66 (53)	21 (17)	6 (5)
Slight concerns n = 46	30 (14)	80 (37)	28 (13)	4 (2)
Moderate concerns n = 50	34 (17)	72 (36)	28 (14)	2 (1)
Strong concerns n = 32	25 (8)	66 (21)	19 (6)	6 (2)
Vehement objections n = 35	31 (11)	60 (21)	20 (7)	6 (2)

Note. Data are given as percentages, with n values in parentheses.

variance in relation to treatment refusal, treatment duration, or outcomes determined by BSI–GSI–RCI, RC, or CSC.

To extend our findings in a multivariate context, we conducted six fixed effects multilevel models where audio/video-recording comfort was the predictor variable at Level 1 (grand-mean-centered) and BSI–GSI–RCI, treatment refusal, treatment duration, RC, and CSC were the respective criterion variables. The results were consistent with our previous analyses and showed that none of the variables related to outcome were significantly associated with audio- or video-recording comfort even after controlling for clinician variance (see Table 6).

Discussion

The current findings are clearly important to the field and have implications for clinical training, research, and practice. Our results suggest that most patients report feeling relatively comfortable with audio or video recording when it is discussed in relation to training and in the context of appropriate safeguards to confidentiality. This information is helpful in that it may alleviate therapists' and trainees' anxiety about introducing audio or video recording to patients. Furthermore, findings that patients who expressed discomfort with audio or video recording were not significantly more likely to refuse treatment, attend fewer sessions, or have negative treatment outcome could also reassure clinic administrators, therapists, and trainees that it is unlikely negative outcomes will result from asking patients if they would consider audio or video recording. Finally, understanding patient and therapist factors that may impact attitudes toward audio or video recording may help inform choices about how to introduce this subject.

Since the earliest research involving audio or video recording, it has been reported that some therapists have been reluctant to use recording techniques, citing patient resistance as the primary reason. However, anecdotal research has repeatedly suggested that therapists may actually be more reluctant than patients to being audio- or video-recorded (e.g., Alpert, 1996; Chodoff, 1972; Zabarenko, Magero, & Zabarenko, 1977). There has not been sufficient empirical research conducted in the mental health field to either support or refute these claims. Therefore, we wanted to directly examine patient attitudes toward audio or video recording in a mental health clinic.

Are There Different Levels of Patient Comfort With Recording Sessions?

We found that the majority of patients reported no objections to audio/video recording (33%), and almost three quarters of patients (71%) were willing to consider audio or video recording after consultation and discussion with their clinician, more than half of whom (52%) expressed no or slight concerns, and less than one third of patients (29%) expressed high levels of discomfort with audio or video recording. This suggests that for the most part, patients are

Table 5
Percentage of Variance in Audio/Videotape Comfort, Treatment Refusal, Length, and Outcome Attributable to Therapist Effects

Variable	Intercept coefficient (*SE*)	$ICC_{therapist}$	χ^2 for therapist random effects	p
Audio/videotape comfort	2.41 (0.08)	.146	227.05	.002
Treatment refusal[b]	1.76 (0.15)	.06	170.05	.42
Number of sessions attended[a]	26.72 (1.55)	.003	128.51	.372
Amount of reliable change in BSI–GSI	−0.002 (0.13)	.017	103.02	>.50
Achieving reliable change	−0.83 (0.14)	.001	109.64	>.50
Achieving clinically significant change	−1.18 (0.15)	.0002	93.17	>.50

Note. Patient n = 243; intake clinician n = 168; therapist n = 152. ICC = intraclass correlations; BSI–GSI = global severity index of the Brief Symptom Inventory (BSI). *Therapist* refers to intake clinician for the audio/videotape comfort and treatment refusal variables and to treating therapist for number of sessions, global severity index, achieving reliable change, and achieving clinically significant change.
[a] Sessions attended beyond the intake = 0. [b] Sessions > 0.

