paid a lesser amount of money than you did on this particular claim?

A. Yes, we would have.

Q. Do you pay your claims based on your belief that the information contained on the claims that are submitted to you is accurate?

A. Yes, we do.

Q. If you found that the information was inaccurate or fraudulently placed on those forms would your company pay the claim or do something about it?

A. We would do something about it.

Q. Now I will note on the very bottom of this form, and I think we're talking about boxes 32 and 33, do you see those?

A. Yes.

Q. In those boxes we have some designations of, it says service facility under 32, and what is that, service facility?

A. That's where the service actually took place. It's the facility in which the service took place.

Q. And it says Endoscopy Center of S. Nevada LLC?

A. Yes.

Q. 700 Shadow Lane?

A. Yes.

Q. In Las Vegas?

A. Yes.

Q. Is that where the bill came from?

A. Yes.

Q. Now under the next one where it says billing provider there is a name over there.

A. Yes.

Q. And it has a designation of CRNA. Do you see that?

A. Yes.

Q. What name is designated there?

A. Mathahs.

Q. First name?

A. Keith.

Q. So is that the provider on this form?

A. That's the anesthesiologist that performed, that provided the service.

Q. Now I want to flip to that explanation of benefits portion which I think you said was on page 2.

A. Two.

Q. Of Exhibit 35. And explain that for the Grand Jury. Again does that have Mr. Meana's name on it?

A. Yes.

Q. Does that payment pertain to the claim form that we had seen earlier?

A. Yes, it does.

Q. And you said that the actual paid amount for this claim was $131.20, right?

A. Yes, it was.

Q. So that's money that actually left your company and went to the Endoscopy Center?

A. That's correct.

Q. The $560 does that correlate with how much was actually billed?

A. That's correct.

Q. And what is the reason why there is a difference between those two numbers?

A. Because our contracted rate, we have a, we had a contracted rate with Endoscopy Center that paid $16.40 per unit per 15 minutes during that time period.

Q. Okay. So it would have been an increase if there would have been more units and a decrease if there had been fewer?

A. Correct.

Q. Because you have a contracted rate it's less money than you actually have to pay than what they submit?

A. Correct.

Q. Is the $560, is that a three unit charge? Was that your experience that it was a three unit charge from, I mean time charge from the Endoscopy Center?

A. Yes.

Q. Did every claim that you had come in that was in the three unit charge range have a dollar figure of $560?

A. I'm not sure.

Q. The ones that you have looked at.

A. Yes, the ones I reviewed all had the $560 billed amount for three time units.

Q. Fair enough. Now I know that we have gone through what we just did on this particular patient. I want to move to the next one which is Gwendolyn Martin I believe you said; is that correct?

A. Yes.

Q. I'm going to hand you what has been marked as Grand Jury Exhibit Number 34. Flip through that again and do the same thing, tell me if you recognize the forms that are there and what they are.

A. Yes, I do.

Q. What are they?

A. Again it's the HCVA 1500 with billed charges for endoscopy services.

Q. Okay. And are there two separate groups

being the HCVA 1500 form and then an explanation of benefits saying what you actually paid?

A. Yes.

Q. Are they all for the same patient Gwendolyn Martin?

A. They're all for the same patient. There's two HCVA 1500s for two separate services on two separate dates of service.

Q. Fair enough. Showing the first page of Grand Jury Exhibit Number 34, and I know we've gone through the exhibit, I'll go through it quickly. Does it show on the form the name of the patient?

A. Yes.

Q. We're looking at the 1500 HCVA form; is that correct?

A. Yes, we are.

Q. And then if we go down does it show the procedure date?

A. Yes, 9/20/07.

Q. So according to this form the procedure occurred on 9/20 of '07?

A. Yes.

Q. Still an endoscopy procedure?

A. Yes.

Q. The point I want to get to on this

particular form, the amount being charged is I think $560 according to this?

A. Yes.

Q. And the number of minutes billed is 31 minutes?

A. Yes.

Q. Endoscopy Center of Southern Nevada still?

A. Yes.

Q. And Mr. Lakeman being the anesthesia person?

A. Yes.

Q. Now on that particular form, going to page 3 of the exhibit, does page 3 relate to the actual, what's called the explanation of benefits form showing the amount paid by your company for this claim?

A. Yes, it does.

Q. And how much was paid on that particular claim?

A. $304.

Q. Even?

A. Yes.

Q. So $304. And the charged amount was how much?

A. Five hundred sixty.

Q. Now I notice between the first product we

looked at on Miss, I think it was Miss Meana's form, or excuse me, Rudolfo Meana's form and this one that there are difference in what you paid based on the same billed charge.

A. Correct.

Q. Can you explain that?

A. Mr. Meana's was, is a senior and his contracted rate was $16.40. The commercial -- this member --

Q. Per unit you mean?

A. Per unit. This member is a commercial member so they're a working employed member with commercial insurance and that rate is $38, was $38 per unit at that time.

Q. So it was much higher?

A. It was much higher.

Q. So is that why there is a difference between how much you have to pay?

A. That's why there's a difference in payment. So the units are the same, eight units, but multiplied by a different contracted rate.

Q. Fair enough. And if you could, if you could let me finish my question before --

A. I'm sorry.

Q. -- you answer that would help the court

reporter taking down what's being said.

A. Certainly.

Q. Now I want to move to page 4 of Exhibit 34 which is the, I think another one of these HCVA claim forms; is that correct?

A. Yes, it is.

Q. It still has Miss Martin's name on it?

A. Yes.

Q. If we move down we see that it looks like this was a claim on the following day, the 21st of September of 2007; is that correct?

A. Yes, it is.

Q. Now I notice that the number here under section D on box, under the box, large box 24 --

A. Yes.

Q. -- has a different procedure type code. Is that still an endoscopy procedure?

A. Yes, it is.

Q. Is that an upper or lower or do you know?

A. I'm not sure.

Q. But clearly there were two different endoscopy type procedures?

A. Yes.

Q. If we move across we see the billed amount is still $560?

A. Yes.
Q. And the minutes that were submitted to your company on this particular claim were 32?
A. Yes.
Q. The CRNA at the bottom in box 33 is I believe Keith Mathahs; correct?
A. Yes.
Q. And then box 32, this was a claim that came from the Endoscopy Center?
A. Yes.
Q. Move to I believe it's page 6 of the exhibit which is titled explanation of benefits. Do you see that?
A. Yes.
Q. What is the date for this particular, the procedure related to this payment of claim?
A. 9/21/07.
Q. Does that refer to the HCVA form we just saw a moment again?
A. Yes, it does.
Q. Same patient's name?
A. Yes.
Q. Dollar amount that was billed?
A. $560.
Q. The amount paid?

A. $304.
Q. So if I understand you correctly this patient had procedures on the 20th and the 21st and that on those two days the amount of anesthesia billed was the same; correct?
A. Yes.
Q. The amount of payment for each procedure was the same?
A. Yes.
Q. If the person had had a, let's say just on the 21st for example had had both the upper and the lower endoscopy done at the same time, would there have been one anesthesia charge or two?
A. One. One base unit charge.
Q. But not two separate?
A. Not two separate base units.
Q. And then the time for doing both would have been certainly added together; correct?
A. Correct.
Q. Are those the only two patients that you reviewed in relation to this particular case?
A. Yes.
MR. STAUDAHER: I have nothing further for this witness.
THE FOREPERSON: Are there any questions?

BY A JUROR:
Q. Miss Myers, there is a commercial product and a senior product?
A. Yes.
Q. On the senior product is Medicare billed for a portion of that as well?
A. No. What Secure Horizons Pacific Care senior product is a Medicare managed, Medicare advantage product. So Medicare subcontracts to other HMO insurance companies to provide health care to their members. So Medicare relinquishes their billing rights to the insurance company that they have contracted, subcontracted with.
Q. Thank you.
A. Does that --
THE FOREPERSON: Any further questions?
BY A JUROR:
Q. If there was a patient without insurance of any sort would that patient pay the full $560.
A. Yes.
Q. No discounts to the patient?
A. Well, that actually is a provider question. I'm not, I'm only speaking as an insurance company.
Q. But you have paid claims for the full amount?

A. They have insurance, if I receive their claim they have insurance.
Q. They have insurance. I see.
A. And they are contracted with us.
Q. I understand. Thank you.
A. To provide that.
BY A JUROR:
Q. Does your billing company or your insurance company require anesthesia records or any other medical records be submitted with the HCVA or do you request those only on a case that you may need them?
A. Only a case that they're required. One of the other items on the form is actually the time. Above the area there is a time.
MR. STAUDAHER: And so that we're clear on this I'm going to hand her back both of the exhibits. I don't know if she needs to refer to both. But if you would tell us which one you're looking at.
THE WITNESS: I'm looking at Rudolfo Meana.
MR. STAUDAHER: So that for the record is Grand Jury Exhibit Number 35 and she's referring to the first page of the exhibit.
THE WITNESS: And above the procedure code there actually is a time entered and this one is 10:30 to 11:03.

MR. STAUDAHER: And I'll display that to the Grand Jury so that we can make sure we see what you're referring to. And I'll zoom in on it actually.

So can you say that once again now that this is displayed for the Grand Jury.

THE WITNESS: Yes. So when we receive the claim we see the 10:30 to 11:03 and that equates to the 33 minutes and as long as that is on the form and it's our contracted provider and there is no reason to have an indication that it's not accurate that is what is paid on.

A JUROR: Thank you.

THE FOREPERSON: Any further questions?

MR. STAUDAHER: I now have a follow-up question to that.

THE FOREPERSON: Okay.

BY MR. STAUDAHER:

Q. Related to that particular item that you just designated, is that also present on Grand Jury Exhibit Number 34?

A. Yes, it is.

Q. I'm going to place that up there so that the Grand Jury can see that as well.

So there is a specific time frame listed; is that correct?

A. That's correct. This procedure took place between 12:20 and 12:51.

Q. And this is the procedure I believe on the 20th; correct?

A. Yes.

Q. And the other one which you mentioned was 10:30 to 11:03 was on the 21st?

A. Correct.

Q. And that was Grand Jury Exhibit Number 35; correct?

THE FOREPERSON: Yes.

MR. STAUDAHER: One second, I'm not done.

Q. With relation to that, did your company require that the actual minute time or the time designated for the anesthesia be submitted along with the bills?

A. Yes.

Q. That was something specific to Pacific Care?

A. That was something specific to our processing of the claim, yes.

Q. So if other insurance companies had that or didn't have that you wouldn't really know?

A. I wouldn't know.

Q. It was just something that your company

required?

A. That's correct.

MR. STAUDAHER: Okay.

BY A JUROR:

Q. Did you have anyone audit those time factors to see if there was any overlap?

A. No, we did not.

THE FOREPERSON: Any further questions? None?

A JUROR: I have one.

THE FOREPERSON: Okay.

BY A JUROR:

Q. I kind of was confused on the contracted rates that you had. When you said you had it with Dr. Desai, so you guys agreed that this is the amount that you're going to pay for this, that's what it meant?

A. Correct.

Q. Okay. So different people, different insurers do different rates with different doctors?

A. Correct.

Q. That's what it meant?

A. Correct, different insurance companies have different payment methodologies and contracts with providers.

Q. Okay.

BY MR. STAUDAHER:

Q. I'm sorry, I have one additional follow-up. I just want to be clear on this. I showed you, and I just want to go, we're looking currently on the screen at Exhibit 35, is that correct? And let me go to that section. We're looking at box 24, section or column D. Correct?

A. Yes.

Q. The number designations on that are 10.30 to 11.03?

A. Yes.

Q. And this is Rudolfo Meana; correct?

A. Yes.

Q. And the 21st --

A. Yes.

Q. -- of September of 2007?

A. Yes.

Q. Now on Gwendolyn Martin, I think I showed you -- and this is Exhibit Number 34.

A. Yes.

Q. First page, Gwendolyn Martin, I'll zoom back out so we can see where we're at here. 9/20 of 07?

A. Yes.

Q. And the time that you're talking about is 12:20 to 12:51?

A. Yes.
Q. Now page 4 of that exhibit, and I'll show it to you here, it's still Gwendolyn Martin; correct?
A. Yes.
Q. And the date is 9/21 of '07?
A. Yes.
Q. And there are specific times listed there. What are they?
A. This is 13:15 to 13:47, that is 1:15 to 1:47.
Q. Now one question. When you receive these claims in --
A. Yes.
Q. -- if you received a series of claims, I assume if you had a lot of Pacific Care patients or Secure Horizon patients who came into a facility on a day for a number of procedures, and since you're having specific times placed on those forms as a requirement, do you ever look at those to see if there is any problem with them, if they overlap, anything like that?
A. Normally they're processed on an individual basis.
Q. But if somebody had a couple of forms in front of them --
A. Yes.

Q. -- and they look at them and for example we're looking at the time range of 1315 to 1347 --
A. Yes.
Q. -- if someone had a form the next form over that says 1330 to 13 whatever, same claim, same company, would that raise a red flag?
A. Yes, it would.
MR. STAUDAHER: I have nothing further?
THE FOREPERSON: Are there any further questions?
BY A JUROR:
Q. Yeah, I do have one.
All right. Based on what Mike said here it would raise a question, I understand. But you wouldn't necessarily handle both claims though, would you? I mean there might be another person sitting down the aisle from you or something.
A. That's correct. I have, there are multiple claims examiners so two claims for the same time period could be processed by two individual people. We were a manual claim shop meaning that we, a person data entered the information from the HCVA into the computer system and it could have been two different people.
Q. Yeah. So you wouldn't, based on that you may never catch the overlap?

A. That's correct, unless a red flag had been raised and we proceeded to investigate.
Q. Okay.
THE FOREPERSON: Any further questions? None?
By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: I do.
THE FOREPERSON: Thank you. You can be excused.
MR. STAUDAHER: And ladies and gentlemen, I was a little remiss at the beginning. Before I bring in the next witness I just want to reiterate the fact that I know there are a couple of Grand Jurors missing this

morning, we still have 12 to proceed on, but I want to reiterate that before you deliberate, if you were absent from any of these proceedings you must read the transcripts of any portion or the entirety of any presentation that you have not been present for. Do I have general acknowledgment that you will do that in this particular case?
THE FOREPERSON: Yes.
MR. STAUDAHER: I don't see anybody saying otherwise on the record. Is that true, Madame Foreman?
THE FOREPERSON: Yes.
MR. STAUDAHER: With that I'll bring in the next witness.
THE FOREPERSON: Please raise your right hand.
You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: Yes.
THE FOREPERSON: Thank you. You may be seated.
You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of

persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Please state both your first and last names and spell them for the record.

THE WITNESS: Corrine Spaeth. First name spelled C-O-R-R-I-N-E, last name Spaeth, S-P-A-E-T-H.

THE FOREPERSON: Thank you.

MR. STAUDAHER: And ladies and gentlemen of the Grand Jury, the testimony of this witness will pertain to the racketeering charges as I've said before, 28, 29, 58 and 59, but in addition to that specifically they will relate to Counts 13, 22, 43 and 52, as well as Counts 17, 26, 47 and 56.

CORRINE SPAETH,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Miss Spaeth, what do you do for a living?

A. I'm the director of the claims department for Sierra Health Services.

Q. And Sierra Health Services, do they go by other names as well?

A. Yes, they sell different products. Health Plan of Nevada, Sierra Health and Life Insurance Company, and we have, we're recently purchased by United Health Care.

Q. So you're associated with them as well?

A. Yes.

Q. So if you have a claim coming in from one of those different entities or to one of those entities like HPN or Sierra Health it would still come to your company?

A. Yes, it would.

Q. Can you explain to us what happens when a claim comes in and -- is it a certain type of form for example?

A. Differences between the two companies?

Q. No. I'm talking about in general when a claim comes in does it come in on a certain type of form?

A. Yes. In-patient claims come in UB forms and physician forms come in on HCVA 1500 forms.

Q. I'm going to specifically be asking you

about some HCVA 1500 forms. But if I understand you correctly that's where the claim comes from a provider to your company and then you pay on those claims?

A. Yes, we do. And yes, it does.

Q. Now when you pay on the claims is that kind of the revenue cycle from your organization, you're the insurance company that insures, you get the claim, you look at it, you decide what your contracted amount is or whatever and you pay on it?

A. Yes, and the member benefits as well.

Q. Got it.

I'm going to direct your attention to two specific patients, specifically Carole Grueskin and Stacy Hutchison. Were they patients with HPN at the time?

A. They were our members, yes.

Q. And did you receive claims from them on the, both of them, on the 21st of September of 2007?

A. Dates of service were September 21, 2007.

Q. Is that what I said?

A. I thought you said received. I'm sorry.

Q. I'm sorry, dates of service. That's what I meant.

I'm going to hand you a couple of packets of information here. I'm going to start off with the

first one which has been marked as Grand Jury Exhibit 37. It bears the name of Stacy Hutchison and I'm going to ask you some questions about that if I could.

Now if you would flip through that and tell me if you recognize the documents and tell me generally what they are.

A. Yes, I do recognize these documents. The first two pages are claim forms for Stacy Hutchison, one is for date of service 9/21 and one is for 9/28. They are each from CRNA, who is a registered, certified nurse anesthetist, and it is a charge for him performing anesthesia for her services on these dates at the Endoscopy Center.

Q. Okay. And the other pages, what are those?

A. Those are the EOB that we generate after we make the payment that are mailed back to the patients.

Q. What is an EOB?

A. It's an explanation of benefits.

Q. Is that the actual explanation to the patient of what you actually paid to the provider?

A. Yes, it is. And what they would owe if they owe anything.

Q. I'm going to display this for the Grand Jury. And they have been through these forms, ma'am,

and I know you're familiar with them too so I'm just going to kind of run through the form.

Is this in fact, this is the first page of Grand Jury Exhibit Number 37, is this what you just designated as the 1500 claim form?

A. Yes, it is.

Q. Whose name is on the form?

A. Stacy Hutchison.

Q. I'm going to move down the form to I believe it's box 24, that column or that row going across, do you see that?

A. Yes, I do.

Q. Date of service is?

A. 9/21/2007.

Q. I'm looking at box D. Does that have a procedure code in it?

A. Yes.

Q. What kind of code is that?

A. It's an anesthesia procedure code.

Q. For a?

A. For a colonoscopy.

Q. If we move across to the charge for that, how much was billed to your company for that service?

A. $560.

Q. And what was the number of minutes or

whatever that are were listed there?

A. The number of minutes for this procedure that he billed us for were 31 minutes.

Q. Does that, do those numbers vary, I mean charges and minutes and so forth vary on typical charges that come in for procedures?

A. Yes, they can vary.

Q. Moving to the bottom, box 30, what is the entity that submitted this claim form to you?

A. Endoscopy -- well, Ron Lakeman is the entity that submitted it. And he performed it at the Endoscopy Center of Southern Nevada.

Q. Is that located at a particular address indicated on that form?

A. Yes.

Q. What is it?

A. 700 Shadow Lane.

Q. Here in Las Vegas?

A. Yes, here in Las Vegas.

Q. So if I understand you correctly that's the form that you get?

A. Yes, it is.

Q. Okay. Now on page 2 of this document still says, it's still another one of these HCVA 1500 forms?

A. Yes, it is.

Q. For Stacy Hutchison?

A. Yes.

Q. We go down to that same line in box 24, it says date of service on this particular one was 9/28 of '07; is that right?

A. Yes, it is.

Q. Same type of procedure, an endoscopy type procedure?

A. It's an endoscopy type procedure, yes.

Q. Under the billed amount the charge that was submitted to you?

A. $560.

Q. Now here I note that instead of 31 minutes it appears to be 32 minutes; is that correct?

A. Yes, it is.

Q. Is that what you refer to as sometimes variation in the amount of time that is submitted to you?

A. Yes.

Q. If somebody submitted a lower bill to you, for example like two minutes, would typically the amount billed under section F be charged at a lower amount? Would that typically show up as a billed amount which would be lower?

A. It should be because if it's a ten minute

or two minute procedure then yes the dollar should be lower.

Q. Okay. Now on the bottom, and I know that the CRNA here is Linda Hubbard I think you designated box 33; correct?

A. Yes.

Q. Does it still come from the Endoscopy Center of Southern Nevada?

A. Yes, it does.

Q. Now moving to what you described as the explanation of benefits form for the procedure for Stacy Hutchison on I think it's the 21st. And I'll zoom in on that a little bit because I know it's hard to read.

Is that the procedure -- based on the explanation of benefits the payment for that procedure on the 21st?

A. Yes. No, that's the bill charge highlighted there, $560. And if you go over --

Q. Under the column indicating, and it's hard to read but it says description, what is described there?

A. Anesthesia intestinal endoscopy.

Q. Now I'm going to take you down to the lower right hand corner of the section where the billing occurs. Do you see a dollar amount there?

A. Yes.
Q. What is that dollar amount?
A. Are you speaking of the very last column?
Q. Yes.
A. That is the allowed amount, the amount we paid on this particular claim which is $90.
Q. I want to talk about that for just a minute. Now $90 as you say the amount you actually paid; correct?
A. Yes.
Q. Now before we go any further with that I want to go to the next page which is another EOB form I think; correct?
A. Yes, it is.
Q. And the date on this one is the 28th of 2007?
A. Yes.
Q. Description?
A. Anesthesia upper gastrointestinal.
Q. Same dollar amount billed?
A. Same dollar amount billed.
Q. But you pay the same amount; is that correct?
A. Yes, we did.
Q. Still $90?

A. Yes.
Q. In the payment, I know that the amount that was submitted to you was for either 32 or I think it was --
A. Thirty-one.
Q. Thirty-one minutes, 31 or 32 minutes, and the billed amount was 560 on both of those, but you paid the same amount on both; is that correct?
A. Yes, it is.
Q. If they had billed, or if they had billed out, I don't know, $120 for ten minutes of anesthesia time, how much would you have paid?
A. We would have still paid $90.
Q. So are you telling us that you paid a flat amount of $90 regardless of what was billed to you?
A. Yes, we did.
Q. So did it matter how many minutes were placed in the boxes?
A. It still matters but it wouldn't have in regard to the payment out the door it would not have changed it.
Q. So the dollar amount coming back to the Endoscopy Center would not have changed regardless of what they put in?
A. Correct.

Q. But is it important to get accurate information?
A. Absolutely.
Q. In some respects does, at the end of a -- I assume that you, you said the contracted amount or something along those lines; is that right?
A. Yes, it's a contracted amount.
Q. I know you're probably not involved in the actual contract negotiations; is that right?
A. No, I'm not.
Q. But is it your understanding or do you have knowledge of the fact that what a provider basically eventually says is what work they had to put in over a period of years or over a period of a year for certain services, that that might factor into what they contract out later on for how much you pay them?
A. Absolutely, the history of claims is looked at to renegotiate contracts.
Q. So when you say history of claims, is that stuff that is, or information that is contained on the 1500 claim form itself?
A. Yes, it is.
Q. So if somebody was doing a procedure for example that was only taking two minutes but they kept submitting bills for 30 or 31 or 32 minutes or something

along those lines, when it came to negotiate would that go into, be a factor, at least considered in whether or not to raise the reimbursement or lower the reimbursement?
A. Yes, it would.
Q. Okay. Now beside those two, or that patient, was there another one that you dealt with beside Miss or Mr. Hutchison?
A. Yes, there is a third.
Q. And who was that?
A. It's -- I need to pull this name out. It's Carole Grueskin.
Q. I'm showing you is what is marked as Grand Jury Exhibit 36. Just flip through both pages of it and tell me if you recognize what's there.
A. Yes, I do.
Q. What is that document?
A. It is the claim form again on a HCVA 1500, it is the explanation of benefits that we generate at the time of making the payment.
Q. Okay.
A. And this one looks a little bit different because this is one of our Senior Dimension members, the explanation of benefits.
Q. Got it. And I'll ask you about that in

just a second.

So I'm going to display this for the Grand Jury. This is the first page of Grand Jury Exhibit Number 36. Again you said it was a HCVA 1500 form?

A. Yes, it is.

Q. It mentions Carole Grueskin as being the patient?

A. Yes.

Q. Slide down again to box 24, the first line across, do you see that?

A. Yes, I do.

Q. Date?

A. 9/21/2007.

Q. Under the type of procedure?

A. It's the anesthesia procedure code 00810, colonoscopy.

Q. And then if we move across, the dollar amount charged in the minutes, can you tell us what those are?

A. The charges are $560 once again and 31 minutes in time that he's stating that he provided for the procedure.

Q. And then on the bottom?

A. Again the claim is from Ron Lakeman, CRNA, and he performed it at the Endoscopy Center of Southern

Nevada.

Q. 700 Shadow Lane, Las Vegas?

A. Yes.

Q. Moving to page 2, this is the one you said had a little bit different look to it as far as the explanation of benefits.

A. It does, yes. It's a CMS requirement that the font sizes be larger, et cetera, so we have to revise the EOB somewhat for this membership.

Q. What is CMS?

A. Centers for Medicare and Medicaid Services.

Q. And do you know why they want the font size bigger on those forms?

A. I believe just so the, it's just easier for the members to read.

Q. And is this group typically an elderly type person?

A. Yes, it is.

Q. As far as the payment, I notice there's a difference in the amount. You told us earlier that it was $90 that you paid on these flat fee kind of services.

A. Yes. And this is still $90 in allowable but the member had a cost sharing of $20 or a $20 co-payment.

Q. So the amount that would have been paid on this claim would have been $90?

A. Had the member had no responsibility, yes, but the member has a $20 responsibility.

Q. So the date on this is still the 21st?

A. Yes, it is.

Q. Of September of 2007?

A. Yes, it is.

Q. The amount billed?

A. Is 560.

Q. But the amount paid is only?

A. $70.

MR. STAUDAHER: I have nothing further of this witness.

THE FOREPERSON: Are there any questions from the jury? None?

By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition,

you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this admonition?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You can be excused now.

Ten minute break. We'd like to call a ten minute break.

MR. STAUDAHER: We could. If it would be possible if I could just put on the next witness who will be a relatively short witness and then take a ten minute break. If that would be okay.

THE FOREPERSON: Okay.

(At this time, Juror Yolanda Parker enters the proceedings.)

THE FOREPERSON: Please raise your right hand.

You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated. Over by the microphone.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Okay. Please state your first and last names spelling both for the record.

THE WITNESS: Patricia Gonzalez. P-A-T-R-I-C-I-A, Gonzalez, G-O-N-Z-A-L-E-Z.

THE FOREPERSON: Thank you.

PATRICIA GONZALEZ,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Miss Gonzalez, what do you do for a living?

A. I do contracting for Blue Cross Blue Shield. I'm the director of network management.

Q. In your job at Blue Cross Blue Shield do you deal or have access to claim forms, payment, EOB forms and things like that?

A. Yes.

Q. And just as we go forward on this if you can let me finish my question before you answer that will help the court reporter because she's taking down the words and it's difficult for her to take it down if we're talking over each other.

A. I understand.

Q. In that process of doing that work I assume you see that kind of form, you look at the claims, things like that; is that right?

A. Correct.

Q. I'm going to direct your attention to three specific patients and ask if they are associated in any way with your insurance company Blue Cross Blue Shield as far as members? The first one being Patty Aspinwall.

A. Yes.

Q. The second being Kenneth Rubino.

A. Yes.

Q. And the third being Sharrieff Ziyad.

A. Yes.

Q. I'm going to start off with Sharrieff Ziyad and ask you some questions about him and some claims

that pertain to him. Is that okay?

A. Yes.

Q. Showing you what has been previously marked as Grand Jury Exhibit Number 31. It's a three page document. Just flip through that if you would and tell me if you recognize the forms that are contained in that exhibit.

A. Yes.

Q. Now I will display those momentarily here but before we do that I wanted to ask you a couple of things. The first page of that exhibit is a certain type of form. What do you call that form?

A. HCVA 1500.

Q. Is that typically the type of information that, or claim type information that is submitted to your company for payment for services rendered to a member?

A. Yes.

Q. And you said Mr. Ziyad was a member of Blue Cross Blue Shield; is that right?

A. Yes.

Q. This first page of the exhibit that's being displayed before the Grand Jury right now, is that the form that was submitted for Sharrieff Ziyad on the date in question?

A. Yes.

Q. And if we go down a little bit we can see the date I believe on box 24, line 1, do you see that?

A. Yes.

Q. What is the date that the service was rendered on this particular procedure?

A. 7/25 of '07.

Q. Okay. And if we go across to column D there is a procedure code listed there. Do you know what that's for?

A. Yes.

Q. And what is that?

A. Colonoscopy.

Q. The anesthesia for it a I assume?

A. Yes, the anesthesia for a colonoscopy.

Q. If we move across to column F there is a dollar amount listed. What is that dollar amount?

A. $560.

Q. And as far as the dollar amount is concerned, what is that? Is that how much is actually submitted by the entity to your insurance company for billing purposes?

A. That is correct.

Q. The charge so to speak?

A. Yes, the billed charges.

Q. I note that on the next column there is a number 8; is that correct?
A. Correct.
Q. Typically on procedures that are done, the anesthesia portion of procedures, do they get billed out in minutes or in units?
A. In minutes.
Q. And do you know what the difference is between minutes and units?
A. Yes.
Q. Go ahead.
A. Every 15 minutes equals one unit.
Q. As far as a base number of units do you start off with, for an endoscopy type procedure is there a base that you start with?
A. Yes.
Q. What is the base?
A. Five.
Q. The base of five and then additional time would then be added to that base of five in the term of increments of 15 minutes; is that correct?
A. That is correct.
Q. So if there was eight units billed would that be three units on top of the base?
A. Yes.

Q. For a total of eight?
A. Correct.
Q. We see the number 8 in that designation. Do you know if that was submitted as eight units or minutes? I'm not asking how you interpret it at this point but how you believe it was submitted based on the dollar amount you see billed for it.
A. Right, eight units.
Q. Looking at the bottom of the screen, I think we're on boxes, both in box 32 and 33, there are providers and locations of service; is that correct?
A. That is correct.
Q. And who are, who is designated as the provider who performed the service?
A. On box 33 Ron Lickman (sic).
Q. Lakeman?
A. Yes.
Q. And the location where the service took place?
A. The Endoscopy Center of Southern Nevada.
Q. Is that on 700 Shadow Lane in Las Vegas?
A. Yes, that is correct.
Q. And I'm going to turn to the next page. Actually the next two pages have I think similar information on them. I'll turn to the last page 3 first

and then we'll come back to the other one because I think it's a little bit easier to read. This is really small. I'll try to zoom in a little bit.
First of all what are we looking at? What form is this?
A. This is the explanation of payment.
Q. And I'm going to, I just zoomed into the portion of the line which is entitled anesthesia which is the top line of the two, the next line down is totals. Do you see what it said we paid at the top of that column?
A. Yes.
Q. Is that what you actually paid on this particular claim?
A. Yes.
Q. What is the dollar amount that you paid?
A. $206.82.
Q. And that's on a charge of $560 for what appears to be eight units; is that correct?
A. Correct.
Q. Now I'm going to flip back to the preceding page, a little bit easier to read. Does it have the same information on it?
A. Yes.
Q. On the left hand side of the column it says

anesthesia under description?
A. Correct.
Q. Billed charge is 560?
A. Yes.
Q. And it says service paid is $206.82?
A. Correct.
Q. Is that what you actually paid for the anesthesia billed to you at 560 on this particular patient?
A. Yes.
Q. I'm going to show you some others in just a moment but one of the things I wanted to ask you is this. If you received a payment, your company, if you received a billed amount minute wise for services, for anesthesia that were let's say the 31 minutes, you said already that that would be considered eight units; is that correct?
A. Yes, that is correct.
Q. If you had a claim come in that say was 22 minutes, how many units would that be?
A. Seven.
Q. Would you pay a lesser amount on that claim than you would on a 31 minute submitted bill?
A. Yes.
Q. Would that relate to the fact that you're

paying on seven units versus eight units?
A. Correct.
Q. If a charge came in that was at 12 minutes how many units would you pay on in that instance?
A. Six.
Q. Would that charge, the amount paid be less than it would for either the 22 minute or the 31 minute charge?
A. Correct.
Q. So if in fact information is put on one of these forms which indicates a higher number of minutes than was actually done in the procedure would that translate into a larger charge if it went into the next unit area?
A. Yes.
Q. Would that be something that your company would just go ahead and pay anyway and not care about?
A. We would pay the amount that's on the claim. If a member came in and said they weren't, you know, there that long, at that time we would ask for medical records to validate the time.
Q. Okay. So you would do something if it was called to your attention that there was a problem?
A. Yes.
Q. If you learned that a claim came in that

was say at 31 minutes and it was in fact only 12 minutes but they were billing at that higher amount, would somebody investigate that?
A. Yes.
Q. I assume you don't want to pay more money than you have to for procedures; correct?
A. Correct.
Q. I'm going to show you -- and is it the same for all claims?
A. Yes.
Q. I'm going to show you the next exhibit which is marked as Grand Jury Exhibit Number 32 and have you -- this is for I believe Kenneth Rubino. Would you flip through that set of documents and just tell me if you recognize them.
A. Yes.
Q. I'm going to display these for the Grand Jury.
This is the first page of this eight page exhibit. And is this that 1500 HCVA form that you mentioned earlier?
A. That is correct.
Q. Under box 2 does it have a designation for the patient?
A. Yes.