Table 6
Testing Audio/Videotape Comfort and Outcome Correlations in a Multivariate Context

Fixed effects	Coefficient (*SE*)	*p*
Treatment refusal		
Intercept (γ_{00})	0.85 (0.02)	.000
Audio/videotape comfort (γ_{10})	0.01 (0.01)	.332
Number of sessions		
Intercept (γ_{00})	26.71 (1.55)	.000
Audio/videotape comfort (γ_{10})	1.07 (1.1)	.330
Amount of reliable change in BSI–GSI		
Intercept (γ_{00})	−0.002 (0.13)	.991
Audio/videotape comfort (γ_{10})	−0.02 (0.09)	.83
Achieving reliable change		
Intercept (γ_{00})	0.30 (0.03)	.000
Audio/videotape comfort (γ_{10})	0.0008 (0.02)	.971
Achieving clinically significant change		
Intercept (γ_{00})	0.23 (0.02)	.000
Audio/videotape comfort (γ_{10})	0.005 (0.02)	.751

Note. Patient n = 243; intake clinician n = 168; therapist n = 152. BSI–GSI = global severity index of the Brief Symptom Inventory.

comfortable with the idea of audio- or video-recording psychotherapy sessions when properly informed about its use and protections of privacy or confidentiality according to the standards of the American Psychological Association (2011) and the Health Insurance Portability and Accountability Act (1996). This information is valuable for academic programs and clinics because it opens up the possibility of using these tools more widely for training and research purposes.

The current findings are highly consistent with research conducted by Bain and Mackay (1993) in a general medical practice, which reported that 54% of patients agreed to having videotaped medical visits. Although Bain and Mackay's study is in the medical rather than mental health field, it is almost identical to the present study in that they examined patient attitudes, with 52% having no or slight concerns. The present study is also consistent with the findings of Marshall and colleagues (2001), who found that 64% of the participants approached were willing to participate in research that involved the audiotaping of psychotherapy sessions. This prior work is complementary to the present study in that it involved participants' agreeing to the actual recording rather than eliciting patient attitudes toward recording.

Does Pretreatment Symptomatology Have a Relationship to Patient Comfort With Recording Sessions?

Given the sparse prior research on pretreatment symptomatology and patient attitudes toward audio- or video-recording psychotherapy sessions, we sought to test these associations. We found that patients who have less comfort about being audio- or video-recorded (i.e., greater audio- or video-recording *dis*comfort) were more likely to exhibit significantly higher levels of paranoid ideation and interpersonal sensitivity. These symptom dimensions associated with higher levels of audio- or video-recording discomfort do not seem to be surprising and are fairly consistent with prior anecdotal research that has suggested audio or video recording may not be allowed by patients who are paranoid, psychotic, or personality disordered (Falzone, Hall, & Beresin, 2005) and that patients who refused to be videotaped "tended to be grandiose or paranoid" (Kornfeld & Kolb, 1964, p. 458). Although, again, it must be stressed that these were small effects ($r < .16$), and therefore their clinical utility may be limited.

Do Different Levels of Patient Comfort With Recording Sessions Have a Relationship to Entering Into Treatment and Its Duration?

The rates of treatment refusal (16%; session = 0) and acceptance (84%; session > 0) in the present study are consistent with or slightly below those of past studies that have examined this construct and defined it in the same way (i.e., failure to return for the first psychotherapy session following the initial intake interview). Refusal rates of 24% (Betz & Shullman, 1979), 19% (Krauskopf, Baumgardner, & Mandracchia, 1981), and 22% (Kokotovic & Tracey, 1987) have been observed in university counseling center settings. In comparing the rates of treatment refusal and treatment acceptance across the five levels of audio- or video-recording comfort, no significant differences were found between groups. This contradicts our hypothesis that participants with higher levels of audio- or video-recording discomfort would have higher rates of treatment refusal. This finding suggests that even patients who are highly opposed to the idea of audio- or video-recording psychotherapy sessions are not repelled by the inquiry, and it does not impact whether they return for treatment. Like the findings for treatment refusal, number of sessions attended was not found to be significantly related to audio- or video-recording comfort, which does not support the hypothesis that less audio- or video-recording comfort is associated with shorter duration. Again, this suggests that regardless of patients' comfort levels with audio or video recording, their subsequent duration in treatment is not based on this factor.

Do Different Levels of Patient Comfort With Recording Sessions Have a Relationship to Treatment Outcomes?

Overall, patients in our sample demonstrated significant improvements, with moderate effects over the course of treatment, that are highly comparable to those of other large naturalistic studies of outpatient psychotherapy provided at university-based clinics (Draper, Jennings, Baron, Erdur, & Shankar, 2002; Snell, Mallinckrodt, Hill, & Lambert, 2001), although no significant differences in outcome according to level of audio- or video-recording comfort were observed. This finding suggests that despite any initial differences in symptomatology (e.g., levels of paranoid ideation and interpersonal sensitivity) between those with high and low levels of audio- or video-recording comfort, there were no eventual differences in treatment outcome or amount of improvement. Further, this may suggest that the psychotherapy treatment provided in the current study was able to address any potential initial concerns and provide symptom relief and overall improvement.