Q. And that patient is who?
A. Kevin (sic) Rubino.
Q. And moving down to box 24, that line, do you see it?
A. Yes.
Q. First line. What is the date of the service?
A. 9/21/07.
Q. Is this has a procedure code of 00810 under column D?
A. Yes.
Q. Is that -- what is that?
A. The anesthesia for colonoscopy.
Q. Is there a difference between the codes for colonoscopies versus upper endoscopies?
A. The code itself is different, the base is the same.
Q. Okay. So it's still five unit base for each procedure?
A. Yes.
Q. In this particular instance I see, if we move over to column F, that the charge is the same, $560. Do you see that?
A. Yes.
Q. But in this case it looks like there is a

three instead of the eight. Do you think that is designating minutes instead of units?
A. Yes.
Q. If we move to the bottom of this page, boxes 32 and 33, who is the provider and where was the service provided?
A. Provider on box 33 is Kenneth, or Keith Mathias, or I'm sorry, Mathans, M-A-T-H-A-N-S, and Endoscopy Center of Southern Nevada is where the procedure was provided.
Q. 700 Shadow Lane?
A. Yes.
Q. And I think you said M-A-T-H-A-N-S. Is it M-A-T-H-A-H-S? And I'll show you the actual exhibit.
A. Yes, it is.
Q. I just wanted to make sure we had that accurate.
I'm going to move to the very last page which I believe would be page 8 of the exhibit and I'll display that to the Grand Jury.
I'm zoom back out a little bit so we can see what we're looking at.
Can you tell us what this is?
A. Our explanation of payment.
Q. Okay. I will zoom in on -- well, can you

tell us how much the charge was again? If this is the explanation of payment for the previous HCVA form that we saw.

A. Yes.

Q. Same date, same procedure code, same dollar amount charged, that kind of thing?

A. That is correct.

Q. Does it show how much you actually paid on the claim?

A. Yes.

Q. How much did you pay on the claim?

A. $245.12.

Q. Is that the portion at the very end of this?

A. Yes.

Q. So the 245.12 is for, is it based on a charge of 560?

A. It's based on 32 minutes.

Q. But again the billed amount of 560; is that right?

A. Yes.

Q. So that was the actual amount paid back to the Endoscopy Center?

A. Yes.

Q. Again if the billed amount, billed minute

amount would have been less would there have been less money paid to the company?

A. Yes.

Q. Now I noticed when I'm looking between the two of these that between, for example Kenneth Rubino's which is Exhibit Number 32, and Ziyad Sharrieff's which is Exhibit 31, that although the charge was the same for the same type of procedure the dollar amount paid was different. Do you know why?

A. Yes. Because the eight was interpreted as minutes and it would have been paid as six units, not eight.

Q. So even though the charge is the same you actually paid out less on that particular claim; is that right?

A. Correct.

Q. As far as the, so there is no difference in their actual coverage, just in how it was interpreted in your company at the time?

A. Correct.

Q. Now let's look to the last one which is Patty Aspinwall. I think you haven't looked at this one yet. This is Grand Jury Exhibit Number 33. Just look through that and tell me if that is recognizable to you and what those documents are.

A. Yes.

Q. What are these documents?

A. It's the HCVA 1500. We were a secondary payer so it's the primary explanation of payment and our explanation of payment.

Q. Okay. Now when you say you're the secondary payer, can you explain that to us?

A. The member has two insurance companies and based on the insurance company they decide who is primary and who is secondary. The primary would pay first. As the secondary payer we pay the member's responsibility.

Q. Do you get some form from the primary insurer saying what they paid on this claim so you know what to pay yourself?

A. The provider submits that information with the claim.

Q. So let's go through this briefly here. Moving to, looking at the first page of Exhibit Number 33, is this, again is this that HCVA 1500 claim form?

A. That is correct.

Q. Under box 2 the patient's name?

A. Patty Aspinall.

Q. Aspinwall?

A. Aspinwall.

Q. And then moving down to box 24, line 1, do you see that?

A. Yes.

Q. In that particular instance do you see the date on that?

A. Yes, 9/21/07.

Q. Procedure date?

A. Yes.

Q. And if we move over we see that there is a procedure charge or procedure code; is that right?

A. Correct.

Q. Now above that I actually see that there's some, of that procedure code do you see that there's a time listed here?

A. Correct.

Q. Is that the time that relates to what is designated over on box I believe it's G which designates the number of minutes?

A. Yes, correct.

Q. So they actually put in when the procedure started and stopped?

A. Correct.

Q. As far as the charges, the charged amount is how much?

A. $560.
Q. And the minutes here in this case are?
A. Thirty-one.
Q. Who is the provider?
A. Ron Lakeman.
Q. And the procedure was done at?
A. Endoscopy Center of Southern Nevada at 700 Shadow Lane.
Q. In Las Vegas?
A. In Las Vegas.
Q. Now the next page I'm going to skip by for just a moment. We'll come back to that. It's a small one and I think it just shows what some of the other information later on in the exhibit. Is that correct?
A. Correct.
Q. I'm going to go to page 3 though which is, it appears to be some sort of explanation of benefits from another company; is that correct?
A. That is correct.
Q. Up at the upper right hand corner of that page and even at the top left hand corner it mentioned a different type of insurance company. What is that insurance company?
A. That would be the primary, United Health Care.

Q. And the primary, are they the ones -- did you get this form as part of the claim that came to you?
A. Yes.
Q. Is that so that you knew exactly what they had paid so you could know what you were going to have to pay?
A. Yes.
Q. So in this particular instance, I'm going to zoom down here to under where it says service detail, do you see that?
A. Yes.
Q. Patient's name listed; correct?
A. Correct.
Q. And I assume this form goes with that HCVA form we saw earlier?
A. Correct.
Q. Date of procedure?
A. 9/21/07.
Q. Amount charged, billed?
A. $560.
Q. Moving across. Now it says paid to provider. Do you see that column?
A. Yes.
Q. It looks like there is an amount of $249.92. Is that what you paid?

A. No, that's what United Health Care paid.
Q. So the primary paid that amount on the claim?
A. Correct.
Q. Now the portion over here that says patient responsibility $62.48, is that what you would pay, the whole amount?
A. Yes.
Q. You would pay on that whole amount rather?
A. Yes.
Q. Did you pay a full amount of $62 on that claim?
A. No.
Q. Okay. So let's go to the very last page which I believe is page 8 of the exhibit and I'm going to zoom out so you can see what form we're talking about here. Are you familiar with that form?
A. Yes.
Q. What is that?
A. That is the explanation of payment from Anthem Blue Cross Blue Shield.
Q. Okay. Now patient's name same, date of service same, that kind of stuff?
A. Correct.
Q. Do you see where it says total billed under

the patient's name?
A. Yes.
Q. Is that amount -- what is that amount?
A. $560.
Q. Now I'm going to go to the line, the first line that, or row that goes across. Do you see that?
A. Yes.
Q. Under type of service here, do you see that?
A. Yes.
Q. What is it?
A. Anesthesia.
Q. Total billed?
A. Five hundred and sixty.
Q. Now if we move over to the one that says other amount, is that that $249.92 amount, is that what the primary paid?
A. That is correct.
Q. If we move to the last column which says payment amount, what dollar amount is listed there?
A. Payment amount is 56.48.
Q. Is that what your company actually paid on this claim?
A. Yes.
Q. So United Health Care pays theirs, you pay

yours for a total combined?
A. Correct.
Q. And is the patient responsible for any remaining balance?
A. No.
Q. So that's just what was paid on the claim at that point?
A. Yes.
Q. Again if this had come in and the amount had been, the billing amount had been less minutes or whatever, would you have paid less on the claim?
A. Yes.
Q. As evidenced by that first one we saw where there was actually, you paid it out of eight minutes because it said eight, even though you think that's units; is that correct?
A. Correct.
Q. As far as this particular one, the amount that was paid out for the claim is different obviously than the previous two that you've looked at. Is that because there was a primary insurer involved as well?
A. That is correct.
Q. So if the primary insurer had not been involved and it would have been your company would you have paid a higher amount on that claim?

A. Yes.
Q. Do you know how much you would have paid out on the base claim if the primary insurer would not have been there?
A. Yes.
Q. What would you have paid out? If you know.
A. We would have paid 245.12.
MR. STAUDAHER: I have nothing further of this witness.
THE FOREPERSON: Are there any questions? Yes.
BY A JUROR:
Q. Who determines on a claim form whether it's minutes or units, who determines that?
A. The providers for anesthesia are told on our provider manual to bill it as minutes.
Q. Okay. Did I see two different, one up there for minutes and one for units, right?
A. Yes.
Q. For the same procedure or different procedure?
A. Same procedure. Two different claims.
Q. Understand. But not to your company though, right?
A. Yes.

Q. I guess you're losing me here somewhere.
BY MR. STAUDAHER:
Q. Let me ask a couple of clarifying questions.
When we looked at the forms, the charges were the same for all of them.
A. Yes.
Q. Every claim that came through, $560.
A. Correct.
Q. With the exception of one claim that had an eight on it.
A. Yes.
Q. All the charges were above 30 minutes; correct?
A. Yes.
Q. On the one claim that had an eight designated the charge was still $560?
A. Yes.
Q. Which was the same as the previous ones that had been submitted at 31 plus minutes?
A. Yes.
Q. If the provider makes a mistake and puts down the number of units which 31, 32, 33 minutes would be; correct?
A. Yes.

Q. If they put down eight units instead, because you have an agreement with them to put down minutes you'll pay them a lower amount based on the minutes there?
A. Correct.
Q. So they make a mistake, you're not going to pay them more because you say look, we told you minutes, you put down eight, I don't care if it's units or not, that's what we're billing you at is eight minutes; is that correct?
A. Correct.
MR. STAUDAHER: Does that help?
BY A JUROR:
Q. Did someone then make a mistake in putting down units versus minutes?
MR. STAUDAHER: I'm going to ask her not -- that would be speculation at this point. We don't know what the billing person who submitted the form actually did and I think that goes beyond the scope of what her testimony could be.
BY THE FOREPERSON:
Q. I have a question.
A. Uh-huh.
Q. Was Ron Lakeman the CRNA for Rubino and Ziyad?

A. You mentioned for Rubino?
Q. Uh-huh.
A. For Rubino it was Keith Mathahs.
Q. And for the other gentleman or woman Ziyad. I might be saying the name wrong.
A. Ron Lakeman.
THE FOREPERSON: Thank you.
Are there any further questions? None?
Yes.
BY A JUROR:
Q. Yes. Can we look at that form again and see the box that says units minutes. Is it described in the block, is it units or units/minutes or -- just for clarification.
MR. STAUDAHER: Based on the Grand Juror's question I'm going to display Exhibit Number 31, the first page of that exhibit which is the HCVA form. I will zoom in on it so we can see what's being talked about here.
A JUROR: Days or units.
A JUROR: Okay. So it's listed as days or units.
MR. STAUDAHER: That's correct. But I'll ask a follow-up question.
Q. But it was your agreement with the

providers that they would put in that box not just the units but the minutes?
A. Correct.
Q. And that's what you would bill at?
A. Correct.
Q. Every bill that you saw come through that you have reviewed which was written in minutes being greater than 30, meaning 31, 32, 33 minutes for all the claims, whether they are these claims or others pertaining to the Endoscopy Center, were they all billed out at a $560 charge?
A. Correct.
Q. Would that $560 charge translate into eight units of anesthesia, five for the base and three for the time period?
A. Yes.
MR. STAUDAHER: Okay. Does that help?
A JUROR: Yes, sir. Thank you.
THE FOREPERSON: Are there any further questions? None?
By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand

Jury, and information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: Yes.
THE FOREPERSON: Thank you. You may be excused.
THE WITNESS: Thank you.
THE FOREPERSON: You're welcome.
MR. STAUDAHER: And we can go off the record so you can take your break.
THE FOREPERSON: Okay. Fifteen minutes.
(Recess.)
MR. STAUDAHER: Ladies and gentlemen of the Grand Jury, we're back from your break. I want to put on the record that prior to the last witness, or from the witness testifying about I think it was Gwendolyn, Carole Grueskin rather, we had one of the Grand Jurors return to the Grand Jury proceeding. I just need to, as I've told the Grand Jurors in the past, to make sure that although you were not present for the first portion

of the presentation today that you acknowledge at least that you will review the transcripts of that portion that you missed before deliberating in this case.
A JUROR: Yes.
MR. STAUDAHER: Okay. And also I asked the other Grand Jurors at the beginning of this proceeding but I did not ask you if in the interim between the last presentation and this presentation if there's been anything that's happened, any testimony that you've heard in this particular case that has caused you to no longer be able to be unbiased. Is there a problem with that at this time?
A JUROR: No.
MR. STAUDAHER: So you can listen to the evidence presented, render a verdict, not a verdict, but deliberate in this particular case based on just that evidence and applying it to the law given to you?
A JUROR: Yes.
MR. STAUDAHER: Thank you.
With that we'll continue.
THE FOREPERSON: Please raise your right hand.
You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and

nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Please be seated.

THE WITNESS: Thank you.

THE FOREPERSON: You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Can you please state your first and last names and spell them for the record.

THE WITNESS: My first name is Nancy, N-A-N-C-Y, my last name is Sampson, S-A-M-P-S-O-N.

THE FOREPERSON: Thank you.

NANCY SAMPSON,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Miss Sampson, I'm going to take you back in time a little bit to an investigation regarding the Endoscopy Center of Southern Nevada. Were you involved in that in some way?

A. Yes, I was.

Q. What time frame were you working in that capacity as an investigator on this particular case?

A. I was working at Las Vegas Metropolitan Police Department, this case happened in the beginning of 2008, so when it was made public and I got involved with it shortly after it was made public.

Q. How long did you continue on with the case?

A. Until we submitted it to the District Attorney's Office in November of last year.

Q. Now you are no longer working for Metro; is that correct?

A. That's correct.

Q. And the reason -- did you retire, quit, what happened?

A. I retired in January.

Q. Prior to that time though you were actively involved in the investigation and analysis done in the

this case; is that correct?

A. That's correct.

Q. Now I know that since you're no longer working at Metro you don't have a job at Metro so I'm going to ask you during the time that you were investigating what was your position?

A. I was an analyst and my focus was as a financial analyst.

Q. And when you say financial analyst I assume you look at bank records, things like that?

A. Yes.

Q. Do you look at other things too as part of the analysis you do in typical cases?

A. I generally look at all the documents, all the evidence, I go through the interviews the detectives do, I prepare association charts, I will schedule out bank records and track money.

Q. Are you present for things like search warrants and things like that as well?

A. Yes, I've been on a number of search warrants and I was on this search warrant.

Q. So there was a search warrant done in this case?

A. Yes, that's correct.

Q. Before we get to that let's do a little bit

more background.

So you do that kind of work. What kind of training or background do you have in that?

A. I was a, I have a Bachelor of Science Degree in Criminal Justice from Arizona State University. I worked as a commissioned peace officer for the Arizona State Attorney General's Office. I was in that position for nine years when I got the position at Metro. The position I had at Metro, it started as a financial investigator which is a civilian position and after awhile it was reclassified to analyst which was an appointed position with Metro and I was in that position until I retired in January.

Q. Okay. So I assume you've been involved in other cases beside just this one then over your time?

A. Oh yes.

Q. Now let's get into this particular case. How was it that you became involved with it in the first place?

A. I was assigned to the public integrity unit in the criminal intelligence section at Metro. Brian Labus and the health district did a briefing to law enforcement, I was not at that briefing, it was on my day off, and when I came back to work on Tuesday we were preparing to do a search warrant and the case was

assigned to the public integrity section.
Q. So really it sounds like the case started after it was initially brought to Metro with a search warrant then?
A. Yes.
Q. So let's go to the search warrant situation. Do you know where it took place?
A. We had several locations. I was at two of the locations. I was at the search warrant on Shadow Lane, 700 Shadow Lane, and also at the location on Tenaya.
Q. So were there others as well?
A. Yes.
Q. Where were all the search warrants served?
A. There was, I think there was six. So there was the Shadow Lane, the one on Burnham, one on Lake Mead, one on Tenaya and one on Rainbow. That's five.
Q. Now you mentioned the two. Let's talk about the Shadow Lane one. You said you were present for that one; correct?
A. Yes, I was at Shadow Lane.
Q. Tell us about that. What did you do as part of the search warrant execution?
A. Once they had secured, the officers had secured the location, the business had been shutdown so

there was no one there, we had to get into the office and once they secured it then I was assigned by the lead detective Robert Whiteley to inventory the documents that were taken and put an inventory in all of the packaging. So I did that. I also went up to the fourth floor to those offices up there and looked at some records that they had found up there and then I was in the clinic side of the location also.
Q. Okay. Before we get too far into what all you found or did at the search warrant locations I'm going to show you what has been previously marked as Grand Jury Exhibit Number 38. It looks like a series of diagrams and so forth. Can you tell us what those are?
A. These are diagrams that are made at the time of the search warrant to identify the locations that we were at. So the cover sheet, the first sheet is 700 Shadow Lane which is the map of the clinic.
Q. And the next page?
A. Next one is 700 Shadow Lane, Suite 470, which are their business offices which were upstairs.
Q. And you went to those offices you said?
A. I did.
Q. And then the next page?
A. 3150 North Tenaya Way.
Q. And I assume -- have you seen all of these

documents before?
A. Yes.
Q. And the next page?
A. 4275 Burnham Avenue.
Q. Next page?
A. 4275 Burnham Avenue.
Q. Next page?
A. 2610 West Horizon Ridge Parkway.
Q. Next page?
A. 1815 East Lake Mead.
Q. And last page? Actually the second to the last. I'm sorry.
A. 5915 South Rainbow.
Q. And last page?
A. Last one is 700 Shadow Lane and this is the doctors' offices location.
Q. So if I understand you correctly the first two pages and the very last page pertain to 700 Shadow Lane?
A. Yes.
Q. You didn't draw any of these maps; is that correct?
A. No.
Q. When I say maps they're really diagrams.
A. That's correct.

Q. The diagrams that are here though to the best of your knowledge, you've been at these facilities; correct?
A. I've been at two of them, yes.
Q. Which ones again?
A. I was at Shadow Lane and the Tenaya.
Q. But you've seen these at least submitted as part of the diagrams for the other facilities as well?
A. Yes.
Q. I'm not going to ask you questions about the other facilities right now. I'm primarily focused with you on the 700 Shadow Lane.
A. Okay.
Q. And the three maps pertaining to that. You were in those locations?
A. That is correct.
Q. Do they fairly and accurately, when I say accurately, they're not to scale I assume; is that correct?
A. That's correct.
Q. They show the location of the rooms and how they're laid out in comparison to each other?
A. Yes.
Q. I'm going to show you the first page here. And this is the first page of Grand Jury Exhibit

Number 38. I want to get the whole thing on and then we can zoom in on it a little bit later.

What are we looking at here?

A. This is the clinic where the procedures were performed.

Q. I'm going to stand over here as we go through it.

I note here that on the top portion of this that there's an area where there's a waiting room. Do you know where the front entrance was to the building based on this?

A. The front entrance to this location was a hallway that was just on the other side of that first row of offices. So the front door was into the waiting room.

Q. So this area right here at the top right hand portion of the screen?

A. Yes.

Q. So this is not from the outside of the building in, it's from a hallway on the inside of the building?

A. Yes.

Q. So you enter the suite area or this area, the patient area so to speak from the waiting room and then come into the rest of the facility based on that?

A. Yes.

Q. As far as your involvement here, I notice that there is a procedure room 1 and a procedure room 2 listed; is that correct?

A. That's correct.

Q. And also a patient area and a pre-op room; is that correct?

A. Yes.

Q. All those rooms exist, they look like they kind of match the map in the area you were at when you examined them?

A. Yes. Some of the -- I didn't go into the pre-op room or the restroom at this end. I was mainly working with the records that were being taken and the other evidence in the other areas.

Q. Okay. As far as the patient procedure rooms do those later factor into some of the analysis that you did?

A. Yes.

Q. And what I mean by that is that there were in fact two procedure rooms and how they were oriented, things like that.

A. That's correct.

Q. Beside that particular diagram you mentioned that there was another one. I think that was

the second page of this exhibit which again is Exhibit 38, nine page exhibit. What are we looking at here?

A. These are the business offices that were on the fourth floor.

Q. So you went up to the fourth floor. Did you gain records or do things up there as well?

A. I was asked to look at some records up there. Detectives were searching those offices and securing the evidence. I didn't get into all of the offices. I couldn't even tell you which offices I got into.

Q. Where were these records that they asked you to look at?

A. They were either in office 5 or office 6.

Q. So down here in the lower right, or left hand corner rather of this screen?

A. Yes. And I believe I was in office either 7 or 8.

Q. As well?

A. Yes.

Q. What were you asked to do? What kind of records did they want you to come up and take a look at?

A. They were, I believe they were contracts, they were some business records. I looked at them quickly. I knew we were taking them so I didn't really

study anything.

Q. Were there any patient files up there?

A. There might have been, I didn't see any.

Q. You said there was another location you went to as well; is that correct?

A. Yes.

Q. I think that was on the last page of Exhibit 38. I'm turning to that now.

I'll zoom back out a bit.

And what are we looking at here?

A. This is the doctors' offices at 700 Shadow Lane. This is where the doctors had their offices, the patients were seen, and then there was a connection between the waiting room here and the waiting room on the clinic side, you could walk back and forth.

Q. So this is located on the same floor --

A. Yes.

Q. -- as the very first picture that we saw?

A. That's correct.

Q. But a separate complete area?

A. Yes.

Q. Now I see that on this particular diagram that there are exam rooms listed, as well as restrooms, lots of exam rooms; is that correct?

A. Yes.

Q. And check-out areas. Was this the medical side of things?

A. This was the medical side where they had the patient files, the doctors all had offices and they did, and they had the exam rooms, yes.

Q. And I notice in the lower right hand corner of that screen there is a room designated as Dipak Desai's office.

A. Yes, that's correct.

Q. And on the opposite side, the left corner, left lower corner of that diagram is Clifford Carrol's office.

A. Yes.

Q. And then there is one in between them.

A. Yes.

Q. Up at the very top of the screen, not the waiting room, there's a large two room with a connector between the two called records room I think; is that correct?

A. Yes, that's correct.

Q. I'm going to talk about this area for a minute. Did you do anything, find anything in this area, look at any records?

A. All of these exam rooms and the doctors' offices were searched. There were patient records found

in all of those. So I was in exam room 10. Next to that is a storage room that was full of boxed records that were older, we took all of those. I don't believe there were any records in exam rooms 5, 6, 7, 8 and 9 on the side. We took records from Clifford Carrol's office, from office 3, from Dipak Desai's office, Dr. Carrera's office. There were some patient files around the nurses stations and then the main patient file area was where the records room is and the check-out area.

Q. At any time in any of these locations did you come across patient files that were of interest to you?

A. In the clinic side they had boxes of -- let me explain how the patient files were set up.

Q. Okay.

A. In this room they had patient files.

Q. In which room? There is a whole bunch of them.

A. In this particular area where the doctors' offices were.

Q. So the medical side, we're talking about the last page of Exhibit 38.

A. Right. Mainly the check-out area and the records room, they had patient files that were on shelves, they were alphabetical for the most part and

they were in manila colored file folders and we call those the patient files.

Q. Right.

A. Okay. Then there were files everywhere. There were files in the doctors' offices, there were files in the nurses station, there were files in the check-out area, there were patient files everywhere in this area.

Then on the clinic side they had --

Q. When you say clinic you're referring to where the endoscopy procedures are done?

A. Yes, where the procedures were done.

Q. Okay.

A. They had more patient files that were in green manila, green file folders, and we called those the procedure files in order to differentiate when we talked about these, where the files were located, and they contained different information.

Q. So there was a difference between the procedure file and the patient file?

A. That's correct.

Q. Now the patient file contained what, what kind of stuff was in there?

A. The patient file had information the patients would give when they signed in, their insurance

information, their addresses, their contact information, it would have copies of reports from the procedure files, it would have the doctor's notes. What I would consider a typical patient file.

Q. And then the procedure file itself, what was in there?

A. The procedure files had the reports from the procedures, they had the anesthesia records, they had the information when the patient checked in at the reception area.

Q. Now obviously you find these in two different locations then?

A. Yes.

Q. So did the procedure files primarily remain on what you called the clinic side where the procedures were done or did they intermix?

A. They were intermixed and they were also intermixed at the other location I was at on Tenaya.

Q. Okay. Now that's what the files generally look like and where they were; correct?

A. Right.

Q. When you were going through the search process did you ever locate a grouping of files of patients that were of interest to you?

A. There was a post office box, a United

States Post Office I believe, and there were the patient files that had been identified by the health department as the victims in this case.

Q. Now let's talk about that. Is that location anywhere on these diagrams that you --

A. It would be on the clinic side.

Q. Let's go back to that one. Referring back to page 1 then of Exhibit 38. What area are you talking about?

A. I didn't find them. I believe they were located in a file room reception area.

Q. Did you see them at some point?

A. I did see them at some point.

Q. You didn't find them initially but then did you did see them together?

A. Right. There were some other of the victim files, we called them victims, located in Dr. Carrol's office on the other side.

Q. Okay. So two different locations where these were grouped?

A. Yes.

Q. So you find -- and these were all patient files essentially or procedure files that were related to --

A. They were both.

Q. They were both. To what the CDC or what the health district had been focusing on as far as patients go?

A. The patients they had identified from September 21st and July 25th.

Q. They were all kind of grouped together in those two locations?

A. Yes.

Q. Did you recover those items, not you specifically necessarily, but did the police recover those items?

A. We recovered all of the patient files from those two areas.

Q. And it was up to you to sort of document and categorize all this information?

A. I focused on the patient files that were our victims from the 21st, all of the patients from September 21st and all of the patients from July 25th.

Q. So not just the ones focused on as potential victims being infected but all of the patients period?

A. For those two days, yes.

Q. Now beside the things you just mentioned did you do anything else related to the search warrant execution or recovery of records or anything like that?

A. After all the evidence was at our office I went through all of the evidence. I went through it looking for business records, bank records, anything related to any of our patients that had been identified as victims.

Q. And did you generate any kind of analyzes or reports or anything like that as a result of doing that work?

A. I did, I generated several.

Q. Okay. Why don't we just kind of walk through them. What were some of the reports or some of the things that you looked at and generated?

A. I started with the patient files because we were trying to get a handle on the sequence.

Q. When you say the sequence what are you talking about?

A. Of what patients were seen first and second and how long the procedures lasted, who was involved in their procedures.

Q. And did you put that in some sort of form so you could look at it or compare between patients?

A. I did, I put them in an Excel spreadsheet.

Q. I'm showing you what has been marked as Grand Jury Exhibit 43, I know that this is going to be difficult for the Grand Jury, it's in the spreadsheet

form but we'll make it available and the Grand Jury can look at it at any time.

But can you tell us what this item is?

A. This is how I compiled the information from the patient procedure files.

Q. What date does this information come from?

A. This is July 25, 2007.

Q. So tell us what we're kind of looking at here. First of all is this all the patients listed for that day?

A. This is all of the patients listed for that day. One of the files was missing was Bruce Young so his information is just -- I couldn't find it.

Q. So he was a patient listed for the day but you couldn't find the information?

A. Right.

Q. Okay.

A. I got the names of all the patients for the day from their endoscopy logs which were maintained at the, on the clinic side. The endoscopy logs are big books, they're about this big and --

Q. And for the record she's measuring it looks like about two feet by, what, one and a half feet, something like that?

A. Yeah, one foot. They were too big to copy

so I had to work off the originals. They had all of the patients listed, it was handwritten by name for the dates, and they had assigned them patient number and this number was also the number on the procedure files.

Q. And you're referring to the right hand column; is that correct?

A. Well, the second column in, the patient file number column.

Q. We're talking moving from right to left on this spreadsheet; is that correct?

A. Moving from left to right.

Q. Excuse me. I'm turned around, left to right. Sorry.

A. Yes.

Q. My perspective, not yours.

Go ahead.

A. I took the information out of the patient, the procedure files which included an anesthesia record and that's the first record that is summarized here. There was also a chart where they noted the procedure time, when it started.

Q. As you go across as you're mentioning things if you'd just give us what the column heading is you're referring to.

A. All of the anesthesia records are

summarized off of, where it says medicine, chart procedure start time, chart procedure end time, and then I calculated using Excel the minutes for the procedure.

Q. And why did you do that?

A. Because we saw a pattern and we had been told that they --

Q. First of all at this point I don't want to get into anything that you were told by someone else. But based on information you had received in your investigation you focused in certain areas; correct?

A. Right.

Q. You focused on those areas. Did you see the pattern that you were looking for?

A. Yes. Excel is a spreadsheet that will calculate, it adds and subtracts and so I put in a formula to calculate the time when the procedure started and when it ended, and they were all 30 to 33 minutes on the average for all the rooms I averaged. The one room was 30 minutes, the other room was 31 minutes.

Q. Now you said there was a difference in rooms. There were different times for different rooms?

A. When I, the first time I did this I, we tried to figure out what rooms the different patients were in.

Q. Okay.

A. And I sorted it by doctor, I sorted it by CRNA, I sorted it by time, and nothing worked because it was, we could not determine what room the patients were in. And then we received information from the Board of Medical Examiners that there was a computer glitch in the reports that were generated, they were generated by a computer. And the glitch actually is this blue column. Those are the report times, the start times and the end times, and that's what this was finally sorted on were those report times. The glitch was in one of the procedure rooms the computer had the wrong date and so we were able to go back through and put all of the rooms, designate all of the rooms that had that glitch as room 1 or room 2.

Q. So you could separate them out based on that information?

A. Yes.

Q. Did you in fact see the computer glitch that you'd been given some information about?

A. Yes.

Q. So did they pretty much divide up the rooms when you did that?

A. Yes.

Q. I'm going to look at one thing here before I ask you another question.

Now on this particular diagram I note on, where you did your minute calculation, I note that virtually all of them are either 31 or 32 minutes; is that correct?

A. That's correct.

Q. With the exception of one patient, Carolyn Clark, who is listed at 30 minutes, and a patient named Katie Lawson who is listed at 14 minutes; is that correct?

A. Yes.

Q. And so the rest of them are either 31 minutes or higher?

A. Right. That was from the anesthesia logs.

Q. And it shows that a total of 65 patients were done that day?

A. Yes.

Q. Is that right?

A. Yes.

Q. And does the first top portion of the chart, does that correspond to one room and the bottom portion to another room? Or how did you designate that?

A. Uhm, you know what, I have to look at this.

Q. Let me put it up here, maybe make it a little easier. Well I don't know if it's easier or not. I'll just let you take care of it.