Is Patients' Comfort With Recording Sessions Affected by the Clinician They Are Working With?

In an examination of therapist effects in relation to audio- or video-recording comfort ratings and outcome, there was a signif-

icant therapist (i.e., intake clinician) effect present with regard to patient ratings of audio- or video-recording comfort. That is, about 15% of the variance in patients' ratings of audio- or video-recording comfort was attributable to who their intake clinician was. However, again, even accounting for the effect of patients' intake clinician, or subsequently their assigned therapist, there were still no significant associations between audio- or video-recording comfort and any of the variables related to treatment refusal, duration, and outcome. That is, although there was a significant relationship between who conducted the clinical intake assessment and audio- or video-recording comfort, when these effects were tested in a multivariate context and controlled for, the findings related to audio- or video-recording comfort were nonsignificant (and all other variables remained nonsignificant as well). The initial finding of an association between audio- or video-recording comfort and an intake clinician effect is important to explore further in terms of what specific therapist characteristics may have contributed to these differential levels of patient comfort with recording practices. It is possible that therapist experience may have played a role, as is suggested by prior research demonstrating different rates of withdrawal from psychotherapy on the basis of therapists' experience level (Swift & Greenberg, 2012). Although all clinicians in the present study were trainees, the level of training they acquired prior to or during enrollment in a doctoral program may have varied somewhat.

Given the initial finding of an association between patient audio- or video-recording comfort and intake clinician (i.e., therapist) effects, it is important to not only explore potential causes but to prophylactically address, where possible, gaps in training and/or procedural issues that may have contributed to this association. Prior anecdotal research in the mental health field has suggested that patients are more likely to agree to recording procedures when they are given a full explanation (Alpert, 1996). It is possible that some patients in the current study were not given as full or detailed follow-up explanation of the audio/videotape comfort form and its related training and research purposes as others were due to factors such as time constraints or perhaps even a lack of therapist commitment to audio- or video-recording research and training. These clinician differences may be reduced by providing more-comprehensive training to trainees about the importance of audio- or video-recording practices for research and training purposes. In addition, it may be valuable to ascertain a clinician's attitude toward audio or video recording. For instance, if a clinician's attitude toward audio or video recording was found to have an effect on patient level of comfort, additional education about the utility of audio or video recording research could be provided early on in the training program.

Despite being the first empirical examination of this issue in the literature, the current study does have some limitations. First, this sample primarily suffered from mild to moderate levels of distress and impairments in functioning (mean intake GSI = 1.08, SD = 0.63). In order to make these results more generalizable to other samples, further research is needed to examine populations with higher levels of global distress and greater functional impairment. The sample was also limited by its relative homogeneity: The majority of participants were female (79%), Caucasian (72%), and highly educated (mean years' education = 15.54). It would be important for future research to explore potential differences in a sample with more demographic diversity. All of the clinicians included in the study were doctoral-level trainees, and further research should be conducted to examine how intake clinician and therapist level of experience may impact patient attitudes toward audio or video recording. Given the intake clinician (i.e., therapist) effect findings in the current data regarding this issue, it is suspected that some clinicians were either more informed or more invested in the process of administering the audio/videotape comfort form at the intake session (i.e., it is possible that some clinicians took more time to explain the form and answer any questions the patient may have had and even followed up with questions when the patient had none). In addition, clinicians' own attitudes toward audio or video recording may have been communicated either explicitly or implicitly to patients, which may have had an effect on patient attitudes. These factors should be explored in terms of how clinician knowledge and bias (specific to the form) may have impacted patient attitudes.

In addition to future research addressing limitations of the current study, there are other areas that would be useful to investigate. It may be important for future research to investigate additional patient and therapist characteristics as they relate to patient audio- or video-recording comfort in order to see if there are any other patient-level variables beyond levels of symptomatology (e.g., demographics, personality traits) that may contribute to different levels of comfort with recording. Furthermore, this study examined only patient *comfort* with audio or video recordings, and at the beginning of the treatment process. However, only some of the patients who expressed a comfort with recording their psychotherapy subsequently had their sessions audio- or videotaped. It is important for future research to examine the relationship between these pretreatment attitudes, as well as whether these attitudes change longitudinally over the course treatment, for patients who subsequently do and do not have their sessions recorded. Additionally, although the effect of the intake clinician and therapist were examined in the current study using HLM analyses, little is known about what specific therapist characteristics may have impacted the findings. A more-thorough investigation into therapist characteristics would be useful in terms of targeting training efforts. This area of research would also benefit from exploration into the effectiveness of interventions designed to increase both patient and therapist levels of comfort with recording practices. Prior research has suggested that many patients (Marshall et al., 2001) and therapists (Yenawine & Arbuckle, 1971) acclimate to the recording process quickly, within a few sessions, and it would be helpful to see whether this can be replicated in settings that may have more of a focus on training and where trainees may have higher or lower baseline levels of anxiety related to recording as well as longitudinally over the course of treatment. Future research in the area of audio- or video-recording psychotherapy sessions will enable clinical supervisors and clinic administrators to more successfully implement audio- or videotape research, which will in turn benefit the field overall in science and practice.

References

Adelson, J. L., & Owen, J. (2012). Bringing the psychotherapist back: Basic concepts for reading articles examining therapist effects using multilevel modeling. *Psychotherapy, 49,* 152–162. http://dx.doi.org/10.1037/a0023990

Alpert, M. C. (1996). Videotaping psychotherapy. *Journal of Psychotherapy Practice and Research, 5,* 93–105.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychological Association. (2011). *Ethical principles of psychologists and code of conduct*. Retrieved July 16, 2011, from http://www.apa.org/ethics/code/index.aspx

Argyle, M. (2013). *Bodily communication*. London, United Kingdom: Routledge.

Bain, J. E., & Mackay, N. S. (1993). Videotaping general practice consultations. *British Medical Journal, 307,* 504–505. http://dx.doi.org/10.1136/bmj.307.6902.504-b

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 258–297). Somerset, NJ: Wiley.

Barnes, L. H., & Pilowsky, I. (1969). Psychiatric patients and closed-circuit television teaching: A study of their reactions. *British Journal of Medical Education, 3,* 58–61. http://dx.doi.org/10.1111/j.1365-2923.1969.tb01593.x

Betz, N. E., & Shollman, S. L. (1979). Factors related to patient return rate following intake. *Journal of Counseling Psychology, 26,* 542–545. http://dx.doi.org/10.1037/0022-0167.26.6.542

Bush, J. D., Bittner, J. R., & Brooks, W. D. (1972). The effect of the videotape recorder on levels of anxiety, exhibitionism, and reticence. *Speech Teacher, 21,* 127–130. http://dx.doi.org/10.1080/03634527209377935

Chodoff, P. (1972). Supervision of psychotherapy with videotape: Pros and cons. *American Journal of Psychiatry, 128,* 819–823. http://dx.doi.org/10.1176/ajp.128.7.819

Civic Impulse. (2016). H.R. 3103 – 104th Congress: Health Insurance Portability and Accountability Act of 1996. Retrieved from https://www.govtrack.us/congress/bills/104/hr3103

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Covner, B. J. (1942). Studies in phonographic recordings of verbal material: I. The use of phonographic recordings in counseling practice and research. *Journal of Consulting Psychology, 6,* 105–113. http://dx.doi.org/10.1037/h0053878

Derogatis, L. (1993). *Brief Symptom Inventory*. Minneapolis, MN: National Computer Systems.

Draper, M. R., Jennings, J., Baron, A., Erdur, O., & Shankar, L. (2002). Time-limited counseling outcome in a nationwide college counseling center sample. *Journal of College Counseling, 5,* 26–38. http://dx.doi.org/10.1002/j.2161-1882.2002.tb00204.x

Ellis, M. V., Krengel, M., & Beck, M. (2002). Testing self-focused attention theory in clinical supervision: Effects on supervisee anxiety and performance. *Journal of Counseling Psychology, 49,* 101–116. http://dx.doi.org/10.1037/0022-0167.49.1.101

Falzone, R. L., Hall, S., & Beresin, E. V. (2005). How and why for the camera-shy: Using digital video in psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 14,* 603–612, xi. http://dx.doi.org/10.1016/j.chc.2005.02.006