A. It doesn't work with bifocals.

On this particular day, the 25th, the computer glitch wasn't, it didn't apply to this day, it applied to the other one. And so these are sorted by CRNA.

Q. Okay. In this particular diagram, this exhibit, you don't have them sorted by that computer glitch?

A. That's correct, it didn't show up on the reports. The reports had the right date for both rooms.

Q. So at this point we don't know which room is which?

A. Right.

Q. Now were you ever able to sort out which room was which for this date, the 25th?

A. No.

Q. As far as the breaking up then you only have two, or how many different CRNAs do you have for that day?

A. We had two CRNAs.

Q. Was it your understanding based on the review of the records that they primarily stayed in one room for the majority of the day?

A. Yes.

Q. So when you sort them by the nurse

anesthetist does that generally group them according to what your analysis was and record review as to the room that they were in?

A. Pretty much.

Q. Now with the exception of I assume they take breaks and so forth?

A. That's what we were told, yes.

Q. Again I want to stay away from things you were told specifically, just things that you did in your investigation. And anything you mention that you were told I'm admonishing the Grand Jury is not offered for the truth of the matter, just to show how she got to the next step in her investigation.

So let's move forward. So what else did you do in this particular situation with this exhibit?

A. In this particular day we had one victim, his name was Michael Washington, and the genetic testing had been done by CDC and they identified the source and the source was Sharrieff Ziyad.

Q. So on this diagram Sharrieff Ziyad is listed here and I think that that is line or patient number what?

A. Patient number 35.

Q. Patient 35.

A. Uh-huh.

Q. Do we see that the infected patient Michael Washington follows him in time?

A. Yes.

Q. And in fact he is the same anesthesiologist or, not anesthesiologist but nurse anesthetist as the one that performed both of those procedures; is that correct?

A. That's correct.

Q. What about the doctor involved, did that change?

A. The doctor was Dr. Desai on both of them.

Q. Now beside that information pertaining to this diagram, I mean you were able to at least sort this as best you could by the times, you said that all of these times varied depending on what you would look at, whether it was I think it was procedure time, machine time, all of that stuff. Is that correct?

A. Right. I took the times from the procedure files, from the anesthetist log which is the first columns here, the chart, the medicine, the chart procedure start time, procedure end time, and then I added them up.

Q. Is that the green column?

A. That's the green column. The green column is my addition on all of those.

The next column is what kind of procedure it was. If it was an endoscopy those were E, if it was a colonoscopy those were C. The doctor was from the report and the signatures. The nurse was also from the report and the signatures. They had the GI tech so those were all listed on the reports.

Q. So each one of these entities has its own time?

A. Well, these were the people, these were the players that were on that procedure.

Q. I see. Okay.

A. Then the different logs started with the times. So the nurse filled out a log, in that she noted the procedure start time and end time, and I calculated the minutes from that. I took what scope they had used because that was written on there, on the file. They had a place where they put what time the physician was at the bedside so I took that time. What time they were discharged, I took that time. I calculated the time from that. Then the nurse who signed off on it, on that discharge. Then we had monitor tapes, one was from a heart monitor and one was from another monitor, so I have tape reading 1 and tape reading 2, and I took those times, and then I have the report time and that's what this is sorted on, the CRNA and the report time. And

then I have what time it ended and then how long it took.

Q. Okay. So that was how you ended up sorting this?

A. Right.

Q. Did you ever have a feel for how accurate the times were that you were looking at, whether they be the taped time or machine time or the doctor's time or the nurse's time or the procedure time or whatever?

A. Well, in order to try to make sense of that and to figure out the order everything happened in I sorted this spreadsheet on all of the times and they were different, it just didn't, it didn't match. So when we got the information about the report time that's what I went with for the sorts.

Q. I note on this particular diagram that there, beside Ziyad Sharrieff which is line or row 35, and Michael Washington which is line, or rather row 39, you have Ziyad Sharrieff in it appears to be sort of orange-ish?

A. That's correct.

Q. And Michael Washington who is the infected patient who is designated in green?

A. Yes.

Q. There are some other lines up here that are

also in orange. What relationship do those have?

A. On the anesthetist log they would note if a patient had a disease and so those are the ones that were designated on the anesthetist log as having Hepatitis C.

Q. So on that particular day we have four patients that are Hepatitis C positive at the facility?

A. That they knew of, yes.

Q. When you say anesthetist form do you mean the anesthesia record?

A. The anesthesia log is what they called it.

Q. Okay. So one of the persons that had been designated that day as being Hepatitis C positive was in fact I think Ziyad Sharrieff?

A. Yes.

Q. And then Michael Washington follows Ziyad Sharrieff after it looks like three patients?

A. Yes.

Q. Now beside the information here, I mean one of the columns I want to go back to is this column designated anesthesia minutes calculated from the records. And you designate that off of chart procedure start time, chart procedure end time?

A. That's correct.

Q. Do those times come from the anesthesia

record?

A. Yes.

Q. So all of the ones designated as 31, 32 minutes and so forth down that line come from that document?

A. Yes, they noted the start time and the end time.

Q. Did you ever add up all that time to see how much it added up to?

A. How many minutes in the day?

Q. Yes.

A. No, I never did.

Q. Did it look like it was possible?

A. No.

Q. Okay. As far as the 25th did you do any other analysis other than what you talked about thus far related to that?

A. On the 25th?

No.

Q. Okay. You said that you moved, you also looked at the same types of information for the 21st of September of 2007; is that correct?

A. Correct.

Q. I'm going to go ahead and change out the exhibit right now.

And I will lay this out here, this exhibit, which is again Exhibit 43, it will be available, it's an admitted exhibit now and it's available for the Grand Jury for review and I'll lay it out on the table.

Okay. Showing you what has been marked as Grand Jury Exhibit Number 42, what are we looking at here?

A. This is the spreadsheet for September 21st. All of the information was taken from the patient procedure files. Same columns as on the 25th. I started with the anesthesia chart, I moved across taking all the information. This is the day that had the computer glitch so we were able to identify the patients that were in one room and the patients that were in the second room.

Q. Was there more than two CRNAs on that day?

A. I don't think so.

Q. Or were there rather.

A. No. We had Keith Mathahs and Ronald Lakeman.

Q. The only two CRNAs on that day?

A. Yes.

Q. So when you sort them in this particular instance, although you've got your blue line here under report procedure start time, are these sorted by that or

not?
A. Yes. They're sorted by the room and the time.
Q. So is the top grouping one room and the bottom grouping another room?
A. That is correct.
Q. On this particular spreadsheet we have colored rows.
A. Yes.
Q. Can you tell us what the colors indicate?
A. The orange are the hepatitis, the people that were identified with hepatitis off the anesthesia logs.
Q. So we have two for that day; is that correct?
A. Yes.
Q. One appears at the end of the day and I believe that is who?
A. Trina Smith.
Q. And one is at the very top of the day and that is who?
A. Kenneth Rubino.
Q. So Kenneth Rubino. Did he have any significance to any of the other patients later on?
A. He was shown to be the source patient

through the genetic testing.
Q. So the patients that follow after Kenneth Rubino are the infected patients?
A. That's correct.
Q. That turn up positive that is.
A. That's correct.
Q. What is the yellow designation?
A. There were two patients who showed up with Hepatitis C but there was not enough genetic material to show the source of their infection.
Q. When you say enough genetic material, the CDC couldn't make a match or they didn't have the resources to be able to do so on those patients?
A. My understanding is the hepatitis virus mutates and it adapts to the host, the person that it's in, so it changes, and there wasn't enough, whether it was too long in time or whatever reason I don't know, but those two people they were not able to genetically link to the source.
Q. But we see that one of those persons directly follows Mr. Rubino; correct?
A. That's correct.
Q. Now what are the green lines?
A. Green lines are the infected patients.
Q. And when you say infected patients are

these the ones that are genetically matched?
A. Yes, those are genetically matched.
Q. Now you have designated these in two separate rooms; correct?
A. That's correct.
Q. I note that there are, there is a source patient on the top half and then it appears to be infected patients below that person.
A. Yes.
Q. And those infected patients are whom? Do you want to read off -- I'm talking about the ones in green.
A. Rudolfo Meana, Sonia Orellana, Gwendolyn Martin.
Q. Let's stop there. Those are the ones in the one room where the source patient was?
A. Right.
Q. We also have three patients listed in the other room as well?
A. Right.
Q. And who are they?
A. Stacy Hutchison, Patty Aspinwall and Carole Grueskin.
Q. Now was there any indication based on your review of things and all of the analysis that you did as

to any cross movement of any personnel or any supplies or anything from one room to the other during the day?
A. Well, we really struggled with this because it was very difficult to try to figure out how it happened. Once we were able to separate the two rooms we looked at the times. So Kenneth Rubino started -- I can't tell what time that is. His procedure started at 9:50 in the morning and it was over at 10 o'clock and Stacy Hutchison who was in the other room started at 9:52 and she was finished at 10:06.
Q. According to the records anyway?
A. According to the computer-generated report. Those were the times I went off of to do this. So we have the CRNA for Kenneth Rubino was Keith Mathahs and the CRNA for Stacy Hutchison was Ronald Lakeman. The next patient after Stacy Hutchison in the second room was Renate Blemings and Renate Blemings records show that Keith Mathahs was her CRNA. So what we have is Keith Mathahs starting up here.
Q. When you say up here you're designating in one room at the top; correct?
A. In the first room and ending up in the second room right after Stacy Hutchison.
Q. So right about that time then somewhere according to the records he at least moves over to that

room?
A. Right.
Q. And I wouldn't want you to speculate as to how, what he brought with him or didn't bring with him or whatever, but at least we have the CRNA, if I understand you correctly, we have the CRNA where the source patient originates and infected patients after that in that same room?
A. Yes.
Q. And then we have around the time that the infection start in the second room we have evidence that shows that Mr. Mathahs is the CRNA that moves to that room at least for a period of time?
A. That's correct.
Q. Now was there any indication that he in fact had been involved in any way with Stacy Hutchison's procedure?
A. Not according to the records. And the records that I used were the ones that were generated and signed off on in the procedure files.
Q. But you said not according to the records. Did you have any other source of information that led you to a different conclusion?
A. One of the depositions I read in the civil litigation that's going on.

Q. And I don't want to get into specifics about what other people said, but were you able to follow-up on any information based on any deposition that you read?
A. Well, the information that I got made this a little clearer for me.
Q. Okay.
A. The person that was deposed said that when they started the computer-generated report they had a drop down list and they would click off who was in the room and I noticed on some of these reports that the person that was listed on the report was not the person who signed off.
Q. And ladies and gentlemen of the Grand Jury, that information is not offered for the truth of the matter and I would ask you not to consider that hearsay statement in your deliberation, just for why this individual, this particular witness was analyzing the things as she did in this particular case.
That being said, did you, you obviously had indication that at least right at the time that Stacy Hutchison's procedure is either finished or sometime within the procedure that Mr. Mathahs moves from the room he was in to the second procedure room?
A. Yes.

Q. Is that correct?
A. Yes.
Q. So we at least have movement and infections follow from thereon after?
A. Yes.
Q. And if I need to leave this up here I can. But I'm talking about the exhibit again, Exhibit 42 if you still need to refer to that.
But the patients that follow in that room, the second room, those patients, the anesthesiologist or the anesthesia person, the nurse anesthetist at least of record for those three procedures was who?
A. Ronald Lakeman.
Q. So Mr. Mathahs at least according to the records had returned back to his room at some point?
A. Yes, but he shows up again.
Q. Go ahead.
A. We were told that they covered each other for lunch.
Q. Okay. And again that's not offered for the truth of the matter.
Based on that information did you see anything that reflected that kind of thing in the records that you reviewed?
A. Well, Keith Mathahs is in this room, in

room 1 until noon, about noon, 11:57, when Ronald Lakeman took this procedure and then Keith Mathahs is back. And then in the other room Keith Mathahs shows up for this procedure after Stacy Hutchin -- Renate Blemings at 10:13, then he comes back again at 11:34.
Q. Did that look like it was around a lunch break then?
A. That's what it looked like to me.
Q. So the prior time when he's actually moved over to that room you don't know why he came over?
A. No.
Q. And he's only over there for one recorded procedure; is that right?
A. Yes.
Q. And that procedure immediately follows Stacy Hutchison's procedure?
A. Yes.
Q. So you don't know if he came in there before Stacy Hutchison or during the procedure at all?
A. No.
Q. Any other information related to this exhibit?
A. On my comments, the last column, I call it comment, and that's what I use for myself to make notes or to notice something that is interesting. So we have

where I would say that in this case Linda McGreevy was listed on the report as the nurse but Karen Richvalsky off on it. So --

Q. And could you spell Richvalsky?

A. R-I-C-H-V-A-L-S-K-Y, Karen.

So that was another discrepancy that I tried to note on the spreadsheets where the names didn't quite match up with the signatures.

Q. So if I understand you correctly, and just so I can reiterate, that sometimes signatures and who was supposed to be in the room didn't match up; is that what you're saying?

A. Yes.

Q. And you saw that also around the time that Mr. Mathahs moves to the room with Stacy Hutchison or not?

A. I don't remember. I know he was on Renate Blemings' report. Or on her procedure file. I don't remember if he was on the report or not.

Q. Okay. Now let's move on. So you do all that analysis work, you lay it all out, that's part of those exhibits that you've got, what is the next thing you do as far as analysis goes in the case?

A. We tried to see from the procedure files if there was another way this infection could have been

transmitted and it could have possibly been in the, when they had the heplock administered to them.

Q. So somebody had raised that issue to you and I assume that meant you went back and tried to find any evidence to support it; correct?

A. That's correct.

Q. What did you do to try to either look at that problem and support it or discount it?

A. Well, I went back to the patient, the procedure files, and I noted who had signed off as the heplock nurse, the person who had inserted the heplock.

Q. And are you all hearing this by the way? I mean can you hear what she's saying?

Try to speak up a little bit into the microphone.

A. Okay. The procedure file shows Lynette Campbell was the heplock nurse for Kenneth Rubino.

Q. What day are we talking about first of all?

A. We're talking about September 21st, this day. So Lynette Campbell was --

Q. And before we go any further, I can see you're referring to a document.

A. Yes.

Q. Is that correct?

This is Grand Jury Exhibit Number 39. What

is this document first of all?

A. This is an association chart that I prepared using software we have at Metro called Analyst Notebook.

Q. Did you take this information in preparing this particular exhibit based on the information you had gotten in your investigation?

A. Yes.

Q. I'm going to go ahead and display that up here --

A. Oh, good.

Q. -- for the Grand Jury. And then you can tell us about it as we go through it and if you need me to zoom in on a particular section let me know.

A. Okay.

Q. Right now I'm zooming out so we have the entirety of the document showing. And if you can tell us kind of what we're looking at.

A. Okay. This room is room 1 and this room is room 2.

Q. And just for the record she's referring to the designations of those things on the document.

A. Right. So based on the sort from the reports we have these people who were these victims and the source Kenneth Rubino who were in procedure room 1.

Q. And for the record she referred to all of the persons along the top portion of the screen going from left to right.

A. And then we have the people who were in the other procedure room, Stacy Hutchison, Patty Aspinwall and Carole Grueskin.

Q. And they are designated on the bottom of the screen for the record.

A. In the center I have Lynette Campbell who was the heplock nurse, she's the person who initialed off that she had given, inserted the heplock into them before the procedure and she did the heplock for Kenneth Rubino, Rudolfo Meana, Sonia Orellana, Gwendolyn Martin and Nguygen -- I don't know how to pronounce his name, it's Vietnamese, he was one of our yellow that we didn't have the genetic matches for.

Q. And when you say yellow are you referring to the yellow marking --

A. Yes.

Q. -- on the spreadsheet on Exhibit -- whatever it is.

A. Then we had Jeff Krueger who was, administered the heplock for Stacy Hutchison, Lakota Quanah, and he signed off on those.

In the interviews that detectives conducted

Patty Aspinwall identified Jeff Krueger, she described him as the person who had given her the heplock.

Q. But you also have a line in that diagram going to Miss Campbell as well; is that right?

A. Right.

Q. Why is that?

A. Well, she signed off on it on the records. Patty Aspinwall described Jeff Krueger.

Q. So tell us what -- I mean I see what you've just described, but how does this, what does this mean?

A. This was to try to show that the same person had given all of the heplocks and that didn't happen because we have Jeff Krueger who signed off on two of them and was identified on a third. It also brought into my mind whether the records were correct or not.

Q. Okay. So at least on this date we have for sure Stacy Hutchison who was not administered a heplock by Miss Campbell; correct?

A. That's correct.

Q. And actually the CRNA Jeff Krueger, not CRNA, the nurse rather, Jeff Krueger, was the one who administered that heplock?

A. That's correct.

Q. And then Miss Campbell seems to be tied at

least to the remainder and possibly Miss Aspinwall?

A. That's correct.

Q. You can sit down again if you would.

Now let's talk about this related to the 25th. Did you look at that issue possibly for the 25th of July of 2007 as well?

A. Yes, we did.

Q. Did you find that there had been a commonality between either Mr. Krueger or Miss Campbell related to that particular procedure date?

A. No. On that procedure date the records show that the CRNA administered the heplock to the source patient Sharrieff Ziyad and somebody else administered Michael Washington.

Q. So two different people administered the heplock?

A. Right.

Q. But the key thing here I want to make sure I'm clear on is that the source patient for the 25th was actually, had his heplock put in by the CRNA who did his procedure?

A. That is correct.

Q. Go ahead. Anything else about that?

A. No.

Q. So based on that did you have any

indication that there was overlap, there was some person who was common between, or persons who were common between all of these people?

A. Well, there wasn't one person who was common between all of them, no.

Q. And in fact on the 25th there was, it sounds like Mr., not Mr. Washington -- who is the source patient?

A. Ziyad.

Q. Ziyad Sharrieff was the individual who didn't even go to the procedure room, he just went, or not the procedure room, to the pre-op room, he went straight to the procedure room?

A. That is correct.

Q. Now what was the next thing you did in your analysis or the next portion you went to?

A. I did a financial analysis to track the money that Doctors Desai, Carrol and Carrera received in 2007.

Q. Now when you say financial analysis what do you mean?

A. I took, I went through the evidence that we had taken in the search warrant and I identified the bank accounts that they had and in the bank accounts summaries they also had listed all of the checks and who

they were paid to, so I took the accounts that had payments to the doctors and I got a Grand Jury subpoena for those bank records from the bank and I scheduled those out to try to determine how much the doctors had received in income for 2007.

Q. What was the purpose of that? Were you trying to find out who was the main player or the minor players or what?

A. Well that, to verify who the main player was. Also to see if there was a financial incentive for this infection.

Q. Okay. And you're looking at a document here, it's marked as Grand Jury Exhibit Number 40, and what is this document?

A. This is the summary page of my analysis with all of the bank records. So I show that for 2007 Dr. Dipak Desai received $6,809,003.74.

Q. What about the other two doctors that you mentioned?

A. Dr. Clifford Carrol received $1,967,446.17.

Q. And what about Dr. Carrera?

A. Dr. Carrera received $1,403,010.64.

Q. So if I have it correct it looks like Dipak Desai made the lion's share of the money?

A. That's correct.

Q. Now the next page, page 3 of the exhibit, the bottom, there is also some numbers listed there is are there not?

A. Yes.

Q. What are those?

A. These were amounts that came from one of the bank accounts. When we took the records in the search warrant one of the file folders said CRNA and it was a bank account with Wells Fargo.

Q. So it was listed, its title was CRNA?

A. The handwritten title on the folder was CRNA. The bank account's name was not CRNA.

Q. What was the bank account's name?

A. I don't remember.

Q. But it was different?

A. Yes.

Q. Do you know who had control of that account?

A. Dr. Desai.

Q. Can you tell us what you found in that account? Are we talking about just one year or more years than that?

A. We're just talking about 2007. I looked at this file folder at the first because I thought it would show bonuses or payments made to the nurse anesthetist,

the CRNAs, and in fact there were no payments to the nurse anesthetists, there were only payments to doctors. So I pulled out these three doctors because they were involved in our infections and it shows that Dr. Desai received $250,000 from that account, Dr. Carrol received 125,000 from that account, and Dr. Carrera received 25,000 from that account.

Q. But based on what you said earlier it would have been Dr. Desai that would have made the disbursements; is that correct?

A. That's correct.

Q. So he was the one who controlled the account?

A. That's correct.

Q. Now beside that analysis what else did you do?

A. We had allegations that they had reused supplies, propofol, so I took all of their medical supplies on those categories and I looked at the vendors who had provided the propofol, the bite blocks and the syringes and I did an analysis to see if they had ordered enough supplies to provide a vial per person without reusing it, adequate number of syringes and adequate number of bite blocks.

Q. And just, you have a document in front of

you, it's quite large, but it is Grand Jury Exhibit Number 41. So if you need to refer to that at any time just let us know you're doing it. It's here available to you and it is available to the Grand Jury as well.

So is that a summary report of that particular analysis?

A. Yes.

Q. And tell us what it is you found related to each one of those categories you mentioned.

A. Okay. I started with trying to determine how many patients had been seen in 2006 and 2007 and the reason I included 2006 was to see if they had an existing inventory of supplies. So I counted the number of patients in the endoscopy log book and we had the registers for both the Burnham clinic and the Shadow Lane clinic.

Q. Before you go on I just want to make sure, you say you're using the endoscopy log books which is the record from the business itself; correct?

A. The big book, yes.

Q. And that was information contained in the search warrant?

A. That's right. And then we also served a Grand Jury subpoena on the custodian for the Endoscopy Center to get the ones we hadn't gotten in the search

warrant from the Burnham clinic, so we had all of the endoscopy registers.

Q. And then beside that what other records did you look at in tabulating and coming up with the information that you're about to testify to?

A. I used the vendor files from the search warrant, identified all of the vendors that provided the propofol, the syringes and the bite blocks, and we subpoenaed those records from the vendors to make sure that I had all of the information. And then I was worried that I had, I might miss a vendor so we subpoenaed that information also from the custodian of records for the Endoscopy Center so that I would make sure I had all of the vendors.

Q. After you did all that did you have a compilation of all the records you were aware of that were related to what you're discussing?

A. Yes, I did.

Q. Okay. Go ahead.

A. Okay. In 2006 there was no existing inventory for the bite blocks or the propofol or the syringes. So in 2007 they had 7,521 endoscopy procedures where they would have used bite blocks and they --

Q. And let me make sure I'm clear on that.

You know there is a difference between a colonoscopy and an upper endoscopy; correct?

A. Correct.

Q. In a colonoscopy they don't use a bite block.

A. That's correct.

Q. On an upper endoscopy they do.

A. Yes.

Q. I assume you know that's to supposedly protect a patient's teeth or protect the scope or both or something along those lines?

A. That's correct.

Q. When you did your analysis, when you say procedures that would have required a bite block, are you talking about strictly upper endoscopy procedures?

A. Yes.

Q. Okay. Go ahead.

A. And I identified those by counting them in the endoscopy logs. So there were 7,521 upper endoscopy procedures and they ordered 3,250 bite blocks. So based on those numbers I did a ratio of the procedures to the bite blocks and it was two to one, two procedures for every bite block.

Q. Go on.

A. I did the same for propofol logs. They

used propofol as the anesthetic for the procedures and the CRNAs or nurses signed out the propofol logs every day. The propofol vials, excuse me, every day.

Q. And before you get to that I want to ask you if during your analysis and research you ever looked into how propofol is distributed, the size, the amount of container, or the size in the various containers that were available at least for purchase.

A. We did. I did some research on the internet, I looked up AstraZeneca and I got their information for propofol, they were the manufacturers.

Q. Do you know what it comes in size wise?

A. They come in 10-milliliter vials, 20-milliliter vials and 50-milliliter vials.

Q. Are you aware of any larger quantity, up to 100CC?

A. I'm not.

Q. At the Endoscopy Center specifically did you look at what they had or what they were using at any of the centers but specifically the Shadow Lane center?

A. Yes, they ordered 20-milliliter and 50 milliliter vials.

Q. Generally through all the facilities or just the one?

A. For both the facilities.

Q. And there were just two facilities that did endoscopy procedures primarily?

A. There was a third one, it was the one on Rainbow, it opened in late 2007 after our infections.

Q. And then it closed?

A. Yes.

Q. Go ahead.

A. The propofol logs were the sign out logs for the vials of propofol that the CRNAs used every day and they wrote how many they checked out and how many they returned so I was able to calculate how many vials they had used for the day.

Q. Okay.

A. The logs that I used were the 50-milliliter logs and after I prepared this report I went back and I found the 20 milliliter vials that they had also checked out.

Q. So this report just deals with the 50 but you've also looked into the 20 as well?

A. Yes, and I have an addendum report that isn't here.

Q. Okay. But you do know the information from the addendum report?

A. Yes, I do.

Q. Okay.

A. So the ratio of patients to propofol vials for July 25th was three to one. So they had one vial of propofol they used for every three patients. And the ratio of patients to vials for September 21st was also three to one.

Q. Now what about the 20-milliliter containers?

A. Twenty milliliter containers on the 21st, they checked out two which did not impact the ratio significantly, and they didn't check out any on the 25th.

Q. Okay. So let's talk about the total number of patients and the total number of vials on those two days.

A. Okay.

Q. And just for the record she's referring to page 9 designated as DA-endoscopy bates number 5211.

A. So on July 25th they had 65 patients. Two of those patients had two procedures so they had 67 procedures. But when I did my analysis I just used the number of patients because there should, the vials were for single use, one patient only. Ronald Lakeman signed out five vials and did not return any. Then he signed out 20 vials and returned five. So the total number of vials they used that day was 20. So the ratio of

patients to vials for July 25th was 3.25 patients to one vial.

Q. So if I understand you correctly 20 vials total that were used or just checked out?

A. They were checked out and I'm assuming that they were used.

Q. So 20 checked out that didn't get returned?

A. Right.

Q. And they had 65 patients that day?

A. That's correct.

Q. Let's move to the 21st.

A. Okay. On the 21st they had 63 patients and they had 64 procedures, one patient had both procedures. So I counted 63 patients. CRNA Keith Mathahs signed out 18 vials and returned none. CRNA Mathahs signed out 20 vials and returned 14. So the total number of vials signed out was 24. So the ratio of patients to vials for this day was 2.62 to one. And then if you include the other two vials that are in the addendum report it doesn't change it significantly, it's still around three.

Q. So it was actually a total of 26 vials that were checked out then?

A. Yes.

Q. Including those two 20 ml ones?

A. Right.

Q. And there was a total of 63 patients?

A. Yes.

Q. Those are the ones you looked at for those two days; correct?

A. That's correct.

Q. Did you do any analysis for any other propofol use on any other days or in general?

A. I looked at the propofol in general to see if they had ordered enough propofol vials for the number of patients that they saw. In 2007 there were 23,576 patients seen at both clinics. We had information that they shared medical supplies between the two clinics so I included both sets of numbers in this analysis. They ordered 11,844 vials of propofol and that would be both the 50-milliliter and the 20-milliliter, and so that's the ratio of patients to vials is two to one. They had two patients for every vial of propofol that they ordered.

Q. Okay. And that's giving at least the benefit of two clinics seeing patients?

A. Right.

Q. Is that correct?

A. That's correct.

Q. Okay. And then just combining all the

patients and all the vials ordered by both clinics?

A. That's correct.

Q. Okay. Go on.

A. I also looked at the syringes to see, because we had allegations that they reused syringes, so I took both clinics once again for this because they shared medical supplies. So on the two days in 2007 when they spread the infection I counted the number of injections off of the anesthesia logs that they used and there were --

Q. When you say injections you would mean drawing up a syringe from a bottle, injecting that, discarding that syringe and then drawing up from possibly the same bottle with a new syringe for another injection; is that right?

A. Well, I counted the number of injections that they had listed on the, the CRNAs had listed on their anesthesia logs.

Q. Okay. That's fine.

A. So I did that in order to get a ratio for the number of injections that they should have had.

Just a minute. Let me make sure this is the right page.

Okay.

Q. And just for the record we're referring to

page 13 of the document designated as DA-endoscopy bates number 5215.

A. I took the number of injections, I counted the number of injections that all of the patients received on both of those two days. On July 25th there were 123 injections and there were 65 patients. So I took that and averaged it to 1.9 injections for that day. On September 21st there were 63 patients and 185 injections so on that day the average was 2.93. And I took an average of both of those averages and I got 1.92, or 2. -- I'm sorry, 2.425. So every patient should have received 2.4 injections for their procedures.

Then I took how many patients Burnham had --

Q. Referring to page 14, DA-endoscopy 5216.

A. -- and for 2007 they had 8,619 patients, they ordered 18,900 syringes, so the ratio of patients to syringes was one patient to 2.19. My developed ratio was one patient to 2.4. So the Burnham clinic was close, close to the ratio that I had developed as to how many injections were actually given.

The Shadow clinic, they had 14,957 patients and they ordered 17,100 syringes, so their actual ratio was one patient to 1.14 syringe. So they weren't even

close to the developed ratio I had.
Q. When you talked about syringes were you talking about all types of syringes ordered by the clinic?
A. I'm talking about the 100C syringes that --
Q. Were typically used?
A. -- were typically used for the injection, injecting propofol.
Q. Okay. Anything else regarding that analysis?
A. I don't think so. I looked at 2008 to see if the ordering changed after they were notified by the health district and in 2008 they ordered more bite blocks. In 2008 they ordered 1400 bite blocks for five weeks. Or for six weeks.
Q. And how many patients during that time if you know?
A. I didn't count them.
Q. Okay.
A. And in 2007 they ordered, for the entire year they ordered 3,250. So they ordered significantly more bite blocks in 2008 than they did in 2007.
The propofol logs show that 38 vials, in 2008 38 vials were checked out for 34 patients, which meant the ratio of patient to propofol vials was one

patient to every 1.1 vial. So they started ordering more than they had in 2007. And that also followed through for the number of vials that they ordered. They ordered 3,125 vials of propofol and they had ordered 11,844 for the entire year of 2007. So the average number of vials ordered per week in 2007 was 228, the number of vials ordered for the six weeks in 2008 was approximately 521 per week.
Q. So at least double?
A. Double, yes. And the same thing happened for the syringes. The orders in 2008 changed, for the period in five or six weeks in 2008 they ordered 5200 syringes and they ordered 36,000 for the entire year in 2007.
Q. So their average per week, did you do that too?
A. I did. Number of syringes ordered per week in 2007 was approximately 692, number of syringes ordered per week for five weeks in 2008 was approximately 1,040.
Q. Now beside the analysis of those three items that you've described was there anything else of significance contained in this report?
A. I don't believe there was.
Q. Now beside that analysis and the financial

one and the spreadsheets, things like that that you did, what else, if anything, did you do in this case?
A. I went through all of the evidence, I went through all of the interviews and indexed them by topics.
Q. Did you do any further analysis work of any type?
A. No, these were the two that I focused on.
Q. Okay. And when you say two, you're talking about the financial analysis and the medical supplies analysis?
A. That's correct.
Q. You also did the actual patient records analysis too?
A. Yes, I did.
MR. STAUDAHER: I have nothing further for this witness.
THE FOREPERSON: Are there any questions from the Grand Jury?
We'll start over here with Bob.
BY A JUROR:
Q. In 2008 when they realized they were under investigation and they ordered more vials of propofol, what size did they order, the 20 or the 50?
A. They ordered the 20. They sent back all of

the 50 that they had.
THE FOREPERSON: Okay. On this side, Lisa.
BY A JUROR:
Q. And when you developed your ratios of patients to supplies, you know, the bite blocks, the propofol and the syringes, did you take into account beginning inventory of 2007 of these supplies and ending inventory in 2007?
A. There was no beginning inventory because I looked at 2006 and they didn't order enough of any of the supplies to have any inventory left over.
Q. Did you take into account beginning inventory in 2006 to see if they ordered enough? I mean because they could have had a significant amount beginning of 2006 to where they didn't need to order as much in 2007.
A. They could have. And there was one period where they ordered in 2006 a significant number of propofol vials, but they didn't, they wouldn't have lasted until 2007.
Q. Were there -- this was a partner, do you know what type of entity this was? Was it a partnership or a corporation?
A. There were several agreements that changed over the years so some of the partners and --

partnership is kind of loose.
Q. Okay. I guess --
A. Some of the partners were early on and they continued through, like I think Dr. Carrol had started early on, but as partners dropped off those agreements changed.
Q. What I'm trying to get at was there a balance sheet where you could go in and see where they had taken an inventory, did you look at a balance sheet?
A. An inventory of what?
Q. Well, a balance sheet for the, for whatever this entity was, did they take a physical inventory at the end of the year that you looked at?
A. I didn't see one.
Q. They didn't have a balance sheet that they published for the partners or --
A. No. One of the doctors that we interviewed, I was present for, he described it that they were employees, the other doctors were employees and Desai, Dr. Desai determined how much they would be paid and how much they would get from the CRNA account.
Q. Okay. So bottom line --
MR. STAUDAHER: And again, ladies and gentlemen, I'm going to admonish you about that statement. I want you to disregard that particular

statement for your deliberation. It's a hearsay statement.
BY A JUROR:
Q. So there was no inventory that we could look at to say beginning or ending for the calendar years?
A. I didn't find one in going through the records.
Q. Thank you.
A. You're welcome.
THE FOREPERSON: Shelley.
BY A JUROR:
Q. You said in 2007 that, referring to the syringes, that, you gave the two numbers of 1.4 and then 1. I think it was 9, and you said that the numbers didn't match, but by what percentage ratio though?
A. I developed a ratio based on these, the two days that I had scheduled out, I counted all the injections, and that ratio was one patient and 2.4 syringes. Then I took the number of syringes and the number of patients at the Burnham clinic and that ratio was one patient for 2.19 syringes. And then I applied the same developed ratio that I had to the number of patients and syringes at Shadow and that ratio was one patient for every 1.14 syringe. So my developed ratio

was one patient for every 2.4 syringes and the number of syringes that they used at Shadow wasn't even close to what it should have been.
Does that answer your question?
Q. I'm not a math person. It just sounds like numbers to me. I was hoping it would be more like if you could give me an answer of they issued so many syringes per person or they didn't.
A. They, at Burnham they used 2.19 syringes per patient.
Q. Is that good or bad?
A. Well --
MR. STAUDAHER: And she can't make a qualification on that. She's just here to give you the information based on the analysis she did so I would ask her not to answer that particular question. Just telling you how many of whatever was used on the patients that were at the clinic when she did the analysis.
BY A JUROR:
Q. Okay. What's average amount of injections does one patient normally get?
A. Well, that varied because the propofol was given according to their size and the duration of the procedure.

Q. Okay.
THE FOREPERSON: Are there any further questions?
Yes, Lisa.
BY A JUROR:
Q. Perhaps you can answer this, perhaps you can't. But we know that they would have needed at least two syringes for their heplock, one for the saline and one for the propofol; correct?
A. That's correct.
Q. Okay. So they, so --
BY MR. STAUDAHER:
Q. With the distinction -- I think I need to add and clarify -- when I asked the witness about the size of the syringe I believe that the size for the syringe that was used for injection of the drug propofol may have been different than for the injection of the flushes. Is that correct?
A. That's correct.
Q. So they would have been two different types of syringes. You only looked at the 10CC syringes which were typically used for the injection of the propofol drug alone?
A. That's correct.
Q. So there were other syringes used in the

practice, 50CC syringes and smaller syringes and things like that?

A. That's right.

Q. You didn't look at any of those?

A. No.

MR. STAUDAHER: Okay.

THE FOREPERSON: Are there any further questions? Yes.

BY A JUROR:

Q. All the analysis you done were only, was only on 25 July and on September 21st, right? There was no, you didn't randomly pick another date and run an analysis as a baseline to correlate these two?

A. Not of a complete day, but I did do some additional work on information that we got from the health district. They provided us a list of the patients that had responded to a questionnaire that said that they were infected. I put those on a spreadsheet, I was looking for another cluster date and I found I think three dates where there were two patients infected on two of those dates and three patients infected on a third.

MR. STAUDAHER: And again I'm going to admonish the Grand Jury at this time there is not evidence that they were infected at the clinic on those

days but just patients that reported infection had procedures on those dates.

Is that correct?

THE WITNESS: That's correct.

THE FOREPERSON: Yes.

BY A JUROR:

Q. How did you know that they only used the 10 ml for the propofol or that they only used 10 ml for the propofol injections?

A. In the interviews that detectives conducted with the CRNAs.

Q. Okay.

BY MR. STAUDAHER:

Q. And one last question I have related to the one that the Grand Juror asked. Typically if you had a large inventory, let's say you had box, case after case of propofol on January 1st of 2006, would you expect to normally see ordering of propofol on a regular basis with a large inventory in place?

A. Yes.

Q. Yes?

A. Well, no, not with a large inventory in place. And I did look at those ordering records and I noticed that one large order in 2006, but they had continued ordering propofol all along.

Q. So there wasn't like January of that year that they didn't have to order any propofol because they had so much left over from the year before?

A. No.

Q. So they kept ordering in January and February and March and April, all the months?

A. Yes.

Q. And then one month along there mid year they ordered actually larger amount than they had even on different months before and after that?

A. That's correct.

Q. Okay. But by the time they got to the end of the year the amount they had ordered throughout the whole year I think you said was not enough to do what they needed to do?

A. Right.

Q. If they had used one per patient?

A. That's right.

THE FOREPERSON: Any further questions? None?

THE WITNESS: I'd like to add one thing. The standard I used on this was one patient, one vial, a syringe per injection, one syringe per injection. So I used that standard care, medical practice, to apply to this ratio also.

BY MR. STAUDAHER:

Q. Was that what you were at least operating on as accepted aseptic technique for handling drugs in the way they were used in that type of practice?

A. Yes.

Q. So every time the vial is entered it should have been entered with a new syringe, that's why if they had a second injection of the drug you would have attributed that to a new syringe?

A. That's correct.

THE FOREPERSON: Any further comment? Questions? Okay.

By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this admonition?

THE WITNESS: Yes, I do.
THE FOREPERSON: Thank you. You may be excused.
THE WITNESS: Thank you.
THE FOREPERSON: You're welcome.
MR. STAUDAHER: One second ladies and gentlemen.
Ladies and gentlemen, that concludes it. Thank you for coming over. I will have one witness after -- they are going to present that case. So it's probably going to be about two hours for them to present it, I believe they're coming back at 1:30 or thereabouts. I know we went over a little bit so I'll let you decide when you want to come back. I know it's an important case for them. They anticipate two hours. I have one witness who is relatively short like the morning witness after that so we should be finished relatively early. So I know they'll be back here at 1:30.
(Recess.)
(Juror Agnes Parker exits the proceedings.)
MR. STAUDAHER: Ladies and gentlemen of the Grand Jury, we're back in case 09BGJ049A-C, Dipak Kantilal Desai, Ronald Ernest Lakeman, Keith H. Mathahs, State versus those individuals. We have one additional

witness to provide to you after you had your break earlier today. I'll call that witness in now.
THE FOREPERSON: Please raise your right hand. Thank you.
You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: Yes, ma'am.
THE FOREPERSON: Thank you. You may be seated.
THE WITNESS: Thank you.
THE FOREPERSON: You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.
Do you understand this advisement?
THE WITNESS: Yes, ma'am.
THE FOREPERSON: Could you please state both your first and last names spelling them for the record.

THE WITNESS: First name is Joanne, J-O-A-N-N-E, last name Sams, S-A-M-S.
THE FOREPERSON: Thank you.
THE WITNESS: You're welcome.

JOANNE SAMS,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Miss Sams, what do you do for a living?
A. I'm a certified coder for the Veterans Administration.
Q. What do you do as a coder for them?
A. What I do is I take medical documentation and I turn it into codes for billing and for reporting purposes.
Q. Okay. In that process do you receive forms called HCVA 1500 forms from different providers?
A. Yes, sir.
Q. Do you take the information off that form and then base -- I assume that's a claim coming in; correct?

A. Yes, sir.
Q. Do you then formulate what you would reimburse based off that claim?
A. That's correct.
Q. And then go through the process of actually paying out the vendor?
A. And validating that the codes are verified by the documentation submitted.
Q. Okay. I'm going to show you what has been marked as Grand Jury Exhibit Number 44, ask you to just flip through that document and tell me if you recognize it.
A. Yes, I do recognize this.
Q. Look at all the pages. I think there are five or six pages.
A. Yes.
Q. Five page document.
A. Yes, sir.
Q. What is this document, ma'am?
A. This is a sample of a HCVA 1500 form.
Q. Page 1.
A. Page 1. Page 2 is a payment history for a veteran.
Q. And who is that veteran?
A. Michael Washington.

Third page is the operative report for a procedure performed on Michael at the endoscopic center. The fourth page is a spreadsheet that I created that provides a description of services and definitions of what the modifiers on the claim form and the time indicated on the claim form as well. The fifth page is an overview, it's an expanded view of the claims history from page 3.

Q. Okay. So the first page, this HCVA form is not filled out; is that correct?

A. That's correct.

Q. In this particular case were you able to find the actual form that was submitted on that claim?

A. No, we were not.

Q. Do you normally get claim forms like this?

A. Yes, we do.

Q. Now you had said that the succeeding pages of this exhibit though contain information that's in your computers that was basically inputted from that information form?

A. That's correct, yes.

Q. Is that correct?

A. Yes, sir.

Q. So even though you don't have the actual HCVA form you have the information that was inputted

from the form?

A. Absolutely, that's correct.

Q. Have you gone back and looked at this information to see if it conformed or if it matched this operative report that was provided as well?

A. Yes, I have.

Q. Does it?

A. Yes, it does, it does match.

Q. I notice on page 3 of this document there is an operative report from the Endoscopy Center of Southern Nevada; is that correct?

A. Yes.

Q. I'll show it to you right here. And again we're still looking for the record at Exhibit 44.

Is that a requirement from the Veterans Administration that they provide an operative report of the procedure done and the dates and times and all that stuff associated with it?

A. Yes, it's for continuity of care and to validate that the services were in fact rendered to a particular patient, yes.

Q. Who was the information pertaining to on that particular form?

A. This is for the patient Michael Washington.

Q. Who was the doctor who actually performed

the procedure?

A. Dr. Desai.

Q. Dipak Desai?

A. Dipak Desai, yes.

Q. Who was the individual who performed the anesthesia services?

A. Anesthesia was provided by Ronald Lakeman, CRNA.

Q. What procedure was performed?

A. A colonoscopy.

Q. What was the procedure date?

A. 7/25/2007.

Q. Now beside that information on the operative report, you mentioned on page 4 that this was information pertaining to this specific claim; is that correct?

A. That's correct.

Q. What information is on that page?

A. The CPT code which is the procedure code, the description of that code, the modifiers that the provider billed us with the anesthesia time and the units billed.

Q. Okay. I'm going to display this for the Grand Jury so that we know what we're talking about as we follow along.

I'm going to go back to page -- we'll start off with page 1. And this is just, I think you said just the blank --

A. It's the sample form, yes, sir.

Q. Page 2. And I note that up in the left hand corner, upper left hand corner is Michael Washington's name; is that correct?

A. That's correct.

Q. What is the information on this form showing us?

A. It is showing us, the first entry is the surgical center that they billed for the services, for the use of their facility, vendor identified as Endoscopic Center of Southern Nevada. The second entry is the vendor, the Gastroenterology Center, it is an office call, the date of service is 2/1/08.

Q. And I think what I'd like to do is move down to the actual date for the procedure.

A. The 7/25?

Q. Yes, the 7/25 date.

A. The highlighted 7/25/07 is the, 00810 is the anesthesia code.

Q. For what?

A. For the colonoscopy performed on that day.

Q. Let's move to the next page. I know you've

already testified to it but I just want you to highlight the portions that we specifically discussed. This is the operative report is it not?

A. Yes, sir.

Q. And it shows the Endoscopy Center of Southern Nevada, 700 Shadow Lane?

A. That's correct. Michael Washington as the patient, it shows your procedure date of 7/24/07.

Q. 7/24?

A. 7/25, I'm sorry, '07. It shows the attending physician is Dr. Dipak Desai and the medication used and their findings of the procedure.

Q. Now one other thing I wanted to point out to you. Under the indications does it also have, or the providers, does it also have CRNA Ronald Lakeman's name?

A. Yes, sir.

Q. Beside that type of anesthesia --

A. Is the propofol.

Q. What does that mean exactly?

A. That was the type of medication, the anesthesia, that they administered to the patient.

Q. Okay. Next page which I just want to make sure we have is page 1, 2, 3, 4 I believe, this is the spreadsheet information that you said came from this particular claim?

A. That's correct.

Q. And tell us what we're looking at here specifically.

A. Okay. What I did is I took the procedure codes from the previous page and I just did a description showing what the procedure was, as a lower intestinal endoscopic procedure, the modifiers that were billed and the total units billed being eight, the total anesthesia time as 31 minutes for a total of three units.

Q. So explain the difference between three units versus the total eight being billed.

A. Okay. The anesthesia code, the anesthesia services comes with a base code, base unit value of five, it's in the very first block, I identified that as five, that is added to the times units.

Q. So if the base is five and the time is three that would be a total of eight?

A. Total of eight. And that's what they billed us for was a total of eight units.

Q. And the total time they billed you for was?

A. Thirty-one minutes.

Q. Let's go to the last page of this exhibit and we'll start at the top. There's a lot of stuff here so why don't you walk us through what we're looking at

just generally and I would like you to focus on just that procedure date at this point.

A. Okay. Again this is the claims history for Michael Washington with the date of service of 7/25/2007, the anesthesia, the 00810, showing the P3 modifier, the -- what I did was I expanded that view to show the procedure code, the amount that the Veterans Administration paid --

Q. So if I understand you correctly this number 4 listed in the middle of the page refers back to this number 4 here?

A. That's correct.

Q. Is that correct?

A. That's correct.

Q. And that's the date of 7/25/07?

A. Correct.

Q. And then down below --

A. It gives you more detail to that particular line.

Q. So you just expand out number 4?

A. That's correct.

Q. Let's talk about that for a moment. On number 4 walk us through what we're looking at.

A. Okay. What it's showing you is the amount that was paid to the provider, it shows the amount of

units that was paid, total number of eight, it shows you the anesthesia time as 31 minutes and any of the modifiers, the QZ, the QS and the P3 modifiers that were also billed.

Q. What are those?

A. Those identify that it was monitored anesthesia care, that it was provided by, services performed by a CRNA, and that the patient has a systemic disease, he's categorized as having a severe systemic disease.

Q. Okay. Let's talk about the top. It says service provided, that's 00810?

A. That's correct.

Q. Is that a colonoscopy?

A. That's --

Q. Or anesthesia for a colonoscopy?

A. Anesthesia code for colonoscopy, yes.

Q. Got it. And below that it says amount paid. What does that mean? Is that the actual dollar amount paid to the clinic?

A. That's correct.

Q. And how much is that?

A. That's a hundred dollars.

Q. Now if we move over where it says, on the right hand side of that expanded section, it says amount

claimed. Do you see that?
A. Yes, sir.
Q. It also has another number there. What is that number?
A. That is also a hundred dollars.
Q. Is that what was actually claimed on this?
A. That's right, they billed a hundred dollars and they were paid a hundred dollars.
Q. Now if we go down to the bottom we see it says units paid and it has a number there.
A. Yes, sir.
Q. What is that?
A. That is the number 8.
Q. And anesthesia time?
A. Was 31 minutes.
Q. So even though the amount billed was a hundred dollars and the amount claimed was a hundred dollars, this 30, I just want to be clear, this anesthesia time of 31 minutes and the units that they claimed were eight, were actually, that's the information that was contained in the form that was submitted to you for payment?
A. That's correct, uh-huh.
Q. So if this was an incorrect amount, if it really wasn't 31 minutes, that would be something that

would be incorrect on the form that was submitted to you?
A. That's correct, yes.
Q. Now did you have anything else to do with this particular claim or work or are you just providing this information to us today?
A. That's it, uh-huh.
MR. STAUDAHER: I have nothing further for this witness.
THE FOREPERSON: Are there any questions from the jury?
There are none.
By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.
Do you understand this admonition?

THE WITNESS: Yes, ma'am.
THE FOREPERSON: Thank you. You may be excused.
THE WITNESS: Thank you very much.
MR. STAUDAHER: One second ladies and gentlemen.
Ladies and gentlemen of the Grand Jury, that concludes the testimony in this particular case today. We are not going to submit it for deliberation at this time. We have at least one more presentation to make. So I will submit it to you at another date but at this point we'll conclude testimony. Thank you.
(Proceedings adjourned, to reconvene At a later, undetermined time.)
--oo0oo--

REPORTER'S CERTIFICATE

STATE OF NEVADA)
: Ss
COUNTY OF CLARK)

I, Danette L. Antonacci, C.C.R. 222, do hereby certify that I took down in Shorthand (Stenotype) all of the proceedings had in the before-entitled matter at the time and place indicated and thereafter said shorthand notes were transcribed at and under my direction and supervision and that the foregoing transcript constitutes a full, true, and accurate record of the proceedings had.
Dated at Las Vegas, Nevada, May 15, 2010.

Danette L. Antonacci

Danette L. Antonacci, C.C.R. 222

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding TRANSCRIPT filed in GRAND JURY CASE NUMBER 09BGJ049ABC:

X Does not contain the social security number of any person,

-OR-

___ Contains the social security number of a person as required by:

A. A specific state or federal law, to-wit: NRS 656.250.

-OR-

B. For the administration of a public program or for an application for a federal or state grant.

Danette L Antonacci

Signature

5-15-10
Date

Danette L. Antonacci
Print Name

Official Court Reporter
Title

that that was done so that the turning could be done quicker.

Q. Okay. And, again, at this point, you said that this had a pretty significant affect on you; is that right?

A. Right.

MR. STAUDAHER: That last statement and any statements related to that one that she elicits are hearsay statements, ladies and gentlemen. They are being offered for the truth of the matter at this point under a hearsay exception, which is the effect on the listener, how these things that happened to her affected her and what she did as a result of them.

So with that, I would like to continue on.

BY MR. STAUDAHER:

Q. So during your training, had that ever occurred to you before? Had anybody ever come up to you and given you something that was already filled out on the condition of the patient or what the patient was experiencing or not experiencing before you ever actually saw them?

A. You mean prior to working?

Q. At the Endoscopy Center?

A. They had discussed it in nursing school that that was improper procedure.

Q. So you were actually taught that that was not proper?

A. Yes.

Q. So when you saw it on your first job on your first day, what was going through your mind?

A. That I didn't want to work in a place like that because I don't want to risk my license doing the same thing.

Q. Okay. Now, when you raised this to these nurses, I mean did you -- did anybody else work with you at the time that was new?

A. No.

Q. Did you, during the three days you were there, were there any other additional nurses or personnel that came on that were also in the same position as you were in?

A. No.

Q. Did you ever work with people who were already at the clinic who were in the same position that you were in?

A. I'm not sure.

Q. I mean as nurses, charting, things like that in procedure rooms?

A. No.

Q. Now, when you said that the charting was

done beforehand, or when the -- when some of the stuff came to you. I mean we're talking about filled out documents on patients that you have not seen yet?

A. Right.

Q. Now, that's different than them just handing you a blank document and saying, you know, go ahead and start filling out vital signs or whatever on this patient, even before he's wheeled in the door?

A. Right.

Q. Did both of those things happen, though?

A. Yes, both happened.

Q. What about the documentation after the patient leaves your sort of area and goes out into the post-care area?

A. Again, in training, I was encouraged to start charting post-op information on a patient to save time.

Q. Okay. And when you say training, you're talking about training at the Endoscopy Center?

A. Yes.

Q. Again, did that affect you in any way as far as being something that concerned you?

A. It did because that's still pre-charting.

Q. So you -- if I understand you correctly, you were encouraged to pre-chart for other persons down

the line as well?

A. Right, right.

Q. Now, as far as the types of things that were being pre-charted or that you were encouraged to pre-chart, did that include start times and stop times for procedures, and things like that?

A. Yes, it did.

Q. Did it include vital signs or, like you said, how the patient was doing, things like that?

A. Not vital signs, but yes, how the patient was doing.

Q. As far as the condition of the patient, had you had a chance, when asked to just go ahead and fill out stuff about the patients, to actually maybe step out and look at the patient in the post-op area just to confirm that that was the way they were?

A. No.

Q. What happened if you -- well, I guess let me step back.

If you were encouraged to pre-chart the condition of the patient, was the condition supposed to be a certain way all the time?

A. Generally, it was documented the same way every time.

Q. And how was that documented?

A. That the patient was in good condition and good health.
Q. What happened if you had a patient that came in that was not in such good condition or good health?
A. Every time it was documented exactly the same way, that they were in good health.
Q. Were you ever asked, or did you ever change the documentation if, in fact, you saw that somebody was not doing well?
A. I did, yes.
Q. Okay. Was that something that you were allowed or you were told to do or was it just something you did?
A. Just something I did.
Q. Did you, in fact, comply with what they were asking you to do in and pre-chart?
A. No, I didn't.
Q. Did that cause trouble for you?
A. Yes. The nurses were continually saying "Hurry up, hurry up." And the doctors were like "Why aren't we ready yet?" So there was a lot of pressure, a lot of frustration in the procedure room because I wouldn't pre-chart.
Q. And was this pervasive amongst the --

during the time around the people that you were working with --
A. Yes.
Q. -- that this was going on?
Did you ever get the impression that just what was happening with you was an isolated thing, and this was not happening elsewhere in the practice?
A. No, I felt it was general to the practice.
Q. Did you ever see Desai?
A. No, I didn't.
Q. So during the three days that you're there, you didn't work with him as a doctor during any of these procedures?
A. No, I never saw him.
Q. Never interviewed with him?
A. No.
Q. When you left, did you see him?
A. No.
Q. So this whole operation, the way you described it, was able to run without him being present?
A. Yes.
Q. Do you know if vital signs at any time would be faked on charts?
A. No, I don't recall any of that.

Q. You had said that people were described as being happy or being healthy, everybody was supposed to be in good condition, things like that, correct?
A. Correct.
Q. Do you recall having an interview with the police?
A. Yes, I do.
Q. Was that interview taped?
A. Yes, it was.
Q. Was that interview provided to you in advance of this testimony today so that you could review it?
A. Yes, it was.
Q. I'm showing you what has been -- I think the front page of it. It's not an exhibit. The front page of it bears your name; is that correct?
A. Yes.
Q. And the date of the 29th of May of 2008?
A. Yes.
Q. Does that look like the transcription of the -- not the testimony but the statement that you gave to the police?
A. Yes, it does.
Q. I'm going to ask you to — or ask you to review page 8, the bottom of it. When you're done, let

me know. Just turn that over, give it back to me, and then I'll ask you if that refreshes your memory as to the issue regarding vital signs.
A. Okay.
Q. Okay. Does that refresh your memory?
A. Yes, it does.
Q. I'll ask you the question again. Were you aware of or told to document fake vital signs on patients?
A. No.
Q. Do you see what the words were there and asked? Can you explain what you meant by that?
A. Sure. I was responding yes to the second portion where he asked if the patient was bluish.
Q. Okay. What you're talking about is the condition of the patient?
A. The condition of the patient.
Q. So not vital signs?
A. Right.
Q. So with regard to that, were you told -- what were you told to do as far as charting the patient then in a situation like that where the patient came in and they weren't happy, healthy, and doing well?
A. I'm not understanding.
Q. Well, if you had a patient come in, you

said that you would -- you would actually do your own thing. You would re-chart or fix the chart so that it would reflect that.

But were you ever instructed on what to do in a situation like that?

A. No, I wasn't.

Q. So you just -- that everybody's supposed to be in good shape?

A. Right.

Q. Now, as far as propofol, let me ask you some questions about that. And, actually, let me go back just a minute and ask you some things about some safety issues.

Did you have, beside that whole pre-charting thing, did you have any concerns about safety issues within the practice, the things that you saw in your limited three days you were there?

A. At the time, I didn't.

Q. Was there anything about the speed of the procedures or the volume of procedures that were being done?

A. Yes. I did have some concern about that. People were going in pretty rapidly. It seemed like sometimes seven minutes' time would pass and the procedure would be over. I wouldn't be done charting,

and they would be moving another patient in the room.

Q. Now, the CRNA that was present, the person giving the anesthesia, did you ever see that person get up and walk out and administer to the patients out in the recovery area?

A. I saw them leave the procedure room, yes. I didn't have a view of the recovery area.

Q. Okay. Would they leave after every single patient?

A. No.

Q. How often would they leave and why, if you know?

A. I don't know how often they would leave or why.

Q. Were they in the room more often than not? I mean how was it going? Did they reside in the room most of the time, or did they get up and leave after every patient?

A. The majority of the time they would stay in the room a nd would not leave. Occasionally, they would leave for about 30 seconds at a time maybe.

Q. Was there ever an incident that you recall regarding a scope, a special request for a scope?

A. Yes, there was a doctor who was requesting a special type of scope. And from the room where the

scopes are being cleaned, somebody said that scope is not ready.

Q. Okay.

A. And then all of a sudden that scope came out, and it was handed to the doctor.

Q. Did that give you concern at the time?

A. It did because I wondered how it wasn't ready and then all of a sudden it was ready.

Q. Did you know that there was a specific amount of time that was needed to process the scopes after they had been used?

A. I'm not aware of the length of time, no.

Q. But that there was some time?

A. There is some time.

Q. Now, let's move on to the issue of propofol. You're familiar with that drug, I assume, or at least it's used at that time in the facility?

A. Yes.

Q. Did you notice how propofol was used at that facility when you were in the room?

A. I did. There were roughly two vials of it at any given time. They were in a drawer. The doctor would pull them out. I mean, sorry, not the doctor. The CRNA would take them out and draw from the two vials at any given time.

Q. Would that -- would there be a vial maybe or two left on the table when a patient was moved out of the room and a new patient was moved in?

A. Yeah, the same two vials.

Q. Okay. Would you see those subsequent vials being used on another patient?

A. Yes.

Q. Not the subsequent vials, but the vials that remained used on a subsequent patient?

A. Right.

Q. Did you see them being drawn up individually out of different vials for the same syringe, so to speak?

A. I didn't see the syringe actually taking from the propofol, but I know that at any given time there were only two vials that were being drawn from.

Q. Did you see the new ones being opened up periodically or not?

A. No.

Q. Do you remember the sizes of the bottles that were up there?

A. I could show with my hand I guess the size. I'm not sure of the milligrams or anything.

Q. Okay. Just were they big bottles or small bottles?

A. They were larger, yes.
Q. Now, as far as the multiple patients, multiple use of propofol, you actually saw this, right?
A. Yes.
Q. What about syringe reuse, did you ever see syringes being used on more than one patient?
A. No, I couldn't see the syringe use, how they CRNA was using the syringes.
Q. Is that because of your positioning in the room?
A. Yeah, because of my position.
Q. So you're still in the room, you're doing your charting. Did you ever see the CRNAs move from room to room?
A. At lunchtime they would switch from one room to another to fill in for each other.
Q. Did you ever see the CRNAs leave the room when a patient was unconscious?
A. I did.
Q. Was the doctor still in the room at this point or was nobody in the room beside you?
A. The doctor was there.
Q. So the CRNA might leave the room. Was he gone for a very short time or for a longer time?
A. About 30 seconds.

Q. Then would come back?
A. Yes.
Q. Did you ever see when the CRNAs moved from room to room for lunch or whatever that they carried anything with them, syringes, propofol, anything like that?
A. No, I didn't see that.
Q. Okay. What was your concern -- what was your sort of observation about the cleanliness and sanitation of the rooms?
A. There was no cleaning crew between the procedures. One person would -- one patient would come in, the procedure would be done, then the patient would be taken out and someone else would be brought in without the room being cleaned.
Q. What about the table that the patient had been lying on having the procedure? Were they wiped down and cleaned?
A. They had their own individual gurneys that we brought in, individual bed. They would already start on the bed and then that would be brought in. Then that would be wheeled out, so they would be on the same bed the whole time.
Q. Okay.
A. Now, when we had spare time, the nurses

were training me to try to clean the rails on the beds to, you know, just for cleanliness.
Q. Did you have a lot of spare time?
A. No.
Q. Now, after you left the facility, and did you leave the facility because of the things we've described?
A. Yes, I did.
Q. When you left the facility, did you tell anybody about this or try to?
A. In my resignation letter, I specified why I was leaving.
Q. So the resignation letter to the facility?
A. Yes.
Q. Who was that addressed to?
A. Katie Maley.
Q. You specifically mentioned this pre-charting stuff that was a concern?
A. Yes, I did.
Q. Ever get a response back from them?
A. No.
Q. Did anybody ever call you up to even talk to you about trying to come back or anything?
A. No.
Q. After you sent the -- or put that

information in the resignation letter, did you ever try and tell anybody else?
A. Yes, I reported it to the State Board of Nursing.
Q. And what happened with that?
A. I was told that I had to specifically pick a certain nurse that was doing it.
MR. STAUDAHER: And I'm going to caution the Grand Jury, that statement is not being offered for the truth of the matter, just for what happens next and why.
BY MR. STAUDAHER:
Q. Go ahead.
A. And at the time, we only knew each other by first names, that's how we worked together. You know, it was Jane or Bob, so I didn't know the nurses' last names. There was no way to specifically pick a nurse to report to the State Board of Nursing.
Q. So because you didn't have a name to report to them, is that why it didn't go any further than that?
A. Right. They said they couldn't process it any further without somebody to point a finger at.
Q. Okay. Did you ever follow-up after that or not?

A. I sent a couple emails saying that this was a practice that was occurring there and hopefully that someone would follow-up with it.

Q. And just so I'm clear, you're there during, I think it was -- what was the date that -- you said it was in January, or excuse me, July, right around the Fourth of July?

A. Right.

Q. Of 2007?

A. Right.

Q. Okay. So on July 25th, you actually weren't there, though?

A. Right.

Q. Now, as far as the postoperative area, did you ever see doctors in there seeing the patients or taking care of the patients out there?

A. I didn't see it, no.

Q. Did you ever see that there was any changes in paperwork if a biopsy was done, for example?

A. During a procedure, a doctor would be possibly looking at a biopsy, and then they might discover something else going on with the patient, and we would have to change some paperwork to update the condition, say there was a mal polyp that they had discovered, so then the paperwork would change to

document the polyp.

Q. So that's a time when it might change?

A. Yes.

Q. As far as the change, who would do that? Would that be something you were supposed to do or what?

A. Yes, the doctor would say, "Okay, now we have a polyp," and then we would have to pull out specific paperwork and start completing that.

Q. Now, walk me through, just if you would, you're sitting in the room before the patient actually rolls in. Let's say the patient you just have done a procedure on has just left the room. CRNA still present in the room, right? Is that correct?

A. Yes.

Q. Did the doctor walk out or would the doctor have still been hanging around at that point?

A. The doctor is still there.

Q. Okay. And you're there?

A. Yes.

Q. Is there a tech there also? Somebody helping the doctor with the scopes, or did they already take the scope away?

A. I don't recall.

Q. Okay. So roughly the three of you are

still there?

A. Yes.

Q. What was the process at that point until the next patient actually was wheeled out of the door? Kind of walk us through it. What you would do? When the patient would come in, what would happen? Just kind of tell us what would happen.

A. The patient would come in, and we would document their condition and find out who their family physician was so we could send them the information on their records.

Ask the patient their name, of course, how they were feeling. If they're anxious. Set up -- start charting like the time that the patient had entered the room.

Then, you know, the doctor would come in and the anesthesiologist would be there, and he would start to put the patient under, and then we would document on how the patient was doing.

And then that was about it. And then when the procedure was done, we would document the time that it's over.