Friedman, C. T., Yamamoto, J., Wolkon, G. H., & David, L. (1978). Videotape recording of dynamic psychotherapy: Supervisory tool or hindrance? *American Journal of Psychiatry, 135,* 1388–1391. http://dx.doi.org/10.1176/ajp.135.11.1388

Gelso, C. J. (1973). Effect of audiorecording and videorecording on client satisfaction and self-expression. *Journal of Consulting and Clinical Psychology, 40,* 455–461. http://dx.doi.org/10.1037/h0034548

Gelso, C. J. (1974). Effects of recording on counselors and patients. *Counselor Education and Supervision, 14,* 5–12. http://dx.doi.org/10.1002/j.1556-6978.1974.tb01987.x

Gelso, C. J., & Tanney, M. F. (1972). Patient personality as a mediator of the effects of recording. *Counselor Education and Supervision, 12,* 109–114. http://dx.doi.org/10.1002/j.1556-6978.1972.tb01937.x

Harper, R. A., & Hudson, J. W. (1952). The use of recordings in marriage counseling: A preliminary empirical investigation. *Marriage and Family Living, 14,* 332–334. http://dx.doi.org/10.2307/348726

Jacobson, N., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12–19. http://dx.doi.org/10.1037//0022-006x.59.1.12

Jacobson, N. S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for defining and determining the clinical significance of treatment effects: Description, application, and alternatives. *Journal of Consulting and Clinical Psychology, 67,* 300–307. http://dx.doi.org/10.1037/0022-006X.67.3.300

Ko, K., & Goebert, D. (2011). Factors influencing consent to having videotaped mental health sessions. *Academic Psychiatry, 35,* 199–201. http://dx.doi.org/10.1176/appi.ap.35.3.199

Kokotovic, A. M., & Tracey, T. (1987). Premature termination at a university counseling center. *Journal of Counseling Psychology, 34,* 80–82. http://dx.doi.org/10.1037/0022-0167.34.1.80

Kornfeld, D. S., & Kolb, L. C. (1964). The use of closed-circuit television in the teaching of psychiatry. *Journal of Nervous and Mental Disease, 138,* 452–459. http://dx.doi.org/10.1097/00005053-196405000-00005

Krauskopf, C., Baumgardner, A., & Mandracchia, S. (1981). Return rate following intake revisited. *Journal of Counseling Psychology, 28,* 519–521. http://dx.doi.org/10.1037/0022-0167.28.6.519

Lamb, R., & Mahl, G. F. (1956). Manifest reactions of patients and interviewers to the use of sound recording in the psychiatric interview. *American Journal of Psychiatry, 112,* 731–737. http://dx.doi.org/10.1176/ajp.112.9.731

Marshall, R., Spitzer, R., Vaughan, S., Vaughan, R., Mellman, L., MacKinnon, R., & Roose, S. (2001). Assessing the subjective experience of being a participant in psychiatric research. *American Journal of Psychiatry, 158,* 319–321. http://dx.doi.org/10.1176/appi.ajp.158.2.319

Niland, T. M., Duling, J., Allen, V., & Panther, E. (1971). Student counselors' perceptions of videotaping. *Counselor Education and Supervision, 11,* 97–101. http://dx.doi.org/10.1002/j.1556-6978.1971.tb01491.x

Owen, J., Drinane, J., Idigo, K., & Valentine, J. (2015). Psychotherapist effects in meta-analyses: How accurate are treatment effects. *Psychotherapy, 52,* 321–328. http://dx.doi.org/10.1037/pst0000014

Poling, E. G. (1968a). Video tape recordings in counseling practicum: I—Environmental considerations. *Counselor Education and Supervision, 7,* 348–356. http://dx.doi.org/10.1002/j.1556-6978.1968.tb00827.x

Poling, E. G. (1968b). Video tape recordings in counseling practicum: II—Critique considerations. *Counselor Education and Supervision, 8,* 33–38. http://dx.doi.org/10.1002/j.1556-6978.1968.tb00962.x

Raudenbush, S. W., & Bryk, A. S. (2002). *Hierarchical linear models: Applications and data analysis methods* (2nd ed.). Thousand Oaks, CA: Sage.

Raudenbush, S. W., Bryk, A. S., Cheong, Y. F., & Congdon, R. (2005). *HLM6: Hierarchical linear and nonlinear modeling* [Computer software manual]. Lincolnwood, IL: Scientific Software International.