Q. Now, as far as the procedure itself, procedure times and so forth like that, was there any issue about being careful about over — you know, the

times that you were documenting, not overlapping with other patients?

A. Right. With the pre-charting issue, we would have the situation where, let's say that it's 9:45. The procedure isn't supposed to start until 10:19 and you already have the chart. That -- it's 9:45 now, but make sure you write 10:00 so that you're not documenting on what the previous nurse

MR. STAUDAHER: Now, again, I caution the Grand Jury about that.

BY MR. STAUDAHER:

Q. Did this statement, the way that they were describing this, and how to handle that, did that have an affect on you as far as what you're doing and whether that's proper or not?

A. Yes, it did.

Q. And, obviously, gave you concern, I assume; is that correct?

A. Right.

Q. Okay.

MR. STAUDAHER: With that, ladies and gentlemen, that statement is being offered for the effect on this listener as to how she's supposed to do her job and the issues that that may have caused with her, you know, mentally and emotionally at the time.

BY MR. STAUDAHER:

Q. So if you're being told to do that, you're given specifics on how not to overlap patients essentially, correct?

A. Yes.

Q. Now if I understand you correctly, you have a -- and I just want to walk through this so I understand it. You have a patient that, let's say, the information you're getting from the pre-procedure room has a time on it of say 10:00 o'clock. And it currently in your room is 9:45.

A. Yes.

Q. In that situation, you're still writing something down on the chart, correct?

A. Encouraged to, yes.

Q. Okay. Encouraged to.

What are you -- how are you supposed to handle that situation if the times on the chart at the point you get it says 10:00 o'clock and you know that it's not 10:00 o'clock yet, what do you do?

A. I refused to write the incorrect time.

Q. What were you supposed to do based on the policy or what was going on at the time?

A. Based on what I was encouraged to do, I should have written 10:00 o'clock when it was 9:45 to

be able to start the chart earlier.

Q. So you would match whatever the time was coming in or put it a little bit, few minutes ahead?

A. Yeah, make sure that the times don't overlap. Excuse me. Like if it's 9:45 and that nurse previously is still working on the chart, make sure that you give enough leeway so that by the time the patient gets into your room you've documented the correct time.

Q. Now, I want to be clear on this. Desai is not standing there during this process, correct?

A. Right.

Q. All of this is going on, all of these people are doing all of this stuff without him being present?

A. Right.

Q. Now, at the point that that level of deception is going on, I mean, are you telling people about this, saying "I'm not going to do this," or at least expressing some concern and about that issue?

A. I was a new nurse, and I was anxious. I wasn't sure of how procedures were done like that. I thought it was maybe just how this particular office did it, but I expressed that I wasn't going to do it improperly.

Q. You're there three days during July. Do you see that happen on all those days?

A. Yes.

Q. Do you see it happen more than once on all those days?

A. Yes.

Q. Did it appear to be a regular thing on each day you were there?

A. Yes.

Q. Was there ever any issue of the pre-charting thing and overlapping of times related to specific insurance companies, like Pacific Care, for example?

A. No.

Q. Just in general this is the way you did it?

A. Right.

Q. As far as the times that were in the room that you -- or times that you were supposed to document, what times in the record were you supposed to document?

I mean, I assume there is a place in the chart or the record where a patient comes in and you're supposed to write down when the patient is in the room, when the patient is out of the room, various things

during the process?

A. Uh-huh.

Q. Are you the one responsible to put all that information in at the time?

A. Yes, I am.

Q. Now, beside you doing your work, does the doctor do things with his record as well?

A. Yes.

Q. Does the anesthesia or anesthesia person do things with their record?

A. Yes.

Q. Are there machine tapes and things that are handed to you that have times and things stamped on them?

A. Yes.

Q. Did you ever look at all those times?

A. No.

Q. So you don't know if they were all the same time or if they were all different?

A. Right.

Q. Would it surprise you to find out that they were all different times?

A. It would not surprise me.

Q. Did you ever have a situation occur where you saw patients waking up prematurely on the table?

A. Yes, I did.
Q. Was that something that happened on infrequent or frequent basis?
A. Infrequent.
Q. Okay. How often did you see that while you were there?
A. I would say twice.
Q. And that's during three days?
A. Yes.
Q. And you had a regular shift?
A. Yes.
Q. And what was happening during those instances?
A. The patient would have been administered the propofol. And the procedure would have almost started or started, and the patient would sit up during the procedure. And I would ask the nurse training me is that normal and she said yes, that happens, sometimes people will sit up during the procedure and not know it.
Q. Okay. Did it kind of startle you when that happened?
A. Yes, it did.
MR. STAUDAHER: Again, that statement is offered for the effect on the listener at this time,

not offered for the truth of the matter.
At this stage, I have nothing further for this witness.
THE FOREPERSON: Are there any questions from the jury? None at this time?
A JUROR: I have one.
You talk about this 9:45, 10:00 o'clock. If the procedures stopped at 9:45, were you ever told to put down 10:00 o'clock?
THE WITNESS: No.
A JUROR: So you were never told to lengthen the procedure?
THE WITNESS: No. Not ever to lengthen it.
THE FOREPERSON: Any further questions? None.
By law these proceedings are secret. You are prohibited from disclosing to anyone anything that transpired before us, including evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury, or information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In

addition, you may be held in contempt of court punishable by an additional $500 fine, and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: Yes, I do.
THE FOREPERSON: Thank you. You can be excused.
Okay. At this time, I would like to call for our lunch break, please, for an hour and a half.
MR. STAUDAHER: I have three more witnesses here right now. We can just keep going if you would like.
(A lunch recess was taken.)
THE FOREPERSON: Sir, can you raise your right hand, please? Thank you.
Do you solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: Yes.
THE FOREPERSON: Thank you. You may be seated.
You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of

persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman, and Keith H. Mathahs.
Do you understand this advisement?
THE WITNESS: Yes.
THE FOREPERSON: Could you please state both your first and last names and spell them for the record.
THE WITNESS: My first name is Vincent, V-I-N-C-E-N-T. My last name is Sagendorf, S-A-G-E-N-D-O-R-F.
THE FOREPERSON: Thank you.

VINCENT SAGENDORF,
having been first duly sworn by the Foreperson of the Grand Jury to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:
Q. Mr. Sagendorf, what do you do for a living?
A. I'm a certified registered nurse anesthetist.

Q. And what do you do as a nurse anesthetist?
A. I administer anesthesia to patients who are having surgery or procedures.
Q. Can you give us a brief synopsis of your background and training?
A. I went to Middlesex County College in New Jersey for my RN. I went to Jersey Shore Medical Center Hospital in 1970 for my CRNA for my anesthesia training. I graduated in 1972, took my boards and came to California.
Q. Okay. And you eventually got to Las Vegas?
A. Yes.
Q. And how was that? Not by car or boat or whatever.
A. I had worked in San Luis Obispo for approximately 36 years. My wife and I were looking for a place to retire so we thought we would take a look at Las Vegas, so I quit my job in California. I came out here. I got an apartment, and I started working for Gastroenterology of Nevada.
MR. STAUDAHER: And can everybody hear this witness?
THE FOREPERSON: Yes.

BY MR. STAUDAHER:
Q. Sir, now you -- that was your first job that you had when you came to Las Vegas then is the Gastroenterology Center?
A. Yes.
Q. And who was the individual who was in charge of that center at the time?
A. Desai.
Q. Is that Dipak Desai?
A. Dipak Desai. I'm sorry.
Q. And as far as your -- let's just touch on your background just one minute for just a -- or just a second.
A. Okay.
Q. You said that you're a nurse primarily by training at one point, and then you went and later got your anesthesia portion of that, or was it one program altogether?
A. No, it was two programs, but I immediately went from the nursing program to the anesthesia program.
Q. The anesthesia program itself, how long is that?
A. Two years.
Q. The program that you -- is it all focused

specifically on anesthesia?
A. Yes.
Q. Do you work in a hospital or some sort of setting where you're giving anesthesia to patients during that time?
A. Yes, hospital.
Q. Do you do any kind of apprentice program afterward or are you able to just go to work?
A. No, you have to take boards. And if you pass boards, you get to practice anesthesia.
Q. Now, when you go to facilities, and I assume you can practice in hospitals and clinics and things like that if you need to; is that correct?
A. Yes.
Q. Do you work with any other physicians when you perform your services?
A. Not necessarily.
Q. So you can independently perform anesthesia services?
A. Yes. As long as there is a physician or a dentist there.
Q. Okay. And I guess that's what I meant, not necessarily an anesthesia doctor --
A. Right.
Q. -- but an MD or something --

A. Right.
Q. -- or dentist, at least in the facility doing the procedure with you?
A. Right.
Q. So if I understand you correctly, you would not just be able to go set up shop on Las Vegas Boulevard and give anesthesia to Michael Jackson or anybody else that came by?
A. No. Good name, but no.
Q. Okay. As far as this particular case is concerned, I know that you're familiar with the circumstances surrounding the endoscopy matter; is that correct?
A. Yes.
Q. With regard to your time with Dr. Desai when you first came to work here, when was that again?
A. I started October 1, 2007.
Q. And how long did you work at that facility?
A. The facility closed March 4 of 2008. I was paid through April the 25th of 2008.
Q. So you -- did you stay in town or did you leave at that point?
A. Well, I had a seven-month lease on the apartment so I went back and forth to California.

Q. Okay. And is that where you currently live is in California?
A. Yes.
Q. Are you performing anesthesia services in California?
A. Yes.
Q. Where do you work currently?
A. I work at Pain Management Specialists in San Luis Obispo and in Santa Maria, California.
Q. Do you work with physicians in that location --
A. Yes.
Q. -- or those locations? I guess you said two, correct?
A. Two.
Q. Now, as far as the time that you were with Desai, that period --
A. Uh-huh.
Q. And when I say Desai, I'm talking about the Endoscopy Center.
A. Right.
Q. He had a number of clinics in town, did he not?
A. Yes.
Q. And did you work at all of them or just

one or two or ...
A. I was mainly at Shadow, but I did get to Burnham, and then there was one over on Flamingo that they opened just before we were closed up, and I don't remember the name of it.
Q. Okay. But, primarily, you were working at the Shadow Lane clinic?
A. Yes.
Q. Now, at the Shadow Lane clinic, what were your job duties exactly?
A. Just to put the endoscopy patients to sleep -- the colonoscopies and the endoscopies.
Q. Beside doing the anesthesia portion, did you do any nursing functions as well?
A. No.
Q. Just anesthesia?
A. Just anesthesia.
Q. At any time after you came to the clinic, did you work with an anesthesiologist, an MD anesthesiologist at the time?
A. Never.
Q. Did you work with MD physicians that were in the practice, the gastroenterologists?
A. Yes.
Q. Were they the only physicians that you

worked with in the practice?
A. Yes.
Q. Were there specific physicians that you worked with more than others?
A. Yes.
Q. And who were they?
A. Dr. Carrol, Dr. Faris, and Dr. Carrera.
Q. Now, did you work with other physicians within the practice beside those three?
A. Yes, Dr. McCurdy, Dr. Sharma and Dr. -- I forget his name. It starts with a Y, so ...
Q. Y?
A. Yeah.
Q. Okay. Did you ever work with Dr. Desai?
A. I worked with Dr. Desai a few times, maybe half a dozen to a dozen times.
Q. So, primarily, when you were at the facility, he either was not there or there infrequently or how -- or how did that work?
A. When I first got there, he was recovering from what was supposed to be a stroke. And so we didn't see him for the first two or two-and-a-half months.
And then he came in, and he wanted to see if he still had the hands to do the endoscopies so he

had Dr. Carrol come in the room with him. I happened to be there and he did one colonoscopy.
Q. How did that go?
A. It went okay.
Q. So he seemed to be functional and able to do that work?
A. Uh-huh.
Q. Any problems associated with the procedure?
A. No.
Q. Now, as far as the procedures that followed after that, was he then back at full strength or was he doing work intermittently?
A. Intermittently.
Q. Now, prior to his return to the clinic, had you noticed that there was any kind of a volume decrease at the clinic?
A. No.
Q. So when you start, when you were working with him, when did you start working in proximity to when he had his stroke?
A. Well, I don't know exactly when he had his stroke. He was out of the country, but he came back like two-and-a-half months after I got there. We had the same volume of patients from day one that I got

there.
Q. After he comes back fully into the practice which happens at a later date; is that correct?
A. Uh-huh.
Q. Did you notice that the patient load increased?
A. No.
Q. So from your standpoint, it was always about the same?
A. Yes.
Q. Now, did you work full time at the Shadow Lane clinic primarily?
A. Yes.
Q. When you were working at the clinic, were there other certified nurse anesthetists that worked at the clinic as well?
A. Yes.
Q. Did you work with all of them or just a few?
A. Eventually I worked with all of them, but mainly with Keith Mathahs and Linda Hubbard.
Q. Was there a supervisor amongst the anesthesia individuals?
A. When I first got there, it was Ron

Lakeman, but he left two weeks after I got there or approximately two weeks after I got there, and then it fell to Keith Mathahs.
Q. And, again, I know you told me this already, but could you tell me once again the date that you actually arrived in October?
A. October 1 of 2007.
Q. Now, you're aware that as part of this case that there were two specific incident days on July 25th of 2007 and September 21st of 2007?
A. I wasn't aware of the July one but now I am.
Q. Well, if I represent that to you, at either of those two dates, I know that you didn't start work, but had you visited the clinic and done any locum tenens work or anything like that at that time?
A. I visited the clinic to apply for the job, but I had never done any locum tenens or done any anesthesia until October 1 of 2007.
Q. So, basically, the questions that I have will be from that short period from October through the time that you left the clinic the following year, mid year, so you're only working at the clinic for half a year roughly?
A. Five months.

Q. Five months.
A. Yeah.
Q. Now, during the time you were with the clinic, did you -- when you came to work there, who did you interview with?
A. Tonya Rushing.
Q. Did you ever interview with Dr. Desai at any point?
A. I did. After I interviewed with Tonya Rushing, she told me to go down and talk with Dr. Desai so Ron Lakeman took me down there.
Dr. Desai asked me if, you know, I had used propofol before, and I told him I was working in a pain center where we did approximately five to 10,000 cases since I was there for 10 years, 11 years. And he said the job is yours, and that was the end of the interview.
Q. So when he found out that you used propofol, he hired you on the spot?
A. Yeah.
Q. Okay. As far as the use of propofol, I am assuming you're familiar with the drug; is that correct?
A. Yes.
Q. Had you used it many, many times in the

past over those years?
A. Yeah. I work in a pain center again, and when I worked at Desai's, I did 3600 cases, which is in the report, and I have been doing 70 cases a week since I went back. So I'm constantly using propofol every day.
Q. And I assume you're aware that the package insert on the medication has some wording as to whether it's single use or multi use; is that right?
A. Yes.
Q. And what is your understanding as to whether it's a single --
A. It says single use.
Q. And just for the -- I know that you're being -- trying to answer the questions, but for the court reporter, who is sitting here taking down all the words, if you'll let me finish my question before you answer --
A. Okay.
Q. -- I'll try to do the same thing for you.
A. Okay. I'm sorry.
Q. It just makes it harder for her to take down everything if we're talking over each other.
A. I'm sorry.
Q. Okay. Now, single use only, I think you

said, for that drug?
A. Yes.
Q. The label actually says that on the package or on the bottles in which they're contained?
A. Yes.
Q. As far as that drug is concerned, was there any other -- I mean, I know that that was the primary drug that you used in the facility, and I'm talking about the Shadow Lane clinic that you worked primarily with; is that right?
A. Yes.
Q. Were there other drugs used for anesthesia at that location?
A. For the rare patient who would be allergic to eggs or lecithin or sulfa, not so much sulfa but the eggs, if there was a patient who was highly allergic to eggs, we would have to use something different besides propofol, and so we had some Versed and Fentanyl there that we would use in lieu of it.
Q. And you said that Keith Mathahs was kind of in charge of the CRNAs at the time at least that you were working there?
A. Yes.
Q. And that Mr. Lakeman, I think, had been the one in charge prior to that time?

A. Yes.
Q. Now, let me ask you a couple questions about just the process by which the procedure got done at the facility or was done.
Where typically would you stay in the facility? Would you be in the room where the procedure was done primarily, or would you circulate? How did you interact at the facility?
A. I would circulate until the patient was rolling into the room. Then I would be in the room.
Q. Okay. Now, in the -- during the day, there were lots of patients that came through, were there not?
A. Yes.
Q. Once the patient started rolling through, did you primarily stay in the room and just administer to the patients that came in and then after they left the next patient that came in after that?
A. Yes.
Q. Did you ever go out to the recovery area and follow patients out there and take care of them out there?
A. Yes, I would try and see most of my patients. At least I would walk by and look behind the curtain and see, make sure they are doing okay.

Q. Okay. Now, was this primarily every time a patient left, or would this be periodically walking out to try and check on some of the patients?
A. Just periodically walking out to check on the patients.
Q. So is it fair to say that primarily your time was spent in the room?
A. Yes.
Q. Now, as far as the procedure itself was concerned, tell me how you did a procedure, I mean from the anesthesia side.
You've got a patient that is about to, let's say, either is the first patient of the day just rolling into the room, or the last patient you have just done has left the room and they are about to bring that next patient in.
Tell me what happens from your side.
A. Okay. I would usually fill two syringes, one with propofol and Xylocaine and one with just propofol because propofol by itself is acidic, and it hurts a lot when you inject it into a patient's vein, so we would add the Xylocaine to cut down the amount of pain.
If I had the time, I would go out and talk to the patient and try and get a part of the history

and physical done in the PI or actually the bed's across from the door.
Q. Okay. And a PI is what?
A. Preinduction room.
Q. Induction meaning anesthesia?
A. Yes.
Q. So the area where the patients are held before they are brought to you?
A. It served both as preinduction and recovery.
Q. Oh, same area?
A. Okay. Our door was here and eight feet away were six beds.
Q. Okay. And here you, just for the record, you kind of motioned in reference to closer to this person, and then the area that you -- that the patients were coming from and going to was a few feet away, eight or so feet away?
A. Yes.
Q. Is that correct?
A. Yes.
Q. Now, the patients come into the room, into the procedure room from that area?
A. Yes.
Q. Once the patient gets into the room, what

do you do, besides drawing up those two syringes?

A. We place the patient on the table, and the physician necessary for the procedure, being an endo, they would be sitting up. Or being a colonoscopy, they would be lateral, on their side, usually on their right side.

And I would put -- they would put the blood pressure cup on, EKG leads, o2 sat monitor, and then I would wait for the doctor to come in the room and I would take and give the propofol.

Q. Would you ever go ahead and start the propofol before the physician got into the room?

A. Not usually.

Q. Was there ever situations where you maybe started anesthesia and the physician left the room for some reason?

A. Yes. And as I told you, that's a little different than what I had said in there.

Q. And, again, for the record, what are you referring to, your statement to the police?

A. My statement to the police.

Q. Okay.

A. In reflection, there were a couple of instances when Dr. Carrol would be in the room and I would start the anesthetic. I would turn around and he

would be gone.

I would say, "Where is Dr. Carrol?" And the nurses would usually say, "Well, he had a meeting with Dr. Desai." And I'd say, "So when was somebody going to tell me this?" And I would say, "Go get him. I have a patient asleep on the table."

MR. STAUDAHER: And, again, ladies and gentlemen, none of that is offered for the truth of the matter, just to answer the question about why he did what he did at this point.

BY MR. STAUDAHER:

Q. So that's a correction to the statement that you made to the police?

A. Exactly.

Q. Any other issues regarding that particular statement?

A. No.

Q. Okay. And you don't have in front of you at the moment as you're testifying your statement sitting in front of you referring to it?

A. No.

Q. If you need to look at that statement to refresh your memory at any time during this proceeding, just let me know and I can provide it to you. Okay?

A. Okay.

Q. Now, patient in the room, positioned, you're ready to give anesthesia, waiting for the doctor. Are you with me?

A. Right.

Q. What is the next thing that happens? Doctor comes in the room, and then what goes on?

A. He usually types in a few things into the computer, and then he goes ahead and starts the procedure.

Q. What -- as far as the bottles of propofol that you were using, do you remember the sizes that you were using at that time?

A. It was either 20s or 50s. It depended on the cost at the time.

Q. Did you use predominantly one versus the other?

A. Predominantly 50s.

Q. So let's say you have a 50cc syringe --

A. They're not syringe, but a bottle of propofol.

Q. Right.

Open that up, draw out your syringes.

A. Uh-huh.

Q. They're not drawn up, your syringes, both of them; is that correct?

A. Uh-huh.

Q. Now, at any time, would you use, in doing that, a syringe that you had used on a prior patient?

A. No.

Q. Would at times you use the same syringe on the same patient?

A. No.

Q. So you always got rid of the syringes?

A. Yes.

Q. Was that a general practice or your specific practice?

A. It's supposed to be general practice.

Q. Was it your specific practice?

A. It was my specific practice.

Q. Now, once the syringes are drawn up, though, obviously if you're using a 50, I mean what size syringes are these?

A. These are 10cc syringes.

Q. So there is approximately 30cc's left in the bottle?

A. Yes.

Q. Now, at that point, it's clean?

A. It's still sterile.

Q. You could potentially use it on this patient again?

A. Yes.
Q. Could you use it on another patient?
A. Yes.
Q. Did you do that?
A. Yes.
Q. Now, before we get to that, let's stick with where we're at with the patient rolling in the room. You have two syringes drawn up. Doctor's ready to start the procedure. What do you do?
A. I take -- pick up the syringe with the Xylocaine, I give that, usually the 10cc's, depending on the ability of the patient. Older patients receive less. Alcoholic patients receive more just depending on how their reaction was to the drug.
And then I would take that syringe, put it in the sharps container, take the next syringe, uncap it, and put it into the line.
Q. So when you say put it into the line, are we talking about like one of the heplocks that are --
A. Yes.
Q. -- at the IV access ports?
A. Yes.
Q. And, again, if you can wait until I'm done --
A. I'm sorry.

Q. -- just to make it a little easier.
You say that you would hook it up to that port, or would it be, a needle be penetrating the actual port itself?
A. Yes.
Q. So if I understand you correctly, I have a picture in my mind of a patient with a heplock in a vein and the procedure beginning and you taking the second syringe with the needle on it and basically inserting it into the heplock; is that correct?
A. Yes.
Q. So now the syringe is connected to the patient?
A. Yes.
Q. Once that is done, I assume as the patient needs additional anesthesia would you give some?
A. Yes.
Q. So you monitor the patient for their needs and do that?
A. Exactly.
Q. At the end of the procedure, if you hadn't given all of the propofol in that particular syringe, what would you do with the syringe?
A. I would take it out of the line, I would squirt the remainder into the garbage can and put the

needle and the syringe in the trash container.
Q. Okay. Would you ever, after that had been connected up like that to the patient, take the syringe out with propofol in it or empty, remove the needle, put a new needle on it, and re-enter the propofol container?
A. Never.
Q. Why would you never do that?
A. Because you don't know what's -- what's happening with that out of the -- that syringe out of the patient. You don't want to cross contaminate anything.
And if you're going to use that method, blood is drawn up into the old -- to the syringe, so you could contaminate. If you have to go back and get more propofol, and you're not using the sterile syringe, which I always did, you would contaminate the propofol.
Q. So you saw that there was at least a risk of that happening; is that correct?
A. Yes.
Q. Now, were you told by anyone to reuse syringes?
A. Never.
Q. And you did not do that as part of your

practice I think you said?
A. Right.
Q. Now, you've left now, the patient is done. Let's say that you've either wasted the remainder of the propofol and the one syringe where you've used it, and those syringes are discarded?
A. Uh-huh.
Q. Patient leaves the room. And you have a bottle, a 50cc bottle that has roughly 30cc's remaining, correct?
A. Yes.
Q. New patient is rolled into the room. What do you do?
A. I draw up two more syringes of propofol, one with Xylocaine, from that bottle because it's still sterile with two sterile syringes and needles and proceed.
Q. Okay. Was that common practice to continue to use the propofol until it was gone on the next -- on subsequent patients?
A. Every place I have been, yes.
Q. Including this clinic?
A. Yes.
Q. Now, the practice that you described, the technique that you used, would that be termed a septic

technique?
A. Yes.
Q. No cross contamination possibility based on the way you did it I think?
A. Right.
Q. If somebody had done what I described earlier, hypothetically, removed a syringe and potentially -- and put that syringe with a new needle or not into the propofol bottle and drawn up a new syringe, would that, even for use on the same patient, could that bottle be contaminated?
A. Yes.
Q. Possibly contaminated?
A. Yes.
Q. If you had ever done something like that, would you have used that propofol on a subsequent patient?
A. No.
Q. Would that be the appropriate method of dealing with that situation?
A. You should never try -- you never cross contaminate anybody.
Q. Now, were you told to reuse propofol on subsequent patients?
A. Yes.

Q. And who told you that?
A. Mr. Mathahs.
Q. Specifically?
A. Well, he told me that that was Dr. Desai's order.
Q. And did you try to carry out that order?
A. Not always.
Q. When would you not carry it out?
A. Well, if I had a hepatitis patient or an HIV patient, I would throw everything away that I had.
Q. So would there be times that you would actually know that you had a patient like that?
A. Oh, yes. Because you knew the history and physical on them.
Q. So they would tell you that they had those conditions?
A. Yes.
Q. Were there situations in which the clinic doctors were actually treating patients for conditions like Hepatitis C that came in for procedures?
A. No.
Q. That you were aware of anyway?
A. Well, we just did them one time for a colonoscopy or upper endoscopy. The liver situation was treated by somebody else.

Q. Do you know, in fact, if any of the clinic doctors treated those kinds of conditions on patients?
A. I don't know.
Q. So it's possible that they did that?
A. Yes.
Q. Now --
A. Can I make a point?
Q. Certainly.
A. None of the other doctors cared whether you kept or threw away the propofol, only Dr. Desai.
Q. How do you know that?
A. Because they never said a word to me, and I would throw it away. So I just assumed that he was -- he was -- that was something that they weren't going to pay attention to.
Q. So they never mentioned it to you, and they don't object when you throw it away?
A. No.
Q. Did you throw it away when he was around?
A. When he would leave the room.
Q. Okay. Did he ever talk to you about that or admonish you about throwing away propofol?
A. No.
Q. Did he even know that you were doing it?
A. No.

Q. Now, we talked already about the bottles being labeled as single use?
A. Yes.
Q. Do you know if you ever witnessed or were involved with propofol being moved from room to room at any time during the days?
A. Usually at the end of the day, if one of the other practitioners would usually have bottles partially filled with propofol, and she would bring them over and lay them on my counter and say, you know, "If you have another patient, you can use these."
And I would usually ask the nurse for another clean bottle of propofol, and I would throw all those away because I don't draw out from bottles that I didn't draw from in the first place, and I don't give anything I haven't drawn up personally.
Q. Did you see that that happened on a few occasions at least?
A. No.
Q. As far as you just mentioned that sometimes they would bring those bottles --
A. Oh, they would bring the bottles to me, but I never saw anybody use those bottles.
Q. My point is, did you see the propofol from one room was at least brought to another room?

A. Yes.
Q. Okay. Did that happen on more than one occasion?
A. Yes.
Q. And but you said you would never use that?
A. No. If I don't draw it up, I don't give it.
Q. As far as the lunch breaks and any other break that you might give to a fellow CRNA, go into their room, were there times when you did that that you walked into the room and saw propofol syringes drawn up or open bottles of propofol?
A. Yes.
Q. In situations like that, would you use those open bottles of propofol or syringes to administer anesthesia to a patient?
A. No.
Q. Did you always start fresh with your own stuff if you were there?
A. Yes.
Q. Did you have a discussion with Mr. Mathahs about not throwing away propofol on more than one occasion?
A. No.
Q. So he told you that initially?

A. Yes.
Q. Did he indicate what would happen if you didn't try to use all the propofol?
A. Well, his term was that Dr. Desai would have a hissy fit.
Q. Did he tell you why or did you know?
A. Money.
Q. Now, we talked about the lunch issue. I'm going to ask you about some other issues regarding some other items besides propofol.
A. Okay.
Q. Did you ever witness the reuse of bite blocks? And you know what bite blocks are?
A. Yes.
Q. And so you know what they are?
A. Yes.
Q. And did you ever witness the use -- reuse of those items?
A. Yes.
Q. What would happen with those? How would they get reused?
A. Well, they would take them and they would wash them, and I don't know, they may have sterilized them. I don't know that, but they would bring them back in and use them, yeah.

Q. Okay. We're talking about the --
A. Single use bite blocks.
Q. The things that you put around the scope, so that you don't bite the scope?
A. Well, you put it in the mouth. It's got a hole in it. You put the scope in there so the patient can't bite down on the $30,000 scope.
Q. To try to protect the scope then?
A. Yes, but also that protects the teeth, so ...
Q. And then you saw those washed or whatever and processed in some way?
A. They were processed in some way and brought back, yes.
Q. Did you ever see any other items like airway tubes or anything like that reused or washed?
A. Yes. Single use airways were washed and reused.
Q. And what is an airway?
A. Airway is a device that keeps the tongue from falling back and obstructing the trachea. So during a situation where the patient is not breathing on their own, or you have to bag them or whatever with the ambu bag, you put it in the mouth, it keeps the tongue away from the epiglottis, and it also gives you

an airway.
Q. So this is not a tube that goes into the trachea then?
A. No.
Q. This is just one of those little plastic things that keeps the tongue down essentially?
A. Exactly.
Q. Are those really expensive items?
A. No. They are a nickel.
Q. But you guys would rewash and reuse those?
A. Yes.
Q. Was there ever an issue or concern that you had regarding the handling of certain items in the endoscopy suites, such as forceps, anything like that?
A. Yes. The techs tended to not pay attention to what those things were touching, and they may touch the floor, they may drag them across the patient or they may hit me in the head with them.
It's a long, long cable with scissors-type handle, and it goes through the scope. And you can take bites of things and move things out of the way or whatever. And they just -- their sterility technique was questionable.
Q. So you actually saw these things contacting the floor and the various things you talked

about and then being used on a patient?
A. Yeah.
Q. As far as the -- that situation, did you ever try and tell anybody about that or get anything done regarding that issue?
A. I told Mr. Kruger, who was the head nurse.
Q. Okay.
A. And he said he would take care of it.
Q. Well, I was going to say without getting into what he said.
MR. STAUDAHER: And I would ask the Grand Jury to disregard that statement.
BY MR. STAUDAHER:
Q. You at least sought out somebody to take care of that?
A. Yes.
Q. To your knowledge, did the practice change?
A. No.
Q. Now, I'm going to ask you specifically about -- I know that you didn't work extensively with Dr. Desai, but specifically, I want to ask you about any issues you ever had with him with trying to start a procedure before anesthesia was actually on board on a patient?

A. I think two instances for upper endoscopies. I turned around to administer the propofol, and he was already inserting the endoscope into the esophagus.
Q. Did you indicate to him that you hadn't given anesthesia yet?
A. I said, "We're not ready." And he just kept on like I wasn't there so I gave the propofol as fast as I could.
Q. In those instances when you yell out to him what you just said, did he tell you he was just going to go forward anyway I mean or just do it?
A. No, he would just ignore me.
Q. So what was -- how was the patient reacting during these times?
A. The patient was gagging and bucking.
Q. Was he, in those instances, those couple of instances, were they both upper endoscopies you said?
A. Yes.
Q. How long a procedure did that take to do those with the patient bucking and writhing like you said?
A. Well, two or three minutes.
Q. So those would be done within that time

period. Was the patient still writhing or had the anesthesia taken effect by that time?
A. Well, by the last minute, it had worked.
Q. Okay. Now, as far as upper endoscopies are concerned for most of the doctors in the group, I mean what were the average times for doing that? And I'm not talking about Desai or Carrol, who I believe also was pretty fast.
A. Well, if you averaged it out, an endoscopy would be 15 minutes. A colonoscopy would be 20 minutes, tops.
Q. Okay.
A. Except for the slower ones.
Q. And when you say slower ones, are you talking about slower doctors?
A. Slower doctors.
Q. And who were the slower doctors?
A. Dr. Manuel. He was a new physician out of school. He was quite cautious and quite slow. Dr. Faris was another one who was slow. Those are the two slowest.
Q. How did Dr. Carrera fare in that group?
A. He was in the middle.
Q. And then on the faster end, who are we talking about?

A. Dr. Desai and Dr. Carrol.
Q. Who was the fastest in the group?
A. Dr. Desai.
Q. Noticeably faster than the rest?
A. Yes.
Q. For him to do -- and how long did it take? You said the average colonoscopy was around 20 minutes or so?
A. Yes.
Q. How long did it take Dr. Desai to do an average colonoscopy?
A. Six, seven minutes.
Q. What about an upper endoscopy?
A. Minute or two.
Q. Now, did you ever have a situation happen where a patient woke up during the time that the procedure was going on and started having trouble while a procedure was actually happening?
A. Yes.
Q. What happened? What typically would happen?
A. They would either have a spasm because they got light. It looked like the doctor might be finishing, so you would start cutting back on the titration, and they would spasm or just buck a little

bit or move around a little bit, and then we would just give them more propofol.

Q. Now, did you ever have any issues with regard to how patients were moved out of rooms to the recovery area and the way they were positioned out there?

A. I had big situation with that because the protective equipment for the patient is on the far wall. And that means that the oxygen was there, the suction was there, the ambu bag was there.

Q. And what is an ambu bag?

A. Ambu bag is a bag that you see the rescue squads use, you put a mask over it, and then they pump on it --

Q. So it has a portion of the bag that you can squeeze?

A. Right. And you're forcing air up to the lungs.

All that equipment was on the far wall, and they would push the patients in feet fist. So the equipment that was necessary to take care of them if there was a problem was at the other end of the bed and it wouldn't stretch.

So if you had a problem, you would have to pull the patient out, turn the bed around, and shove

the patient back in.

Q. Why didn't they just bring the patients in headfirst to begin with?

A. We're lazy.

Q. Was there -- was speed any portion of that?

A. That was the whole thing.

Q. So was that the resuscitation kind of equipment if there was a problem with the patient that needed help?

A. Yes.

And I made mention of that, and they said that's the way we've always done it.

Q. What about issues regarding suction tubing on canisters and so forth?

A. When I first got there, there were no canisters.

Q. And what are we talking about when we say --

A. Canister is attached to a vacuum and fluid are sucked up out of the patient's pharynx and it goes to this canister, which collects it.

Q. Is that an important thing to have available?

A. It is because it maintains the vacuum for

the suction.

Q. But why is the suction in itself even important --

A. Because the patient may be having a problem with saliva or lauren's spasm or they are bleeding or, you never know, they are vomiting, and you want to get that out of the trachea or out of the posterior pharynx so you need the suction. It's one of the most important pieces of equipment.

Q. So posterior pharynx, just so we're clear, is the back part of the throat; is that right? Is it the back part of the throat?

A. Yes, yes, I'm sorry.

Q. So if fluids or things, whatever, collected in that area, would the potential be to breathe that into your lungs?

A. Yes.

Q. Is that why you would want to try and suck it out?

A. Yes, or they would have a lauren's spasm, which means that the vocal cords clamp together, and then you have to get the ambu bag to breathe for them.

Q. Now, as far as this suction tubing then, you said the canisters didn't even exist when you first got there?

A. They weren't on the wall.

Q. How was it that they later came to be on the wall?

A. Because I insisted.

Q. Now, did they work in that current condition with just being hooked up to the wall?

A. Yeah.

Q. Okay. Were they usable by you at that point?

A. Yes.

Q. Did you require anything else like tubing to utilize them?

A. Yes.

Q. Was there an issue regarding the tubing?

A. Not the tubing on those, but the tubing on the ventilator. The tubing on the ventilator had dry rotted from years of -- we didn't use a ventilator very much, but the tubes were all dry rotted.

And I had noticed that one day and said, "How are you going to use this piece of equipment?" The head nurse said --

Q. And, again, I don't want to get into --

A. Okay.

Q. Who was the head nurse? Was this Mathahs?

A. No.

Q. Who was it?
A. Kruger.
Q. Kruger. Okay. I don't want to get into what he said.
A. Okay.
Q. You pointed it out?
A. Yes.
Q. Was that corrected at some point?
A. Yes.
Q. Okay. Now, after but beside that issue, any other concern you had with regard to how things were done, sterility, cleanliness, anything like that?
A. Well, overall the facility itself was -- sterility wasn't one of the main concerns.
Q. And I guess sterility may not have been because this wasn't necessarily -- colonoscopies aren't a sterile procedure?
A. They are not a sterile procedure, but you can make them clean.
Q. And was the facility clean?
A. Relatively, yes.
Q. Were there any problems with that that you were concerned about?
A. Not that I recollect.
Q. Now, I want to move to another area

regarding anesthesia times and start times and stop times.

You do this type of work, and you know, I assume, what anesthesia start times and stop times are supposed to be, correct?

A. Yes.
Q. When is anesthesia start times supposed to begin from your perspective?
A. When you give the anesthetic.
Q. So does it begin when you first make contact with the patient or when they enter your room or anything like that?
A. No.
Q. Okay. So at some point when you're ready to give anesthetic, that's when your anesthesia would start?
A. Yes.
Q. Is that what you would typically document on paperwork?
A. Yes.
Q. What about anesthesia stop time, when would that supposedly happen?
A. That would be when you turn the patient over to the recovery room nurse.
Q. So in this instance, you said most

instances the patient, you didn't follow the patients out. They would leave the room. Would it be then when they left the room?

A. Yes.
Q. So start time beginning of anesthesia, stop time beginning patient leave the room?
A. Yes.
Q. Was there an issue with the stop times and the start times --
A. Yes.
Q. -- of anesthesia?

And tell us about that.

A. When I got there on the first day, I went downstairs and to get the lay of the land from Mr. Mathahs. And he told me that Dr. Desai insisted that the cases last at least 31 minutes. So we juggled the numbers usually to make sure that it always came up to 31 minutes or close to it.
Q. Now, when he told you this, did it have some -- did it have an affect on you as far as what was going on?
A. Yeah. I knew it was wrong, but I had quit my job in California. I had a wife, and I had house payments, and I needed that job.
Q. Okay. So as far as the times that you

actually witnessed from all of these doctors, the procedures, would you say they typically went 31 minutes or more or less?

A. Less.
Q. Significantly less than that?
A. Yes.
Q. Did you see any that went above 30 minutes?
A. Yes.
Q. Was that a rare event?
A. Except for Dr. Manuel.
Q. Excluding Dr. Manuel?
A. Yes.
Q. For most of the other doctors?
A. Ask me the question again.
Q. I said excluding Dr. Manuel, from most of the other doctors, was that a rare event?
A. Yes.
Q. Now, when you said you had to juggle the numbers, tell me how you guys would juggle the numbers.
A. Well, we would -- you could start by when the patient -- when you went out and saw the patient for the history and physical.

And then you could just add, at the end, you could add some, whatever you needed to make up for

the 31.
Q. So was it pretty clear that you were having to do that on pretty much every single patient that came through?
A. Yes.
Q. The -- I assume -- well, again, I shouldn't assume.
Did you know if you were the only one that was doing this in the practice?
A. Everybody was doing it.
Q. And was it pretty well a common occurrence then?
A. Yes, and if I didn't put down the correct numbers, either the nurses would tell me that I hadn't, or a young lady from upstairs would come down and say you forgot to sign this and the times are wrong.
Q. When that would happen, would that cause some affect on your person as well?
A. I didn't feel good about it.
Q. Now, did you then correct the sheets?
A. I corrected them to the day. I left the 31 minutes.
Q. Was it always 31 or was it sometimes 32 or 33?
A. Sometimes 32, sometimes 33.

Q. Would you have put your start time down at some point and then just calculate how many minutes it was beyond that to get your stop time?
A. Yes.
Q. Now, on the anesthesia records that you're keeping track of, there are also vital signs being tracked during that entire 31, 32, 33-minute period; is that correct?
A. Yes.
Q. And, obviously, the patient isn't even in your care during that whole time?
A. Right.
Q. So the documents that were being produced, did they contain accurate patient information?
A. No.
Q. Did you know what was happening with those anesthesia records?
A. No.
Q. Did you involve yourself at all in the billing?
A. Never.
Q. And why was that?
A. I made a point when I started in anesthesia to never find out or know about what things cost or what the billing was all about. I don't

practice anesthesia by the bills, so I never -- I was always salaried, so there was no reason for me to find out. And to this day, I don't know what things cost.
Q. As far as the anesthesia times and so forth are concerned, you are aware how anesthesia is typically billed, though, in increments and things like that?
A. Yes.
Q. So are you aware that there is, usually based on whatever the code is for the procedure, that there is a base number of units that's assigned to that procedure, and then your time is added on to that in increments?
A. I know that.
Q. Okay. And what are the typical increments that are time added on?
A. That I don't know.
Q. So it could be one minute, five minutes, ten minutes?
A. Exactly.
Q. If I represented to you that the increment typically is 15 minutes, would that surprise you?
A. No.
Q. So in a situation where a person was billing for 31, 32, 33 minutes, in that scenario,

hypothetically, you could bill for three anesthesia units on top of the base, correct?
A. Correct.
Q. If you were using 15 minutes as the increment?
A. Right.
Q. Now, did you ever get the actual -- when the bills went in, I know you weren't involved with the actual mechanics or nuts and bolts of doing that, but when the anesthesia bills went in to get paid to whatever insurance company it was, did you ever get any of that money directly back to you?
A. No.
Q. Did you ever get bonuses or other remuneration based on the number of procedures you did or the amount of minutes that were billed to your knowledge?
A. No.
Q. What kind of bonuses, if any, did you receive?
A. None.
Q. The entire time you were there?
A. Entire time I was there.
Q. Now, when you first got there, were you under the impression that there would be some bonuses?

A. They said that they always gave out quarterly bonuses.
Q. But you never got one?
A. No.
Q. As far as the anesthesia records, although you weren't involved with the actual billing itself, I assume you knew that they were used for billing purposes?
A. Yes.
Q. That those would be submitted in some way to an insurance company and they would make a determination based on that to provide money back to the practice?
A. Yes.
Q. Was it general knowledge that those -- well, I think you've already testified that it was general knowledge that you guys were fudging the time, so to speak; is that correct?
A. Yes.
Q. Did everybody realize that those bills were going to insurance companies, generally?
A. I would think so.
Q. And you did, certainly?
A. Yeah.
Q. Now, as far as the times were concerned,

if you didn't know, I know you said you were going out there and you're using -- adding on a few minutes.
Did you ever have to extrapolate times like to get out to that 31, 32, 33 minutes?
A. Yeah.
Q. Okay. As far as the people that would come down from billing or whoever they were, was Tonya Rushing ever one of those persons that would come to you with the records and say you need to fix this?
A. I know that young lady worked directly with Tonya, but I don't know if Tonya sent her down.
Q. So she never came down and actually --
A. No.
Q. -- did that with you?
Okay. As far as the records themselves, did -- were there times where somebody would change the record for you?
A. On a couple instances, the nurses would say, you didn't get this time right. Do you want me to change it for you? And I would say yes.
Q. Was it a well-known fact that Desai wanted at least 31 minutes put on those anesthesia records?
A. Yes.
Q. Did everyone work within the practice to make that happen?

A. I think so.
Q. And I'm talking about the billers, the nurses, supervisors, all that stuff?
A. I don't know.
Q. That you were aware of or that you saw happen?
A. I just knew about the nurses. I don't know about the supervisors.
Q. Okay. Why did you do that? I know you said the things about your job and your family. Is that the main reason why this was going on?
A. I needed that job. And like I had said to you earlier I had to -- another job that I had applied for, and I was about -- after three weeks there because I wanted to leave.
Q. So you actually get into Desai's practice and then you start applying for another position?
A. Exactly.
Q. Talk to me about that for a minute.
A. When I got there, there was a -- there was some openings over at Southwest. So I went over there and I talked to one of the CRNAs over there, and I talked to their hiring people, and they had me take a battery of tests on line for executive positions.
And I guess I passed all of those. And

then I had a round-table discussion and interviews, and then I was offered the job and told what the salary would be and what the benefits would be and that I was first in line and that there were two jobs.
And so I assumed that I would be leaving posthaste, but United came in and said they were buying the business and that they suspended all contracts. Nobody could sign a new contract.
And by the time January rolled around and they still hadn't called me because they still had the moratorium on the contracts, the CDC came and laid that bomb on the group, and I wasn't hireable anywhere.
Q. So that's after, at least, the CDC comes in to do the investigation, is that what you're talking about?
A. And it gets reported in the papers and on the news and so on. I couldn't get a job as a janitor.
Q. As far as the work that you were doing, so initially you come in in October of the prior year, '07. This practice is going on pretty regularly and rampantly at that time?
A. Yes.
Q. Is that fair to say?
A. Yes.
Q. Am I clear that within three weeks of that

you were out looking for another job?
A. Yes.
Q. Was it because of that stuff that was going on in the practice?
A. That was part of it. Plus when I came to work there, I was told it was an eight-hour-a-day job, five days a week. And I never got out of there with at least 10, 11, 12, 13 hours, and I worked 56 hours in the first week. Well, that's two more days over 40 hours.
So I was looking -- I was -- I'm not a youngster anymore, and I needed to find something else to do because I couldn't handle that kind of schedule.
Q. Just be careful of this microphone. I think it's hurting some ears in the room.
A. I'm sorry.
Q. As far as the story, you said that once it broke that that became an impossibility, correct?
A. Yes.
Q. As far as the story itself, when you have that happen, when this starts coming out, are you guys at some point talked to by the administrative personnel?
A. We were talked to by Tonya Rushing.
Q. Okay. Now, was that at a meeting or was

that individually?
A. It was at a meeting.
Q. How many people were at the meeting?
A. I think four.
Q. Four people total?
A. Five with Tonya.
Q. And who were the people at the meeting except Tonya?
A. I think it was myself and Keith and Vinnie Mione, and Ralph.
Q. I believe it's M-I-O-N-E.
Now, before we get to the part about what may or may not have been said at that meeting, at this point, you know what's been going on in the practice and what you've been doing?
A. Yes.
Q. The CDC has come?
A. Yes.
Q. They have left, and they have -- they have given you kind of a report, correct?
A. Yes.
Q. This has been in the news?
A. Yes.
Q. Were you concerned at this point?
A. I was because all this was coming out.

Q. So when Tonya Rushing comes down to talk to you, or gathers you together to talk to you, without telling us what she said at this moment, when she said those words, did that affect you in some way?
A. Yes, because I knew that this was -- that this was all going to be coming out and we were in a lot of trouble.
Q. So did you see the implications of what was about to happen?
A. Yes, I did.
Q. Did you see the implications of what she was about to say to you or what she said to you? What it potentially meant?
A. Yes.
Q. What did she say to you?
MR. STAUDAHER: And, ladies and gentlemen, at this time, this is going to be a hearsay statement, but it's being offered for the affect on this listener, how it affected him in relation to hearing the words that were said, not necessarily for the truth of the matter, although they are offered for that at this point, but the affect on the listener.
BY MR. STAUDAHER:
Q. Go ahead and tell us what you were told by her.

A. She said that no one is allowed to mention Dr. Desai's 31-minute add on times.
Q. Was that pretty much it?
A. Yeah.
Q. So the whole meeting was about that particular issue?
A. Exactly.
Q. So what did you do after you -- after that was said to you? What was going through your mind?
A. Well, that we were, you know, they knew about that, and we had been doing it, and we were in a lot of trouble for it and life was not going to be the same.
Q. So a significant affect on you, basically?
A. Oh, yes.
MR. STAUDAHER: I have nothing further for this witness, ladies and gentlemen.
THE FOREPERSON: Are there any questions from the jury?
Yes.
A JUROR: How many patients a day did you work on approximately?
THE WITNESS: Sixty to 70.
A JUROR: Okay. Now, how did they justify 31 minutes a person? Let's just use your lower figure

60. That's 30 hours.
THE WITNESS: Yes.
A JUROR: Right? At 31 minutes a piece, that's 30 hours.
MR. STAUDAHER: I'm going to interrupt for just a second.
BY MR. STAUDAHER:
Q. I think they did run two rooms; is that correct?
A. We ran two rooms, yes.
A JUROR: Okay. Well, still that's 15 hours then, let's say cutting it in half. I don't know how they could justify the time or juggle your sheets to show 31 minutes on each sheet and have that many people in a day, in a 10-hour, 12-hour --
THE WITNESS: I don't have an answer for that. I know that the numbers were juggled, and whatever they did upstairs in billing was totally out of my hands. So they may have hedged funds then -- those just the same way.
MR. STAUDAHER: And I would admonish the Grand Jury not to take that speculation at issue here or to consider it in your deliberations later on.
THE FOREPERSON: Bianca?
A JUROR: So, Mr. Sagendorf, all of the

other things that they asked you to do at the Endoscopy Center, you didn't do morally, reusing propofol and things like that.
Just out of curiosity, you had a lot of concern for your job, your security. If you didn't do those items, why did you juggle the numbers?
THE WITNESS: All I had was my job security. That's the only excuse I have for juggling the numbers. Why I didn't — why I didn't do the propofol thing is --
A JUROR: No, that's not what I'm asking. I'm sorry to cut you off, but what I'm asking you is all of the -- you didn't do those things because morally you knew that it wasn't the right thing to do.
So in regards to that juggling the numbers, would you say it's fair to say it wasn't morally correct either?
Were you not concerned about your job security when you refused to do those other things with propofol or reusing items or where you would throw things away behind Dr. Desai's back? I'm just trying to understand why the juggling of the numbers weighed differently?
THE WITNESS: Well, it was morally wrong, yes. But the other things I couldn't do directly to a

patient because I had never done them. I had never done this either, but I don't have a real good answer for you. It was wrong. I was wrong. What I did was wrong.
A JUROR: Did you ever at any time report or try to report that facility to a higher authority?
THE WITNESS: No.
THE FOREPERSON: Are there any further questions? There are none.
MR. STAUDAHER: I have one related to that that I just want to clarify.
BY MR. STAUDAHER:
Q. The fudging of the numbers did not have a direct impact on patient care; is that correct?
A. Right.
Q. The reuse of a syringe or the reuse of propofol that might be contaminated would have a direct impact to a patient's potential health and outcome; correct?
A. Most definitely.
Q. Okay. Is that part of the reason why that is the line you would not cross?
A. Right.
MR. STAUDAHER: I have nothing further.
THE FOREPERSON: Yes.

A JUROR: Did you ever discuss with the other nurse anesthesiologist about this timing problem?
THE WITNESS: No. We were all doing it.
A JUROR: You were all doing it. But how can you say that? You were in one room, they are in another room, how do you know they were doing it in the other room?
THE WITNESS: I wouldn't know. I just know that they weren't getting hollered at so I assumed that they were doing it, too, because they were the ones that told me they -- you know, at least Keith was the one told me to do it.
A JUROR: So you never discussed it over a cup of coffee or a drink or anything?
THE WITNESS: No.
THE FOREPERSON: Any further questions? There is none.
By law these proceedings are secret. You are prohibited from disclosing to anyone anything that transpired before us, including evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury, or information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark

County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine, and 25 days in the Clark County Detention Center.

Do you understand this admonition?

THE WITNESS: Yes.

THE FOREPERSON: Thank you. You may be excused.

THE WITNESS: Thank you very much.

THE FOREPERSON: You're welcome.

Okay. We're going to call a ten-minute break.

(A recess was taken.)

THE FOREPERSON: Please remain standing and raise your right hand.

Do you solemnly swear that the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes.

THE FOREPERSON: Thank you. Please be seated.

You are advised that you are here today to give testimony in the investigation pertaining to the

offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman, and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Could you please state both your first and last names and spell them for the record.

THE WITNESS: Ryan Cerda. R-Y-A-N. Last name C-E-R-D-A.

THE FOREPERSON: Thank you.

RYAN CERDA,

having been first duly sworn by the Foreperson of the Grand Jury to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Mr. Cerda, what do you currently do for a living?

A. Right now I work security.

Q. I want to take you back in time to around

July/August of 2007. After you -- I assume you shortly before that graduated from high school; is that correct?

A. Yeah.

Q. Did you get a job in a business that did some medical billing around that time, July/August of that year?

A. Yes, I did.

Q. And if you could, tell us what the name of the -- excuse me. Excuse me. If you could, tell us what the name of the business was, if you know?

A. Health Care Business Solutions.

Q. Who was the owner of that business?

A. Tonya Rushing.

Q. Where was the business located at?

A. Cheyenne and Tenaya.

Q. There was not — or was it associated in any way that you know of with the Endoscopy Clinics of Southern Nevada, anything like that?

A. Yes.

Q. And how was it associated with them?

A. We did the billing for them.

Q. Okay. Physical location, though, was it the same or different? Obviously, the Tenaya address isn't on Shadow Lane.

A. Yeah, it was different.

Q. Okay. Who was the owner of the business to your knowledge?

A. Which business?

Q. The one you worked at.

A. Tonya Rushing.

Q. How did you come to work in that facility?

A. I knew her son and I just graduated high school so, you know, I needed a job. I didn't really want to go to college. I was -- I could type fast so, you know, he brought me to his mom, I spoke with her, and she interviewed me and got me started.

Q. Now, once you go to the Tenaya facility, you said Cheyenne and Tenaya, correct?

A. Yes.

Q. What kind of place was that? Was it an office building? Home?

A. Yes, it was a little office building.

Q. How many people worked in the facility, roughly, if you know?

A. Around six or seven.

Q. What was your job specifically?

A. Well, the medical billing. The data entry and ICD 9 coding.

Q. What is ICD 9?

A. Basically, the coding of the diagnosis that we got from the anesthesia records.
Q. So at this point, if I understand you correctly, you get records from some source, and then do some coding, and then take those records and bill the insurance companies?
A. Yes.
Q. What kind of records did you bill from? What kind of records did you get to bill with?
A. Like how, what do you mean?
Q. Well, you had mentioned anesthesia records.
A. Yeah.
Q. Were there other types of records that you billed beside anesthesia?
A. Well, it was just a packet of it, yeah, and then the anesthesia records basically.
Q. Did you ever do colonoscopy billing or endoscopy, upper endoscopy billings, EGDs?
A. Yes.
Q. So those as well as the anesthesia?
A. Yes.
Q. When you would get those, would they come -- how would they arrive in your office?
A. They would be brought in by a courier, and

then be in like stacks and then they would be handed to us.
Q. Was this every day that you would get these?
A. Yes.
Q. And how many days a week did you work?
A. Monday through Friday.
Q. How many would you typically get from say the Endoscopy Center of Southern Nevada on Shadow Lane, that clinic?
A. A day?
Q. Yeah.
A. Probably roughly around maybe a hundred or more, around a hundred.
Q. So you would get a lot of them?
A. Yeah.
Q. When you got those from that center, tell me how -- I know you said that the courier brings them over, they are in stacks. When they get to the business, are you the one that actually takes them?
A. Well, they were brought to me, but yeah.
Q. So you actually get them at some point, though?
A. Yes.
Q. What do you do with them when you get

them?
A. There is a sheet that we fill out, and basically you would fill it out, patient's name, and then you would enter their data entry, like their name, address, and you would look at the anesthesia time, get the time, the diagnosis, the ASA classification.
Q. What is ASA?
A. It's -- I really don't know. It's just like a P1, P2, P3 or P4.
Q. So whatever it said, you just put down on the records?
A. Yeah, exactly.
Q. So one of the items that you mentioned that you specifically looked at and utilized was the anesthesia billing time; is that correct?
A. Yes.
Q. What did you do with the -- was it in minutes or what?
A. It was in minutes.
Q. What would you do with that?
A. Well, basically, depending on the minutes, where it ranged, around 30, you know, 28 up through about 34, was depending on how much the anesthesia billing would be.
Q. Were they billed -- were the increments --

were the billing increments in 15-minute levels or increments at that point?
A. When I had first started, no. But then later on as I was working there, yeah, they had dropped to about ten minutes, around that area.
Q. Okay. I'm not talking about what the actual minutes that came in were. I'm saying the amount that you would then bill to the insurance company or code, was that based on a certain number of -- like an increment, a 15-minute increment?
A. Yes.
Q. Okay. So for a 31-minute or 32-minute or whatever it was, was that the typical number that you were seeing?
A. Yeah.
Q. For ones that were in that range, how many units were you talking about?
A. It would be like $560.
Q. So would that relate to three separate 15-minute increments, though?
A. No, no, not that I know. I mean it would just be from 31 and up would be 560.
Q. So you knew it by just looking at the minutes, period?
A. Yeah, there is a paper that we had been

given with the times and what they would be money-wise, how much they would cost.

Q. So when you saw 31 minutes or more, you would bill $560?

A. Yes.

Q. Every single patient?

A. Yes.

Q. Now, if the minutes were less than 30 but more than 15, what would be the amount that you would bill?

A. 490.

Q. And if you know, below 15 minutes, what would you typically bill?

A. Well, what I can remember was 150.

Q. Okay. Is it possible that it's a little bit different than that but close to it?

A. Yeah.

Q. Okay. When you were working for -- and you worked there from this -- you said you thought it was around July/August or so of 2008 until when?

A. Well, I worked --

Q. I think I meant July/August of '07 until --

A. Well, six months. Six months at least I know that.

Q. So that would have put it around January or so of the following year?

A. Yeah, it might have been a little bit after that sometime.

Q. Okay. At some point in early 2008, you stopped working there; is that right?

A. Yeah.

Q. Why did you stop working there?

A. I just -- well, it wasn't for me really. I didn't enjoy sitting there doing that all day. It was kind of boring for me.

Q. Now, during the time that you worked there, did the stacks of papers that came from the Endoscopy Center with the billing minute times on them, were they all about the same or did they vary?

A. Yeah, they were all around 31 around, yeah.

Q. If there had been some big differences in that, would that have been something that you would have noticed?

A. Yes.

Q. So if you're getting upwards of a hundred of these a day, you're coding them and writing those $560 charges for all of these during that time, pretty much it's 560 for every one of them?

A. Well, yeah, about 560 or 490.

Q. Okay. So if it fell below that 30, was it --

A. Thirty-one.

Q. If it fell below, you would have to charge 490?

A. Yes, from what I remember. Yeah, I'm pretty sure.

Q. Now, somewhere down the road, did you notice that the actual anesthesia records that were coming in had changed dramatically?

A. Yeah, they had changed.

Q. Do you remember roughly about when that was?

A. No, I don't really remember around what time because I wasn't, you know, I was just --

Q. Was it around the time that all of this endoscopy thing was hitting the news?

A. Not that I remember. I mean, I wasn't, no, not that I know of.

Q. Was it in 2008 that that happened?

A. Yes.

Q. Okay. So in 2008, and obviously you left in early 2008, so it had to have happened before you left?

A. Yeah.

Q. So at some point, you said that the times dramatically changed. What are we talking about as far as dramatically changed?

A. Well, the anesthesia times were around like 10, 12 minutes. They were roughly around there like all of the stacks that we were getting.

Q. So instead of 31 plus, they are now down to the 10, 12, even up to 15 possibly?

A. Yeah, up to 15, yeah.

Q. Okay. At that point of this, of all these stacks that were being billed, how much were you then billing out to the insurance companies to pay?

A. From what I remember, 150.

Q. So big difference between 150 and 560?

A. Yeah.

Q. Were there many that were -- I mean, of all, let's say, out of a hundred that you received on average that were down in that range, how many of those would be in this 12-to-15 range and how many of them would be higher than that?

A. Well, I remember getting a few stacks of them. All of them were like that, so ...

Q. So at this point, was it unusual to see one that was higher?

A. Yeah, it was.
Q. When you saw that happen, did that kind of get your attention?
A. Yeah. I had brought it to my supervisor's attention because, you know, the billing is different, you know, the times and it's not normal for me. I haven't seen that. You know, I don't know if I should send it to the insurance or not, you know.
Q. And if I understand you correctly, your job is to take that, code it, and then actually send it off to the insurance with that dollar amount in it; is that correct?
A. Yeah, on the computer, yeah.
Q. Without getting into what people told you, after your conversations and raising this, did you ever go back to the 30-plus minute billing or did you stick with what was actually showing up on the forms?
A. I stuck with what was on the form then and billed it out that way.
Q. Did that stay like it was until you quit?
A. I don't know. I don't remember.
Q. Okay.
MR. STAUDAHER: I have nothing further for this witness, ladies and gentlemen.
THE FOREPERSON: Are there any questions

from the jury?
Yes.
A JUROR: To your knowledge, did Health Care Business Solutions have any other clients or do any other billing for anybody other than the endoscopy or gastroenterology?
THE WITNESS: Well, from what I know is Desert Shadow and the Endocscopy Center.
A JUROR: Okay.
THE FOREPERSON: Any further questions? None.
A JUROR: I have one.
THE FOREPERSON: Yes. Go ahead.
A JUROR: Did you ever think that the billing time was quite extensive based on how many claims you got each day?
In other words, did you feel that the billing hours were more than what was actually -- had actually occurred based on the claim forms you got?
THE WITNESS: No, not -- when they were normal or --
A JUROR: No. When they were at the 31 minutes, I'm talking about.
THE WITNESS: On the 31 minutes, no, that was normal.

A JUROR: How many people would you say there were claims for at 31 minutes or thereabouts? How many a day on the average?
THE WITNESS: About a hundred a day.
MR. STAUDAHER: And I'm going to ask a follow-up to that.
BY MR. STAUDAHER:
Q. You worked in a -- did not work in the actual Endoscopy Center?
A. No.
Q. Did you know what was going on there as far as how many patients were seen, what was normal, not normal, anything like that?
A. No.
Q. So you are just taking in what's given you, coding it and sending it off to another entity for payment?
A. Yeah.
Q. Did you ever get the payment to you?
A. No.
Q. Ever get any deposits to your bank to keep doing it the way you were doing it?
A. No.
MR. STAUDAHER: Okay.
THE FOREPERSON: Any further questions?

None.
By law these proceedings are secret. You are prohibited from disclosing to anyone anything that transpired before us, including evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury, or information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine, and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: Yes.
THE FOREPERSON: Thank you. You may be excused.
(A recess was taken.)
THE FOREPERSON: Please remain standing and raise your right hand.
Do you solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: Yes, I swear.

THE FOREPERSON: Thank you. You may be seated.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman, and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Could you please state both your first and last names and spell them for the record?

THE WITNESS: It's Marion VanDruff. M-A-R-I-O-N. V-A-N, capital D-R-U-F, as in Frank, F, as in Frank.

THE FOREPERSON: Thank you.

MARION VAN DRUFF,

having been first duly sworn by the Foreperson of the Grand Jury to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Mr. VanDruff, I'm going to go back and ask you a couple questions about your background.

A. Okay.

Q. What do you do for a living currently?

A. Right now I'm a customer service specialist at Sitel.

Q. I direct your attention back to February of '06. Did you graduate from the Nevada Career Institute?

A. Yes, I did.

Q. What did you graduate with?

A. Just a diploma for medical assisting.

Q. Okay. And after you had that, was it a certificate or degree or what was it?

A. It was just a diploma. It was essentially the same as like a high school diploma, just like a halfway between high school and college.

Q. Okay. So had you gone to college yet or was this just a step after high school?

A. There was a step after high school.

Q. What did you do after you got that diploma?

A. I -- first thing I did was while trying to

find work as a medical assistant, just because it was a little bit more difficult than I thought it was going to be, I worked at Glamour Shots, and then started looking for positions as a medical assistant.

First place I worked was Medical Group at Sun City. After being let go from there, I just got out on foot looking for another job just because I found out my fiancee at the time was pregnant, so I needed to be able to support a child.

Walked into the 700 Shadow Lane building and passed out my resumes, and Endoscopy Center called me back in the next day.