Redlich, F. C., Dollard, J., & Newman, R. (1950). High fidelity recording of psychotherapeutic interviews. *American Journal of Psychiatry, 107,* 42–48. http://dx.doi.org/10.1176/ajp.107.1.42

Roberts, R. R., & Renzaglia, G. A. (1965). The influence of tape recording on counseling. *Journal of Counseling Psychology, 12,* 10–16. http://dx.doi.org/10.1037/h0021936

Roulx, K. R. (1969). Some physiological effects of tape recording on supervised counselors. *Counselor Education and Supervision, 8,* 201–205. http://dx.doi.org/10.1002/j.1556-6978.1969.tb01328.x

Schacter, D. L. (1999). The seven sins of memory: Insights from psychology and cognitive neuroscience. *American Psychologist, 54,* 182–203. http://dx.doi.org/10.1037/0003-066X.54.3.182

Schneider, C. D. (1977). Shame, exposure, and privacy. New York, NY: WW Norton & Co.

Snell, M. N., Mallinckrodt, B., Hill, R. D., & Lambert, M. J. (2001). Predicting counseling center clients' response to counseling: a 1-year follow up. *Journal of Counseling Psychology, 48,* 463–473. http://dx.doi.org/10.1037/0022-0167.48.4.463

Speer, D. (1992). Clinically significant change: Jacobson and Truax (1991) revisited. *Journal of Consulting and Clinical Psychology, 67,* 894–904. http://dx.doi.org/10.1037/0022-006x.61.1.27

Star, B. (1977). The effects of videotape self-image confrontation on helping perceptions. *Journal of Education for Social Work, 13,* 114–119. http://dx.doi.org/10.1080/00220612.1977.10671443

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80,* 547–559. http://dx.doi.org/10.1037/a0028226

Tanney, M. F., & Gelso, C. J. (1972). Effect of recording on patients. *Journal of Counseling Psychology, 19,* 349–350. http://dx.doi.org/10.1037/h0033077

Van Atta, R. E. (1969). Excitatory and inhibitory effect of various methods of observation in counseling. *Journal of Counseling Psychology, 16,* 433–439. http://dx.doi.org/10.1037/h0028005

Walz, G. R., & Johnston, J. A. (1963). Counselors look at themselves on video tape. *Journal of Counseling Psychology, 10,* 232–236. http://dx.doi.org/10.1037/h0047698

Wiemann, J. M. (1981). Effects of laboratory videotaping procedures on selected conversation behaviors. *Human Communication Research, 7,* 302–311. http://dx.doi.org/10.1111/j.1468-2958.1981.tb00577.x

Yenawine, G., & Arbuckle, D. S. (1971). Study of the use of videotape and audiotape as techniques in counselor education. *Journal of Counseling Psychology, 18,* 1–6. http://dx.doi.org/10.1037/h0030394

Zabarenko, R. N., Magero, J., & Zabarenko, L. (1977). Use of video tape in teaching psychological medicine. *Journal of Family Practice, 4,* 559–560.

Appendix

Audio/Videotape Comfort Form

The Center for Psychological Services is a training clinic and some patients may be asked for permission to make audio and/or video recordings of the services they receive for training/educational purposes only. These recordings may enable the clinician and supervisor assigned to a case to more clearly review and understand how to best implement a treatment program with the patients they serve. Only the clinical staff involved with a treatment case at the Center would have access to these recordings. All cases are assigned a code number that will be used to identify any information that is recorded from any treatment. Typically, each therapist has one tape and when the tape is full it is reused and old sessions are taped over. Just like all information regarding treatment cases, any recorded information will be kept secured and locked. These tapes will not be disseminated, and they will be handled in accordance with the ethical and professional standards of the American Psychological Association.

In considering how I might respond to being asked for permission to make audio and/or video recordings of the services I receive for training/educational purposes only (Please check one):

_____ I would have no serious objections to doing this after having the opportunity to discuss these issues with my assigned therapist.

_____ I have some slight concerns, but would probably do this after having the opportunity to discuss these issues with my assigned therapist.

_____ I have some moderate concerns, but would possibly do this after having the opportunity to discuss these issues with my assigned therapist.

_____ I have some serious concerns, but would probably not do this even after having the opportunity to discuss these issues with my assigned therapist.

_____ I would have vehement objections to doing this and would not need to discuss these issues with my assigned therapist.

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