Q. Okay. When you went back in the next day, are we talking about just shortly after your graduation or was it later on?

A. This is about a year after I graduated.

Q. Okay. When were you actually hired by the Endoscopy Center?

A. It was May of '07.

Q. And you worked with them until when?

A. Up until -- up until the center got closed down by the mayor.

Q. So in '08; is that correct?

A. Yeah. I think it was in May or something.

Q. So you worked for them just about a year

then?

A. Yeah.

Q. Now, as far as the things that you did for the center, were you assisting with patients?

A. Well, yeah, I was assisting with patient care. When I first started out there, I was just bringing patients back, triaging them, getting them ready for the procedures, making sure that they had done all their prep and everything properly, making sure that they were ready and getting them into the examination rooms.

After about a month or so, I actually started assisting with the doctors and cleaning the scopes during the procedures and after the procedures.

Q. Okay. And at the time that you finally left the clinic, is that what you were primarily doing then is assisting with the doctors in the procedure rooms and doing the scope work?

A. Well, we would alternate, so it was, you know, one day you would be out on the floor. The next day you would be in back. Or depending on the week, you would spend the first half of the day on the floor. The second half of the day you would be in the procedure rooms and the scope room.

Q. Okay. Let's talk a little bit about the

procedure room when you were there?
A. Okay.
Q. We'll get to the scope room in a little bit.
But when you were in the procedure room, what was your job? What did you do?
A. Just assisting, giving the doctor whatever he needed for the procedure, whether it be getting forceps, giving swabs, just water flushes with the syringe.
It was just, you know -- you watch a medical show and, you know, a doctor calls for a scalpel or something like that, that's essentially what I was doing.
Q. Did you handle the scopes both before they were used and after they were done using them?
A. Yes, I did.
Q. And then what did you do with the scopes after they were done?
A. We would take them into the scope room. Whoever the technician was in the scope room, would be the one responsible for cleaning it.
Q. Now, during the procedure itself, are you helping the doctor then actually do the procedure?
A. Doctor -- the doctor is doing the

procedure. The only thing I'm doing is, I'm essentially an extra arm.
Like if he had to take a -- if one of the doctors had to take a biopsy of a polyp or cancerous part of the colon, I would hand them the forceps. He would squeeze it in.
It was just like this long snake-like thing that had teeth at the end, and there is a little plunger, and my only job would be to open and close the forceps.
The doctor would go ahead and pull the forceps to take the sample, and then I would put it in a specimen bottle.
Q. When you were doing that particular type of work, I mean was there any single physician that you worked with, or did you work with all of them?
A. When it came to the Shadow Lane office, I worked -- I worked with every one of the physicians.
Q. Did you note a difference in, for example, the speed at which they operated, the different doctors?
A. Some were slower, some were faster. There were certain doctors that just based on the caseload that we were hoping that we wouldn't be working with that day just because they had a reputation for being

slower.
And, obviously, now after this all happened and doing my own research, just reading on line on like what the typical time should take, found out that the slower doctors --
Q. I'm not going to ask you to bring -- I mean that was just public information you were just looking at then?
A. Yeah.
Q. Okay.
A. Just like web MD and stuff like that.
Q. Okay. And beside, you know, whatever your research may have been on the computer, and I don't really want to get into that at this point --
A. Okay.
Q. -- but your observation of what a normal procedure would take. I'm not talking about the faster doctors, I'm just saying on an average, how long would they take in a clinic to do? Colonoscopy? Upper endoscopy?
A. Colonoscopy, you're saying pretty much like if I was to take one of the slower doctors versus one of the faster doctors, the average time between the two?
Q. Yeah.

A. Average time between the two would probably be about eight, nine minutes for a colonoscopy. Five, six minutes for an upper endoscopy.
Q. Okay. And was that -- what about the faster doctors, who were they?
A. The faster doctors in the clinic were -- well, the two fastest were Dr. Carrol and Dr. Desai.
Q. Who was the fastest?
A. Desai.
Q. Noticeably faster?
A. Yeah.
Q. How long did it take him to do those two procedures on average?
A. Usually, if I was in the procedure room with Dr. Desai and we were doing a colonoscopy, we would be done with the colonoscopy in five minutes, unless it was something that really caught his attention when it came to cancer and stuff like that.
When it came to the upper endoscopies, those were usually done in about three minutes.
Q. So three to five minutes is what we're talking about?
A. Yeah.
Q. For both types of procedures?
A. Well, like I said, the colonoscopy would

be five minutes. Three minutes for the upper.

Q. Fair enough.

Now, related to Dr. Desai, when he was dealing with the scopes, if he's doing them that quickly, when it comes time to remove the scope, what was the procedure that you had to get involved yourself with as far as he was concerned?

A. He would pull the scope out and hand it to us and take it back in. I mean unless there was -- again, this was unless there was something that, you know, really caught his attention. Then he's like, Okay. We have to make sure that we get that on the way out. Then I would usually get it.

But, typically, on a day-to-day basis, if I was working with Dr. Desai, scope came right out within under a minute and into my hands.

Q. Okay. When he was actually physically taking the scope out, how fast would he typically do that? Would that be a slow process, rapid process, what was it?

A. It was pretty quick. It was -- we joked on the floor that it was almost like he was cracking a whip when he would take the scope out.

Q. Okay. When the scope came out, were you responsible to kind of catch the scope then?

A. Yeah.

Q. Is that a fair description?

A. Yeah, it's pretty fair. I had to — I had to change garb quite a bit just because we couldn't clean off residue and couldn't sterilize afterwards, so ...

Q. What do you mean you had to change garb?

A. Well, we had protective — we had protective barriers we had to wear over our scrubs. Typically, in a day we'd change them maybe two or three times a day. Working with Dr. Desai, that number could have easily doubled.

Q. Why was that?

A. Because it just -- he swings out and you get fecal matter all over it, and then you don't really want to wear that into the next procedure.

Q. Okay. So if I understand you correctly, were you getting this fecal matter on your person because of the speed that he was taking the scope out of the body?

A. On occasion.

Q. Okay. And was this a general sort of joke around the sort of center that he was pulling them out like cracking a whip?

A. It was said a couple of times.

Q. Now, as far as the procedure times and so forth, did you ever see Dr. -- or Dr. Desai start procedures before anesthesia was on, administered to the patient?

A. I don't necessarily know if anesthesia was admitted. Sorry. I don't know if anesthesia was necessarily not administered to the patient yet. Some people just take longer to go under when it comes to anesthesia.

He would start the procedure before they were completely sedated before, though. I had seen that before.

Q. Okay. How often would that occur in your experience with him?

A. In my experience with him, it was probably one in every 20 procedures.

Q. Okay. And in situations like that, would there be any communication between the CRNA and Dr. Desai about that issue?

A. There is -- there was communications. I do recall the CRNAs actually tell me, you know, can you hold on? The patient's not even completely asleep yet, so ...

Q. Were they kind of emphatic about saying that, or was it just normal speech, you know, wait for

a little bit, or --

A. It was -- to me it was real concern. It was, you know, pretty much they were looking at it in a situation of, you know, if that was them on the table, they would want to be completely asleep before the procedure was to start.

Q. Okay. And so about one in every 20 procedures you saw you thought?

A. Yeah.

Q. Did that happen with the other doctors in the group?

A. Not as often. I mean it would happen just on occasion, just out of, I don't know if I ever should really say negligence, but it did. I would say it would happen just out of, you know, general negligence. It's you don't quite realize that the patient's not asleep yet.

Usually other doctors, though, would actually look over the patient, since they are behind the patient, look over, make sure that they are asleep before actually inserting the scope.

Q. Okay. On the instances when the scope was inserted and the CRNAs made some comment about this patient not being asleep yet, did Dr. Desai stop what he was doing?

A. No. I don't think he even heard the CRNA saying the patient wasn't even asleep yet.
Q. You were there?
A. Yeah.
Q. You heard it?
A. Uh-huh.
Q. He was standing next to you?
A. Uh-huh, but I just don't think he was paying attention.
Q. Okay. What about reuse of various items in the -- sort of the procedure room? And I'm talking about, kind of go through them, bite blocks, did you ever see those reused on patients and washed off or whatever?
A. Unless the patient had a sexually transmitted disease, we would go ahead and wash and sanitize them through our scope cleaning machine. And then go ahead and reuse them on the next patient.
Q. So if I understand you correctly, the scopes that have been in somebody's bottom --
A. Uh-huh.
Q. -- so to speak, were put into a machine for cleaning?
A. Well, it's -- we had a -- we had a process we had to go through. We had to first go ahead and

actually clean the outside by hand of the scope, when it came to actually cleaning the scopes.
It would go into a first -- it would first go into a tub with some machines connected to it that would actually go ahead and just flush the solution through it to make sure that it's completely flushed out and cleaned out.
Go through another solution to rinse it, and then into the scope machine to actually go ahead and go through the sterilization process.
Q. Okay. Did the bite blocks go through that same process then?
A. Without flushing them, but we did wash them by hand, make sure they were rinsed, and then put them in the sterilization machine.
Q. So once the scopes have gone through this flushing and whatever, they are put together with the bite blocks and processed; is that right?
A. Yes.
Q. Okay. So the same scopes that go in the bottom, the mouth things are in the same --
A. Uh-huh.
Q. -- together?
A. Yes.
Q. Now, as far as the other items that were

potentially reused, did you notice anything, any forceps or any snares or anything like that that were ever reused?
A. Forceps and snares we did not reuse. We made sure that they went into biohazard sharps to be disposed of properly.
The only thing that I could actually say that on a personal level that I did reuse because I was instructed to use were just syringes for the purposes of flushing water, cleaning out the actual -- the actual -- the actual beaker, container, whatever it was called, that we would actually use to go ahead and suction up the water with the syringe.
And cleaning out another container, we had to go ahead and actually prewash, kind of prerinse the scope in the procedure room before we brought it into the scope room.
Q. What about the solutions that were used to clean the scopes? Was there any issue with that?
A. We -- pretty much we were told -- well, I was told by other techs, by other GI techs on the floor who were the ones that were assisting me and telling me how to do this, that we were supposed to do it by sight.
MR. STAUDAHER: Okay. And I don't want to

necessarily -- that's — I'm going to admonish the Grand Jury on that particular statement about it being a hearsay statement about something related to what he was supposed to do.
BY MR. STAUDAHER:
Q. That's not offered for the truth of the matter, just for what you did or did not do?
A. Okay.
Q. Based on whatever you were trained or told, how did you handle the solutions?
A. Solutions, if they became -- the solutions were like a very bright blue whenever they were completely clean, fresh out of the bottle.
I was told whenever they got murky to a point where you couldn't tell that they were blue, or where you could -- it was — you were able to no longer tell that they were going to be blue for too much longer, then you go ahead and dump it and refill it.
Q. How often would that be? How many scopes would you process through before that would occur?
A. Depending on the procedure, depending on the cleanliness of the procedures, it would be -- sorry -- anywhere from 10 to 20 scopes.
Q. And when the CDC came in, you were there when that occurred, right?

A. Yes, I was.
Q. Did that process change?
A. When the CDC was in there, we were told to go ahead, and this is what I was doing is I was actually cleaning four scopes, and then dumping it.
Found out from the CDC while they were there, though, that we were supposed to be dumping it after every two scopes.
Q. Did that process then get initiated after that?
A. Yes, it did.
Q. Okay. As far as the bite blocks are concerned, just re-visit that for a second. How many of those would you typically open up in a day?
A. Six.
Q. And that was to service everybody for the whole day?
A. Uh-huh. As I said, unless -- it was six at the beginning of the day, unless, as I said, they had, you know, a sexually transmitted disease or a communicable disease, then that bite block would be thrown away and a new one would be opened up for the rest of the day.
Q. Now, when the state CDC were coming in to sort of look at what was going on in the clinic, was

there some discussion about that before they actually arrived?
A. We were told that there were going to be visitors who were coming in, that we would have to change procedures a little bit, such as making sure that after every four scopes were cleaned, that we went ahead and dumped the cleaning solution and re-did it.
We were told that we would be -- we would need to go ahead and change the aprons that we were using during procedures after every procedure and make sure that we were wearing a mask during the procedures.
Q. Okay. Did you actually do those things?
A. Yes, I did.
Q. Now, prior to the state coming in, that, I assume, was not the practice, though?
A. Like I said, it was -- usually you would go through like maybe three aprons in a day before the state had come in.
And I would only ever wear a mask if I was feeling sick as a protective barrier, just to protect other patients from myself, just because I had never worked in the GI field before.
I had never worked doing endoscopies or any other surgical procedures for that matter, so I didn't know that this was really something that I

should be wearing the face masks through every procedure until this happened.
Q. Now, when you -- so I guess where I'm going with this is, when -- before the CDC and the state show up, is there some discussion about at least tightening up procedures?
A. Yeah.
Q. So when they show up, the CDC and the state, did they see the way things had been actually happening in the clinic prior to their arrival?
A. No.
Q. Okay. Had the sort of procedures improved by the time the state actually got there?
A. When the state actually got there, even the doctors that would go, you know, a little bit quicker, would actually slow down and went at the rate of the doctors who were actually going slower, so ...
Q. Was Desai working during any of that time?
A. I don't remember if he was or wasn't actually.
Q. Do you remember during any of the period, and they were there about a week or so; is that correct?
A. Yes.
Q. Do you recall ever seeing Desai work

during that whole time?
A. I mean I hate to say just because it's something on a personal level, but it's my son was actually -- I was actually having my son be born around the same time. So it's most -- my attention was pulled away to that. I really don't remember if Dr. Desai was working during that week or not.
Q. Fair enough. And that's fine. We'll move to another area.
Once the state came and left, though, did the process or the procedures that had been recommended by them, did you guys institute those?
A. We -- yeah, we instituted those. We were under the impression that it was going to be happening again, that they might be dropping by randomly. So we made sure that we continued to do exactly what we were doing prior to them coming in.
We weren't even told why they were coming in. We were just told it was essentially just another inspection that any medical clinic would go through to make sure that they can keep their license to be open.
Q. Okay. Now, I'm going to ask you a couple questions about propofol. You know what that is, do you not?
A. Yes, I do.

Q. Did you ever see propofol being reused by the CRNAs that worked at the facility when you were in the procedure rooms?

A. I do know it was reused from patient to patient.

Q. Okay. And is that because of your personal observation?

A. Yeah.

Q. And was that a -- seemed to be a regular thing or was that just an occasional thing that occurred?

A. That was a regular thing.

Q. Was that one of the things that the CDC had recommended not having occur at the facility?

A. Afterwards, yeah, it was. I found out that it was actually recommended that it was supposed to be one -- one patient per vial.

Q. Okay. Is that the practice that took place after the CDC came, or did that change?

A. Yeah, it went to that practice afterwards.

Q. Okay. Now, did you ever see the same syringe used during this procedure and then used on another procedure?

A. My direction was mostly on the patient, the monitor that showed us what was going on inside the

colon, and the doctor themselves, just so I could know what's going on.

From my understanding -- well, I really shouldn't give what my understanding of what's going on because you said you wanted to know what I actually saw. So I can't really tell you if the syringes were used from one patient to another.

Q. Is that because of your positioning in the room --

A. Yeah.

Q. -- and what you could see?

Okay. That's fine.

A. I was aware of the CRNA, but I wasn't really paying attention to what the CRNA was doing.

Q. Did Dr. Desai ever talk about syringe use or reuse or anything like that at any time, either before or after the CDC came?

A. No, not that I know of.

Q. Did you ever hear him discuss any of this stuff, about propofol use or anything like that?

A. Honestly, when it came to procedures and policies of what was going to be going on inside the clinic, I had no interaction with Dr. Desai.

It was -- it all came down the ladder of okay, well, this is what we're doing. This is what

your job is, so this is the information that you get to know is what's going on because it pertains to your job.

So I never really heard anything of what Dr. Desai was saying about reusing any of the equipment.

Q. How many patients would you typically be seeing in a day, dealing with?

A. If I remember correctly, a minimum of 60.

Q. Was it more than that at times?

A. Oh, yeah.

Q. You said, "Oh, yeah," were there a lot more?

A. There was quite a few days that even with patients canceling and patients being added on the day of we would end up seeing 90 patients in the day.

Q. And that's procedures done on patients --

A. Yes.

Q. -- is that right?

Now, did you ever see CRNAs move from room to room?

A. Yes.

Q. How would that happen? And was it during breaks, was it the end of the day, beginning of the day, what?

A. Typically, there was one doctor working. Okay. Usually I would only see this in the morning or if the CRNAS -- if we were breaking out for lunch because we would only have two CRNAs there.

So for the first two hours of the day, there would be one CRNA and one doctor. So since there is one CRNA and one doctor and we are doing procedures, the CRNA would follow the doctor back and forth to be able to give the anesthesia for the procedure.

If a doctor was -- if we were during our lunch -- if we were during the lunchtime, we would go back to only having one doctor on the floor, and then the CRNA would swap out, half hour for one CRNA, half hour for the other, and then they would go back, but usually it was just from one room to another after the procedure.

Q. So you did see the CRNAs move at least from room to room for various reasons during the day?

A. Yeah.

Q. During the time that you saw the CRNAs go from room to room, did they carry anything with them? Did they carry any syringes, drugs, toolboxes, anything like that?

A. They had like a tackle box that had the medicines that they would use for the day.

Q. And they would take that with them from one room to the other?
A. Yes.
Q. Beside that -- was that a fairly regular occurrence?
A. Yeah.
Q. Beside that, did you ever see a CRNA that came from a different room come into a procedure room that you were in and use propofol or set up or drugs or anything that were in that room already?
A. Typically, what I saw -- okay. So you're asking if a CRNA would come into a room and handle supplies that they didn't set up?
Q. Yes.
A. I don't think I ever saw that happen.
Q. So they would bring their own stuff to the room?
A. Yes.
Q. So did you ever see, when that occurred, a bottle of propofol, for example, that had some propofol in it just sitting on the -- on the table or wherever, where the anesthesia person would be?
A. I would only see that happening if we were just setting up the procedure and it was the CRNA that's been in the room the whole time.

Q. Okay. Who was in charge of the facility?
A. When I was hired in, Katie Maley was the office manager. Shortly after, she was going on to assist in opening up the other clinic that they were opening in the Spanish Hills.
And then Jeff Kruger was the nurse in charge of the facility, and he was the one that I would be taking orders from pretty much.
Q. Okay. As far as procedural stuff that went on in the clinic, who made the shots or who called the shots, so to speak?
A. The doctors. I mean, it's -- I mean I don't think I actually understand the question.
Q. Okay. Was somebody else able to make the decisions as to what happened and how things occurred and what to order and all that stuff in the office?
A. Well, the -- Jeff and then later Janine, whenever she became head nurse, would actually do the supply ordering.
But when it came to how to do the procedures and everything, that was something that was completely handled by the doctors.
Q. Okay. Did you ever deal with the administration and how things, you know, beyond just working in the scope room and the procedures dealing

with the doctors. Did you ever deal with any of the other parts of the clinic?
A. No, I didn't.
Q. Okay. When you were there, was there anything there beside the things we talked about that were -- that you saw that were concerning to you or that gave you pause?
A. I just thought that we were doing too many patients in a day honestly, and it was -- I'm an adaptable person. I just shrugged it off and learned how to cope with it.
But there wasn't a whole lot that I really paid attention to during the day. I just kind of did my job and was hoping that one day I would be able to move on to another clinic because I didn't really like the work.
Q. Did you feel pressure in any way to maintain that schedule and that patient load?
A. Yeah.
Q. And I'm talking about even back in the scope room when you were cleaning scopes, did you feel like you were pushed to, you know, get them ready, keep them available, that kind of thing?
A. Yeah. I mean there was a couple of times, just because we had procedures going on that were just

going on really quick, that it's -- I can't -- I'm processing the scopes for the full time that they are supposed to be processed, but I have them piling up on me, and we have no scopes left available.
So we're getting backed up because they are waiting for me to get scopes finished and cleaned and dried before they can hang up for the next procedure.
Q. So did that sometimes sort of cause trouble with the whole machine?
A. Yeah.
Q. When that happened what would occur? Would somebody come back and talk to you about it, yell at you, anything?
A. They just said, you know, you have to pick up the pace and everything. And it's just, me being just, you know, a typical worker that your boss comes in and tells you that, hey, you need to pick up this pace.
You're just kind of thinking to yourself, hey, you should come back here and do this yourself if you think I'm not doing it that well.
But, like I said, I -- when it comes to medicine, the one thing that I was definitely taught was that you don't do anything to compromise

cleanliness.

So I wasn't going to cut corners or anything like that just to try to catch up, and I wasn't told to, but it just kind of seemed like that's what was expected to me. But just because of the way I was taught that wasn't going to happen, so ...

Q. So you didn't engage in that, but you felt pressure to do that. Is that what you're saying?

A. Yeah.

Q. And if I understand you correctly, the actual things that you were doing back there had fixed times associated with them. You couldn't process -- if you put the machine -- what was the machine that you put the scopes into called?

A. Oh, I don't even remember what that machine was called. It was just a scope-processing machine. I don't remember the actual name of what the machine was called.

Q. Does medivator sound familiar to you?

A. Yeah.

Q. Okay. When the scopes went into that machine, did they have to be in there for a fixed period of time?

A. Yeah. There was just a button you pushed, and it went ahead and did it. It went through the

whole cycle for you.

I mean you could open the machine up, but the machine could possibly fail if you opened the machine up before it finished processing.

Q. But even though that's a fixed amount of time, you're still getting pressure to get the scopes out of the machine?

A. Yeah, but I was waiting until the time was over.

Q. Okay. Anything else that concerned you about anything that was going on with the clinic and what Dr. Desai was doing?

A. Not really. If I had more experience as a surgical tech or as a gastro tech, I probably would have been a little more concerned. But like I said, this was the first job I worked at as a GI technician, so I wasn't really familiar with what should be going on.

MR. STAUDAHER: I have nothing further.

THE FOREPERSON: Are there any questions from the jury?

Yes.

A JUROR: At any time did they tell you, they being one of the doctors or one of the supervisors, tell you take shortcuts if you have to to

get us the scopes, get us mouthpieces faster?

THE WITNESS: No. Like I said, it wasn't exactly something that was actually said to me to, you know, well, get this done, you know, get the machine out quicker, you know, and everything like that.

It was just something that, as I said, in any job, you have your boss hovering over you. You would kind of feel pressured to get things done quicker, but, as I said, when it comes to cleanliness, I'm not going to sacrifice that at all.

THE FOREPERSON: Ann?

A JUROR: You said you felt pressure that they told you you needed to pick up the pace.

Did they in any way instruct you on how they felt you should do that?

THE WITNESS: No. So I just continued doing what I was doing.

THE FOREPERSON: Okay.

Steve?

A JUROR: And back to the same question, are you aware of any of your coworkers taking shortcuts because of that pressure?

THE WITNESS: No.

THE FOREPERSON: I have a question.

On the bite blocks and scopes being

cleaned, were they being cleaned together in the same solution at the same time?

THE WITNESS: Yes.

THE FOREPERSON: All right. Are there any further questions? I do have one more.

When the scope was removed from the patient by Dr. Desai, when you said he came out so fast you got fecal matter on your garments --

THE WITNESS: Yes.

THE FOREPERSON: Did it sometimes go beyond you and splatter around?

THE WITNESS: It would occasionally get on like on the floor or the walls. And, you know, just being the procedure room technician, after I got the scope into the scope room, I would have to go ahead and make sure that that was cleaned up and everything like that.

Going through with actual hospital grade disinfectants and hospital grade sanitizers to go ahead and clean it up and make sure that there was no trace of it before the next patient got in.

THE FOREPERSON: No visible trace?

THE WITNESS: No visible trace. And like I said, it was actually -- we actually used hospital grade disinfectants and cleaners, that if you went into

a hospital, you would see them all around to make sure that it was cleaned up.

THE FOREPERSON: Thank you. Any other questions? None.

By law these proceedings are secret. You are prohibited from disclosing to anyone anything that transpired before us, including evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury, or information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine, and 25 days in the Clark County Detention Center.

Do you understand this admonition?

THE WITNESS: Yes, I do.

THE FOREPERSON: Thank you. You may be excused.

We are off the record now.

* * * * * *

ATTEST: Full, true and accurate transcript.

MARCIA LEONARD, CCR 204

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID DISTRICT COURT

THE STATE OF NEVADA,

Plaintiff,

vs.

DIPAK KANTILAL DESAI, RONALD ERNEST LAKEMAN, KEITH H. MATHAHS,

Defendants.

ORIGINAL

No. 09BGJ049ABC

C245107

Taken at Las Vegas, Nevada

Thursday, April 29, 2010

9:19 a.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 5

Reported by: Danette L. Antonacci, C.C.R. No. 222

GRAND JURORS PRESENT ON APRIL 29, 2010

PAM YOUNG, Foreperson
JOSEPH WILLOUGHBY, Deputy Foreperson
SHELLEY SALAMANOUPOULUS, Assistant Secretary
LISA CAMP
CHRISTINE LYONAIS
AGNES PARKER (Leaves at 3:35 p.m.)
YOLANDA PARKER (Arrives at 10:07 a.m.)
BIANCA ROBERSON
BOB ROSE
ALICE SZURAN
MICHAEL THOMPSON
TOM UHRHAN
ANNE ZARATE

FILED

JUN 08 2010

CLERK OF COURT

Also present at the request of the Grand Jury:
Michael Staudaher,
Deputy District Attorney

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C245

LAS VEGAS, NEVADA, APRIL 29, 2010

* * * * * * *

DANETTE L. ANTONACCI,

having been first duly sworn to faithfully and accurately transcribe the following proceedings to the best of her ability.

THE FOREPERSON: Let the record reflect that I have canvassed the waiting area and no one has appeared in response to Notice of Intent to Seek Indictment.

MR. STAUDAHER: Ladies and gentlemen of the Grand Jury, this is the continuation of Grand Jury case number 09BGJ049A-C, State of Nevada versus Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

As I have said before in the previous presentations to you I told you that I would address you each and every time to make sure that there was, we address the issue of potential bias. If after the testimony that occurred last time and between now and then you have developed any or harbor any new biases now based on that testimony which would cloud your judgment or your impartiality in rendering a decision when you're

asked to do so down the road as to whether or not the State has met its burden in this case on the charges or not, that's the issue that I have to address each time. So with that being said, does any Grand Juror now present, have they developed or has anything came into their mind that would prevent them from being completely unbiased and just listening to the facts and applying them to the charges as presented?

A JUROR: No.

THE FOREPERSON: No.

MR. STAUDAHER: There is a general consensus that there has been no change in that as there has been in the previous presentations as well.

That being said, are there any questions that the Grand Jury has at this time regarding the law pertaining to any of the charges that have been presented? And I will revisit the law at the very end to make sure there is no question as to what law you are to follow. You all have copies of the statutes and they are an exhibit, I think Exhibit Number 2 in this particular case. Any issues with any questions thus far regarding the law?

THE FOREPERSON: No.

MR. STAUDAHER: Are there any questions that the Grand Jury has at this time that they would

like answered if I can?

THE FOREPERSON: No.

MR. STAUDAHER: With that we'll go ahead and continue the testimony.

THE FOREPERSON: Please raise your right hand. Thank you.

You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act of reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Thank you. Could you please state both your first and last names and spell them for the record.

THE WITNESS: Elaine Myers. E-L-A-I-N-E, M-Y-E-R-S.

THE FOREPERSON: Thank you.

MR. STAUDAHER: And ladies and gentlemen of the Grand Jury, before I get started with this witness I do want to refer you to the criminal complaint; or rather the Indictment I think is what we have up there right now before you, the testimony of this particular witness will pertain specifically to Counts, 14, 23, 44, 53, and 18, 27, 48 and 57. The two patients in question will be Rudolfo Meana and Gwendolyn Martin. In addition the racketeering counts will be referred to as well from this testimony which are Counts 28 and 29 and Counts 58 and 59 and that's with the information or the Indictment as it's currently constituted.

ELAINE MYERS,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Now, that being said, ma'am, what do you do for a living?

A. I'm director of operations for Health Care Partners. We are a third party administrator for Pacific Care. We pay their claims.

Q. Now Pacific Care is what, an insurance company?

A. Pacific Care is a HMO. We pay the HMO claims. It's an insurance company for HMO products. They have both a commercial and senior product.

Q. Can you tell us what the commercial product is called?

A. It's Pacific Care Commercial.

Q. What is the senior called?

A. Secure Horizon.

Q. If we see something called Secure Horizon that is in fact Pacific Care?

A. That is Pacific Care.

Q. Now directing your attention to -- well, before I do that let me ask you just a couple more predicate questions regarding what your company does.

You say you take in claims and so forth and then pay those claims?

A. Yes, sir.

Q. How does that work? I mean you're sitting in your office or your company is and how does a claim come in, how does it get processed and then paid?

A. The provider submits the claim via mail, we receive hard copy claims, and then we process those claims, we take them in, date stamp them and then put them through a computer adjudication system that pays the claim.

Q. And when you pay the claim do you pay it back to that provider that sent it to you originally?

A. That's correct.

Q. I'm going to direct your attention to specific instances involving two patients. Let's start off with one, I believe it's a Secure Horizon product, it was an individual by the name of Rudolfo Meana.

A. Yes.

Q. Is that one of the individuals that your company dealt with as far as dealing with the claim and payment for a claim?

A. Yes.

Q. Specifically I'm going to direct you to a time period of September 21st of 2007, a claim regarding that day. Did you have a chance to review any information in your company pertaining to that claim?

A. Yes, I have.

Q. Now I'm going to be showing you some documents specifically related to that particular person and that particular claim. They have been marked as

Grand Jury Exhibit Number 35. It's a six-page document. So if you are referring to this document during your testimony and you're referring to a specific page I ask that you identify which page of the exhibit you're referring to. Fair enough?

A. Yes.

Q. I'm going to hand that to you and ask you to flip through it generally at this time and just tell me if you recognize the document itself or series of document I guess.

A. Yes, I do.

Q. Okay. What are those series of documents? Let's start off with page 1, what is it?

A. That's a HCVA 1500, it's the name of the claim form that providers submit claims for professional services.

Q. Is that the claim that was submitted for that patient for the date of the 21st of September of 2007?

A. Yes, it is.

Q. Company received that. Did your company process that claim?

A. Yes, we did.

Q. After the claim was processed did you actually make a payment on that claim as it was

submitted to you?

A. Yes, we did.

Q. And do you have other documents that show what payment was made on that claim?

A. Yes.

Q. And you're referring now to another page of the document?

A. To page 2 of the exhibit, explanation of benefits.

Q. And how much money was paid on that particular claim?

A. $131.20.

Q. Now the amount that was actually submitted as a bill was greater than that was it not?

A. Yes, it was.

Q. What was the amount submitted initially?

A. $560.

Q. I'm going to take this claim form from you for a moment and the associated document and I'm going to display them for the Grand Jury and I'm going to ask you some specifics about what we're looking at.

Now at the top of the form it says 1500 insurance claim form. Is this where you get your designation of the HCVA 1500?

A. Yes, it is.

Q. Under number 2 on that form we have a name, that's Rudolfo Meana, is that what designates this patient as being on that claim form?
A. Yes, it is.
Q. I'm going to move down the claim form to the section, I believe it is, it looks like it's section 24, do you see that here?
A. Yes.
Q. And then below that where it's talking about date of service and so forth.
A. Yes.
Q. Date of service on that form?
A. 9/21/07.
Q. Now there is a designation for, I believe it's under section D, procedure and services. Do you see that?
A. Yes.
Q. It's got a number there 00810, what does that designate?
A. That's an endoscopy procedure.
Q. So a specific type, upper, lower endoscopy?
A. Yes.
Q. If we move to the end of the claim I see under charges, and I believe that's section F of that portion, there is a dollar amount?

A. Yes.
Q. How much is that?
A. $560, that is the billed amount.
Q. The amount that actually came from the center?
A. Yes.
Q. To your office for a charge or as a charge to be paid?
A. Yes.
Q. And then next to that, specifically I want to ask you about section G across there where it says days or units, that portion. You see that?
A. Yes.
Q. There is a designation of a number there. What is that number?
A. It's blurry, I'm sorry, I can't --
Q. That's fine, I'll show you the document and we'll put it back up. Handing you the direct document.
A. Thirty-three.
Q. Now I'll display that once again for the Grand Jury. I know it's typed and a little difficult to read, but 33, does that designate some sort of unit or minute or something like that?
A. It signifies minutes.
Q. Let's talk about minutes for a minute. So

on that claim form for that patient it's 33 minutes; is that right?
A. That's correct.
Q. Do you know how anesthesia is billed and how it comes in and you pay on it?
A. Yes. Anesthesia is paid by units and the one unit is equal to 15 minutes. There are base units, every unique procedure code, the 00810 signifies a procedure and there is a base unit assigned to that procedure. That base unit is five, an increment of five units. In addition to that there are the 33 minutes. And for every 15 minutes that's one unit. So 15 minutes is one unit, 30 minutes is two units, 45 minutes is three units. It is always rounded up. So 33 minutes is equal to three units. So that claim was paid based on five base units which includes like set-up and the preliminary plan that the anesthesiologist does and then three base units for a total of eight units. That is multiplied then times whatever the contracted rate per unit is by whichever health insurance company.
Q. So let me understand this correctly. That particular bill that we're looking at for Rudolfo Meana which says 33 minutes of anesthesia time, they would have five base units, plus for this particular one an additional three units for a total of eight?

A. Yes, that's correct.
Q. Now if the submitted amount minutes on this particular form had been let's say 29 minutes, how many units would have been paid on by, or first of all how many units would have been billed and how many would have been paid on?
A. Twenty-nine minutes would have been billed and two units would have been paid.
Q. So it would have been seven instead of eight?
A. It would have been seven instead of eight.
Q. If it was 12 minutes how many units would be paid?
A. A total of six because it would be five base units and one --
Q. One unit for the time?
A. -- one time unit.
Q. Is it fair to say then if the submitted claim form contained an increased or fraudulent number of minutes, meaning more than what's used on the actual patient, that your company would pay a claim, pay more money than they should have?
A. Yes, that's correct.
Q. And conversely if you had received this claim form and it had said 22 minutes would you have

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID DISTRICT COURT

THE STATE OF NEVADA,

Plaintiff,

vs.

DIPAK KANTILAL DESAI, RONALD ERNEST LAKEMAN, KEITH H. MATHAHS,

Defendants.

ORIGINAL

No. 09BGJ049ABC

C265107

Taken at Las Vegas, Nevada

Thursday, April 22, 2010

8:53 a.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 4

Reported by: Danette L. Antonacci, C.C.R. No. 222

GRAND JURORS PRESENT ON APRIL 22, 2010

PAM YOUNG, Foreperson
JOSEPH WILLOUGHBY, Deputy Foreperson
LOUISE ZUNIGA, Secretary
SHELLEY SALAMANCOUPOULUS, Assistant Secretary
SVEN BRADLEY
CONSTANCE CABILES
LISA CAMP
CHRISTINE LYONAIS
AGNES PARKER
YOLANDA PARKER
BIANCA ROBERSON
BOB ROSE
STEVE SHLUKER
ALICE SZURAN
MICHAEL THOMPSON
TOM UHRHAN
ANNE ZARATE

FILED

JUN 08 2010

CLERK OF COURT

Also present at the request of the Grand Jury:
Michael Staudaher,
Deputy District Attorney

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CE15

LAS VEGAS, NEVADA, APRIL 22, 2010

* * * * * * * *

DANETTE L. ANTONACCI,

having been first duly sworn to faithfully and accurately transcribe the following proceedings to the best of her ability.

THE FOREPERSON: Let the record reflect that I have canvassed the waiting area and no one has appeared in response to Notice of Intent to Seek Indictment.

MR. STAUDAHER: Good morning ladies and gentlemen of the Grand Jury. My name is Michael Staudaher. I'm the deputy district attorney assigned to prosecute the case of Dipak Kantilal Desai, Ronald Ernest Lakeman, Keith H. Mathahs, Grand Jury case number 09BGJ049A-C.

This is the continuation of the Grand Jury presentment in that matter. At the last time we were here and as I told you on previous occasions I would ask each one of you if after the presentations that had been done, prior to you deliberating or prior to you even hearing additional testimony for a new day, that we would go around the room or at least ask the Grand

Jurors if there has been any change in the Grand Jury's belief that they cannot sit as a, that they can rather sit as an impartial hearer of the facts and can deliberate in an unbiased manner. Can anybody, or does anybody have any change in what they previously stated they could do in this particular case with that regard?

THE FOREPERSON: No.

MR. STAUDAHER: So there is a general acknowledgment from the Grand Jury that they can all still sit as impartial, unbiased listeners of the facts and then deliberate in an unbiased manner in this case just taking the facts and applying them to the law as provided to you; is that correct?

THE FOREPERSON: Yes.

MR. STAUDAHER: General acknowledgment on the record from all Grand Jurors.

And also the other portion that I need to make sure I address is that I know at times during the presentation that one or more of you may have left the Grand Jury proceeding, a prior proceeding for a short time or maybe even a whole day. In those instances I need to make sure that you all are aware that before you can deliberate in this case, and I will not have you deliberate today, but before you can deliberate that you all in order to deliberate must have fully read or been

present, fully read the transcripts of or been present for the presentations for each and every witness in this case. Do I have a general acknowledgment from the Grand Jury related to that?

THE FOREPERSON: Yes.

MR. STAUDAHER: And that's on the record as well.

Okay. We'll continue on with the testimony today. We're going to start off with Dr. Thomas Yee.

THE FOREPERSON: Would you please raise your right hand, sir.

You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: Yes, I do.

THE FOREPERSON: Thank you. You may be seated.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Thank you.

Could you please state your first and last names spelling both for the record.

THE WITNESS: Thomas Yee. First name spelled T-H-O-M-A-S, last name is spelled Y-E-E.

THE FOREPERSON: Thank you.

THOMAS YEE,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Dr. Yee, what do you do for a living?

A. I'm an anesthesiologist.

Q. How long have you been a anesthesiologist?

A. I've been an anesthesiologist for 20 years.

Q. Can you walk us through some of your background and training to get to where you are today?

A. I graduate from Tongji Medical University, spelled T-O-N-G-J-I, in the People's Republic, China in 1989. And I passed the foreign medical graduate

examination and entered internal medicine internship in Roosevelt Hospital in New York City, which is a teaching hospital of Columbia University, and after one year I started anesthesiology residency at University of California San Diego. Three years later I completed a program and passed the certification exam by the American Board of Anesthesiology and I began practicing medicine in Las Vegas.

Q. So what time did you get to or what year did you come to Las Vegas?

A. 1993.

Q. And did you immediately start practicing as an anesthesiologist at that time?

A. Yes.

Q. Now before we get into your work history I'd like to ask you just some general questions about anesthesia and anesthesiologists. Are you with me?

A. Okay.

Q. What is an anesthesiologist, what do you do?

A. An anesthesiologist is a medical doctor whose primary mission are three. Number one, ensuring patient safety in the operating room which includes pre-op, inter-op and post-op. Number two, ensure patient's comfort during that time. Number three is

perform the role of the resuscitation, for example if a patient had any kind of say cardiopulmonary arrest or other serious medical problem during that time we happen to be the medical specialist on-site who are most familiar with the steps that need to be taken to rescue the patient. So these are the three main roles of an anesthesiologist.

Q. And I assume that training, the specialized training that you described is related to just that field; is that correct?

A. Yes.

Q. Are there areas of specialty within anesthesia?

A. Yes. There are areas such as pain management, cardiac anesthesia, obstetric anesthesia and pediatric anesthesia.

Q. Are you specialized in any of those areas?

A. Yes. I have specialized in pain management and cardiac anesthesia.

Q. As far as other individuals that are able to give or utilize some form of anesthesia, who can do this? Does it have to be a doctor like yourself? Can it be a regular medical doctor, a lay person off the street?

A. In the rest of the world my understanding

is that anesthesiology is practiced by doctors only. But in this country, the United States, through some historical factors there are nurses who give anesthesia under the supervision of an anesthesiologist. And in recent years I believe things have evolved so nurse anesthetist in some situations are working either by themselves without any supervision, that's permitted in certain states, or they're under the supervision of the operating doctor, the surgeon. There are also doctors who have not performed, who have not done anesthesiology residency or passed the board certification exam but just through a history of familiarity of practice perhaps in rural area they assume the role of performing anesthesia for patients.

Q. Now you mentioned a certified nurse anesthetist; is that correct?

A. Yes.

Q. Have you ever dealt with nurse anesthetists before?

A. The CRNA nurse anesthetist, I have met them, for example in my training at UC San Diego, but I have never supervised CRNA.

Q. Not any time in your training or history, just in general, or what?

A. In my private practice in Las Vegas I have

never supervised CRNA. In my training as a resident I worked in a sense side by side with some CRNA because they would be attending a faculty member anesthesiologist that would teach me for example who was a resident and there might be a CRNA alongside me in the operating room to perform anesthesia. And also between my training and the time that I was practicing in Las Vegas on occasions I've been to Los Angeles to do temporary work, these are called Locum Tenem work, L-O-C-U-M-T-E-N-E-M, that's just temporary work, and in that capacity as a temporary anesthesiologist in some hospitals in Los Angeles I have worked with CRNA, nurse anesthetist.

Q. Now when you say work with them does that mean you worked with them in a supervisory role or you just, they were just at the hospital doing anesthesia and you were doing anesthesia?

A. It was a supervisory role in Los Angeles on those few. I imagine all together no more than three, four days.

Q. In the instances when you have in fact supervised a CRNA what kind of things did you have to do from your perspective to adequately supervise a person like that?

A. I would have to, and this is required by

regulation, I would have to see the patient before the anesthesia was started, I would have to discuss the anesthesia plan with the CRNA, the nurse anesthetist, and afterwards I have to see the patient to make sure the patient was okay. And if everything was satisfactory then I will sign my name to the anesthesia record along the name of the, with the name of the CRNA, nurse anesthetist. So there would be two signatures on the anesthesia record under anesthesiologist.

Q. Beside meeting with the patient and discussing things with the CRNA and signing documents, I mean is it something that you would have to or did, you know, stand side by side with the CRNA as they were administering anesthesia to a patient?

A. Yes. During the critical stage of anesthesia, for example what we call induction, the beginning of anesthesia, it was my habit, and I believe it's a national standard, that the MD would have to be in the room looking over the shoulder of the nurse anesthetist to make sure everything has gone smoothly at the beginning which is the most critical time during an anesthesia process. And when the anesthesia has started smoothly I would then walk to say another room to supervise another CRNA. And also I'm available on-site. That means in an operating suite with a number of

operating rooms I would have to walk among these two, three, four rooms or sit down immediately outside these rooms making myself available for the nurse anesthetist.

Q. Now we're going to get into the details of issues related to supervision in a moment, but I just want to ask you a couple more general questions before we go to another area.

When you say that you were in the area, what do you mean in the area? I mean could you be in a different building, could you be down the street at your office for example if a CRNA that you were supervising was actually taking care of a patient?

A. No. There are laws on this issue, and also national standard care, which is the MD anesthesiologist supervising the CRNAs have to be on-site, has to be in the same general area. Meaning that in a surgical department with a number of operating rooms that MD anesthesiologist has to be inside that operating suite, maybe not the same room but he has to be in the same suite.

Q. Okay. I'd like to move to another area before we come back to that eventually. I'd like to ask you some questions about a drug by the name of propofol. Are you familiar with that drug?

A. Yes.

Q. Does it have another name; Diprivan?

A. Yes.

Q. Same drug though?

A. Same drug.

Q. And we'll call it propofol from here on out. But I wanted to ask you if you were familiar with that particular drug.

A. Yes, I am.

Q. What is it anyway?

A. It's an anesthetic.

Q. When you say anesthetic what kind of properties or characteristics does it have to make it a anesthetic?

A. It's a medication, it's an injectable medication that has replaced Sodium Pentothal about 25 years ago. It's a emulsified solution so it looks white when you look at it and it renders a person unconscious making that person go to sleep and it has some superior properties compared to Sodium Pentothal. For example, it's very short acting, patients can wake up with relatively clear head, they can regain consciousness very quickly and to some extent it prevents nausea after the patient wakes up. So it has multiple advantages. That's why it's the predominant anesthetic induction agent in the whole world right now.

Q. And when you say induction I think you had mentioned before the actual beginning portion of anesthesia when you're first putting the patient to sleep; is that correct?

A. Yes.

Q. Now if you were having a patient that was going to be asleep for a long period of time would you use Diprivan throughout the procedure? Excuse me. And I said Diprivan, I meant propofol in this case.

A. It is an option that an anesthesiologist may choose, but cost wise it's very expensive so we often would start the anesthesia by injecting propofol and then turn on oxygen nitrous oxide mixed with some anesthetic gas to maintain the whole duration of anesthesia.

Q. Okay. So you said it was short acting. Does that mean it has a short onset of action as well?

A. Yes, it goes in and takes effect quickly and then it's metabolized and loses effect quickly unless you continuously replenish it.

Q. So when you were in a longer procedure after you, or when you were getting near the end of the procedure, is that where you would sort of slow down your use or minimize your use of those longer acting anesthetic agents and start adding propofol back in so

that when you were done with the procedure the person would wake up?

A. Personally as a board certified anesthesiologist my technique is for a long procedure toward the end I would turn down the anesthetic gas so the patient can wake up quickly. Usually I don't give propofol at the end of the anesthesia.

Q. So for you that is strictly, not strictly but it's primarily a induction agent only then?

A. Yes.

Q. Now for shorter procedures, and you know you're here to testify about issues related to colonoscopies and upper endoscopies, for those types of procedures is the use of propofol for the duration of the procedure an appropriate use?

A. Yes, it is.

Q. So the time frame for the use of propofol for an entire procedure ranges into what period usually?

A. It can be as short as one minute and as long as days. In the intensive care unit for example it's very common for a patient to be kept on propofol if you want to induce a coma-like state in a patient. So it can be used for as short as one minute as long as multiple days.

Q. So for a procedure that would last say

between 15 and 30 minutes, would that be an appropriate use of just propofol?

A. Yes.

Q. For that particular type of drug, I know you said the onset and essentially the recovery is very short on both ends; correct?

A. Yes.

Q. As far as the amount that would be required, I'm assuming that it would be different depending on the type of person, how heavy they are, their medical condition, their age, things like that?

A. Yes.

Q. In general for a colonoscopy procedure do you have an idea of what the average amount of propofol per procedure would be necessary?

A. In my own practice, in my own experience for colonoscopy it requires between 10 to 20 ml of propofol.

Q. When you say ml, is that milliliters?

A. Yes.

Q. Is that what you on average would use?

A. Yes.

Q. Sometimes more, sometimes less I would assume?

A. Yes.

Q. What kind of duration of procedure are we talking about for that kind of use?

A. That would be about 10, 15 minutes.

Q. So if you had procedures that were lasting into the 30 plus minute range you would use more?

A. Yes.

Q. If you had procedures that were only lasting between three to five minutes would you use less?

A. Yes.

Q. Now as far as the drug itself, you had mentioned some of the properties it had, primarily to put people to sleep I assume; correct?

A. Yes.

Q. Are there other properties of that drug that make it something that's beneficial? For example, does it have an amnestic effect making people not remember the procedure, things like that?

A. Yes, but it's part of the overall property of an anesthetic. For a drug to be called an anesthetic it has components of three different properties. One is hypnosis, it makes a person go to sleep. The second part is amnestic, it makes a person forget. The third one is it may take away anxiety, antianxiety. So for the anesthetic to work it generally has these three

properties.

Q. As far as the amnestic effect, the part that you mentioned of the three, I want to ask you just a couple of questions about that. If for example during induction or during the time that you're using an anesthetic to put someone to sleep for a procedure, at the beginning of the procedure something would happen, I don't know, you drop a pan on a person's leg and it didn't cause any injury that would be present afterwards but it hurt the patient, would that be something the patient may not remember happening as a result of being given the anesthetic drug?

A. If the patient already received adequate dose of propofol he should not be able to remember that incident.

Q. As far as a procedure being started for example before anesthesia, before propofol is actually given, would the propofol used subsequent to that potentially make a person not remember it?

A. In the usual dose no. That's a phenomenon called retrograde amnesia, making a person forget what has happened before, and propofol in my experience does not have that property.

Q. Okay. So it would be something that would be contemporaneous with the use of propofol?

A. Yes.
Q. Not with things that happened before?
A. No.
Q. Now do you know an individual by the name of Dr. Dipak Desai?
A. Yes.
Q. Before I get to him specifically I have one last question regarding the propofol. You said you're familiar with it, you've used it a lot over the years that you've had it. How many times would you estimate just in generality you've used that particular drug?
A. Probably over 25,000 times.
Q. Is this a drug that the average doctor is, you know, allowed to use in regular practice?
A. I believe the law allows a licensed MD to use just about any drug.
Q. And in your experience as a doctor, not just an anesthesiologist, would you use drugs that you were unfamiliar with or didn't know the history of or the background of?
A. I would not.
Q. Would you think that that was reasonable for a physician to rely on others who had more knowledge about certain drugs to use those particular drugs?
A. Yes.

Q. Would you think that it would be reasonable for a person to supervise another individual if they didn't have, with regard to a drug or any other procedure, if they didn't have knowledge of those procedures or drugs?
A. No.
Q. Now let's get onto Dr. Desai. How did you come to meet or come in contact with Dr. Desai initially after you came into town?
A. I believe, the way we work as anesthesiologists in Las Vegas which is a surgeon request system, we do not just sit in the operating room waiting for patients or surgeons to come along, we actually receive phone calls to, for appointments. The surgeon's office will call days in advance to ask us to appear at a certain place and a certain time to take care of certain operations by giving the patient anesthesia. And on that day and time we, the anesthesiologist, would then go to that facility and perform the anesthesia service. And I believe Dr. Desai, similar to other surgeons and doctors, would have requested my service, simply called my office, requested me to go to a hospital or a facility to give anesthesia for a procedure he was about to perform.
Q. Okay. So is that how it starts, the

relationship starts at the beginning?
A. Yes.
Q. When you said hospital and other locations, what was your primary at least initial interaction with him, where did it occur?
A. I believe it was in his endoscopy center.
Q. Did you also deal with him in the hospital situation?
A. I might have given anesthesia for a few of his patients in the very beginning but I think I have worked with him in hospitals and also in his own endoscopy center.
Q. Now when you were working with him, when you would be called to go to the endoscopy center, was it for these types of procedures, upper endoscopy, colonoscopies, things like that?
A. Yes.
Q. All short duration procedures?
A. Yes.
Q. As far as the other people that may have been providing that service, were you the only one or did other people appear as well?
A. There were many, many anesthesiologists that were called to provide anesthesia service for Dr. Desai.

Q. So you weren't the only individual that was sent over there to do that work?
A. No. I would imagine I probably was the one that went maybe the fewest times to his, to perform anesthesia for him.
Q. In a typical week how many times did you go there?
A. I would go probably once every six month.
Q. So it wasn't very often at all?
A. No.
Q. Now at some point, I mean did that whole process of going to see him change at all and did you go with more frequency, or what he requested or he required of you change during that time?
A. Yes, there was a change around 2001.
Q. What was that change?
A. I believe he hired CRNAs.
Q. So at that time you said the only experience at least supervising or dealing with CRNAs was this Locum Tenem work that you did in California; is that right?
A. Yes.
Q. And I think during your training too did you have some?
A. Right, but my training I did not supervise

the CRNA, I was only a student, a resident.

Q. Now when you go do anesthesia -- and we'll get to the supervision in a minute.

When you go do anesthesia tell me, I'm not asking about the mechanics of doing the procedure itself but I assume that there is sort of a process that happens once you get, if somebody asks you to come in to do a procedure and you come there to do the anesthesia, what do you do when you get on-site?

A. I would evaluate the patient, explain to the patient what we were about to do for him or her and get the permission which is a consent, and then I would check the equipment, the anesthesia equipment, the anesthesia medications, and then I would return to the patient, make sure an IV, intravenous access has been established, and then that's the, those are the preparations that we would do before anesthesia.

Q. Okay. I'm going to show you what has been marked as Grand Jury Exhibit 29 and ask you if you are recognize that item.

A. Yes, I do.

Q. Okay. What is it?

A. It's an anesthesia record.

Q. Okay. Did you in fact bring this with you to the Grand Jury proceeding?

A. Yes.

Q. And you said an anesthesia record. What do you mean by that? Is that something that you just keep track of what you're doing, is it something you fill out in advance; what do you do with that?

A. An anesthesia record is a way that anesthesiologists document the events and the patient conditions during the anesthesia.

Q. And this is a blank document is it not?

A. Yes, it is.

Q. Okay. And I've displayed that for the Grand Jury on the document camera and if we need to we can refer to it as we go along.

Now I know that it looks like, on the top portion of that, it looks like some patient information or at least some things to put various I guess documenting information down. What is the purpose of that?

A. It's for us to record the results of our pre-anesthesia interview. If there were disease states that the patient had we were to record it, if there were allergies to medication we were supposed to record it.

Q. There is a portion that is in sort of box type format that has on the left hand column side of the page it says temperature and there is a bunch of boxes

that go out from left to right across the page. Do you see that?

A. Yes.

Q. And can you tell us what the purpose of all those boxes are that are on the form and what you do with them?

A. Those are for us to record the vital signs such as blood pressure, heart rate and even respiration.

Q. Do you ever have a situation where you know you've just done so many of these and they're all kind of just so routine that you just go ahead and fill that out in advance?

A. No, never.

Q. Would you ever do that?

A. No.

Q. And when I say fill out, I'm talking about the vital signs for example, would you ever say what the patient's vital signs are going to be in advance?

A. No.

Q. Is there any way to really know what their vital signs are going to be in advance?

A. No.

Q. I mean heart rate, blood pressure, respiration rate, things like that?

A. No.

Q. Do the boxes indicate an increment of time as well that those different measurements need to be done or not done or what they are at those times?

A. The standard way of doing this is to designate each small box horizontally as five minutes.

Q. So as we go across each box that we move to would be another five minutes and then another five minutes?

A. Yes.

Q. And I assume you fill that out, based on your testimony, that you would fill that out after that five minute period to say what the patient's blood pressure, pulse and so forth were during the previous five minute interval?

A. Yes.

Q. As far as the start time stop time kind of thing, is that ever designated any place on this particular form?

A. Yes, it's at the bottom of these forms.

Q. I'll move it up so we can see that.

And where specifically would you be talking about; in this area down here, the lower right hand corner?

A. Yes. There is a space for anesthesia start time and anesthesia stop time.

Q. Now how do you figure that out? I mean is that from the time you get called by the doctor to come out to their facility to do the work, is that when your start time starts or is there another time that you use?

A. No, I start at the time when the patient actually enters into the operating room.

Q. So when you actually make contact and start dealing with the patient then?

A. No, I don't deal for pre-op visit, there may be other doctors that do but personally I don't deal with just talking to the patient in the pre-op holding area. I start when the patient is actually brought into the operating room.

Q. Is that the standard that most anesthesiologists use to your knowledge?

A. To my knowledge, yes.

Q. So that would be the start time when they physically enter into your sort of zone of care; is that right?

A. Yes.

Q. Once that happens do you write down that time or do you ask somebody what the time is? I mean how do you actually get that figure, that number?

A. In the operating room we have to synchronize all the times since the operating room

nurses also record the anesthesia time so we talk to each other and announce the time together and then I will write down the time.

Q. Now when you put that start time down then, let's say whatever it is, 12:00 noon, and then I assume at some point the procedure takes place; correct?

A. Yes.

Q. Now during the time after you put that start time down are you doing things like monitoring the patient's blood pressure and vital signs, things like that?

A. Yes. First I would apply the monitors, the EKG, blood pressure cuff, and the pulse oximeter probe to the patient.

Q. Are any of those things ever done in advance before they wheel the patient into the room?

A. The monitoring?

Q. Any of it, the IV access, any of that stuff?

A. Yes, IV access can be put in before the patient's entry into the operating room.

Q. So once they come in and you're working on them, again the procedure goes on, whatever that procedure is at some point?

A. Yes.

Q. Now after the procedure is completed at what stage do you sign off or put down your end time for anesthesia?

A. The end time is the time when I walk away from the patient which is after I have pushed the patient's bed to the recovery area and after I have given the report to the recovery nurse. So I write down the time that I walk away and hand over the care to the recovery nurse.

Q. Do you ever continue to have anesthesia time recording when you are not in fact dealing with the patient? If you walked away from the patient and let's say you're going to have a cup of coffee or you're actually going to go pre-op another patient, would you still continue to record anesthesia time for the patient you just finished with?

A. No.

Q. Would that be an inappropriate recording if you did that?

A. I think that's correct, it is not appropriate to count that time.

Q. Now if you were in a situation like in the short colonoscopy endoscopy procedures where you were the anesthesiologist and you just stayed in the room and, you know, you said bye to the patient as they are

wheeled out of the room but never went out to the recovery area, checked on the patient or gave a report to the nurse or whatever, would your anesthesia time then stop when they left the room?

A. First of all I would not accompany the patient to the recovery area and give a report to the recovery nurse, but if there is a situation where say some other professionals such as other anesthesiologists are taking over immediately outside the operating room and escort the patient to recovery and so on, I would stop my own anesthesia time at the moment when the patient is pushed out of the operating room.

Q. Even if the place where they were taking the patient to was 10, 20 feet away from where the anesthesia room that you are were in was?

A. No. Because an anesthesiologist cannot claim service to two patients at the same time. If the next patient's wheeled in after the first patient has been wheeled out I can't take credit for both care for both patients.

Q. I'm going to give you a hypothetical situation. You're supervising a CRNA, the CRNA stays in the room from the point that the patient is wheeled in to the point the patient is wheeled out and does not accompany that patient into the recovery area, what

would the appropriate times to mark anesthesia time for that particular patient be?

A. It would be, in my own opinion, in my own practice I would mark the start time as the time when the patient was brought into the room and the finish time as the time when the patient was pushed out of the room.

Q. Okay. Now have you ever in your practice ever documented vital signs on a patient when that patient was no longer in your care?

A. No.

Q. And billed for that or charged for that time?

A. No.

Q. Have you ever submitted or put one of these forms together that you said these anesthesia forms with incorrect information to your knowledge?

A. No.

Q. As far as the forms themselves are concerned what do you do with those forms after the procedure is done?

A. One copy stays with the patient file and stay with the hospital, that goes into the patient's permanent record. I will also make a copy, a Xerox copy and I will bring that along with the patient insurance

information which we call a face sheet that has the patient's name, address and insurance information, I will bring the face sheet and a copy of the anesthesia record back to my own office for my assistant to bill the insurance company with.

Q. So anesthesia record and the patient information for insurance?

A. Yes.

Q. Those two documents?

A. Yes.

Q. So then you or somebody for you bills for your services then?

A. Yes.

Q. Do you ever have the doctor bill for your services that you didn't work with?

A. Never.

Q. Now the reimbursement that comes in, does that reimbursement come to you or does it go to the doctor who did the procedure?

A. It does to the anesthesiologist, me.

Q. Does the doctor get a piece of that at all?

A. No.

Q. When I'm saying the doctor, not that you're not a doctor but I'm talking about the doctor who did the procedure.

A. No.

Q. Do you ever fee split or give him a portion of that because of the referral?

A. No. In many situations my understanding is that fee splitting, for a physician to pay another physician for referral, is illegal.

Q. And you have not done that I assume?

A. No.

Q. Now going back to this form again, I think it's Grand Jury Exhibit 29 if I'm not mistaken, below those little small boxes up here on the upper half of the form there is some larger boxes that are just immediately below that. Do you see those?

A. Yes.

Q. What are the purposes of those boxes?

A. The boxes toward the top are meant to provide a space for us to enter the more complicated vital signs such as oxygen saturation, entitled CO2, we had a machine that measured the exhaled carbon dioxide in a patient's breath, and there is one that we would record the oxygen level concentration that patient was receiving, and there is a box for recording the time, and in the next box is remarks, that's for us to designate a symbol such as number one, number two, number three, so that we can explain the event on the

right hand side of the chart. Typically I would mark say number one and explain the number.

Q. Is that this space over here on the right hand side of the chart that you're referring to?

A. Yes. I would explain the remark number one as pre-oxygenation, giving the patient oxygen and begin intravenous anesthesia induction.

Q. Would you also put down things like when you administered drugs and so forth with the patient?

A. I would mark the beginning of the propofol as induction, but also in the boxes on the, in the middle of the page at the appropriate time in that particular box I would write down all medications given to the patient.

Q. So if you were in your first beginning portion and you gave your let's say 10CCs of -- and CCs are like milliliters, correct, they're individual units of drug or whatever fluid that you're using?

A. Yes.

Q. When you gave the dose of, the initial dose of the propofol and wrote that down, if you had to give a subsequent dose would you then write that down as well?

A. Yes, I would write down every dose I give to the patient.

Q. Would that be chronologically in the right time frame that dose was given?
A. Yes.
Q. So when you look at this record after the fact if you were an anesthesiologist and you were looking at the record would you expect that if it had those kinds of things on it that would have indicated when drugs were given, when vital signs were taken, that information would be accurate?
A. Yes.
Q. Do you ever have a situation where you want to know how somebody has reacted to anesthesia from previous procedures?
A. Yes.
Q. And the types of drugs that had been given to them and how much had been used and things like that?
A. Yes.
Q. How does that play or why is that a concern to you?
A. If a patient told me pre-op that last time he had anesthesia there was complications I would want to review the anesthesia record from that previous surgery.
Q. If you reviewed that anesthesia record and it hypothetically turned out to have false information,

false recordings of time, vital signs that the patient had actually done well when maybe even the patient wasn't even there, would that give you false information to which you would base your plan on potentially?
A. Yes.
Q. Would that be something that would be concerning to you?
A. Yes.
Q. Would you ever do that yourself, give false information out to somebody that might rely on it later on in the anesthesia record?
A. No.
Q. As far as the documentation of the things you're talking about, do you also, in those numbered boxes where you put the comment on the right hand side, do you discuss any problems that may have occurred during the anesthesia?
A. Yes.
Q. Do you ever just say that somebody is healthy and happy and did well when in fact you hadn't even worked on them yet?
A. No.
Q. Now let's go back a little bit to the process by which you go through the anesthesia on a particular patient on these type of procedures, the

colonoscopy endoscopy. Okay? Are you with me?
A. Yes.
Q. Patient is wheeled into the room, you go ahead and perform the various things that you said, give the anesthetic agent and procedure is performed, patient leaves the room, you, typically you said follow that patient out?
A. Yes.
Q. Let's say that's the only one you did for the day. If I understand you correctly you take this anesthesia form and you would take the patient's insurance information and you would leave and then later bill the insurance company with that?
A. Yes.
Q. When you bill the form, the insurance company form, do you use a specific type of form that you submit to insurance companies?
A. Yes.
Q. Are those called claim type forms or what?
A. Yes, those are insurance claim forms submitted by physicians.
Q. Do they have a particular number designation?
A. I'm not sure.
Q. What type of form, is it the same form for

all insurance companies essentially?
A. Yeah, there is a uniform form used for all insurance company.
Q. Okay. And when you submit that form I assume that the information contained on it needs to be accurate as well?
A. Yes.
Q. Would you ever put false information on a insurance form to submit for a claim?
A. No.
Q. Once that claim goes in typically you said I think you get reimbursement back to you directly or to the company that's billing for you; correct?
A. Yes.
Q. Is that based on the actual amount of work that you did?
A. Yes.
Q. Now let's talk about your work for a minute. How does anesthesia work, sort of designated or recorded, how is it that you derive an amount to send to the insurance company for reimbursement?
A. There is a conversion based on the complexity of the case, so we're given a certain number of units or different type of procedures, and for the time we spend with the patient usually is one unit for

every 15 minutes.
Q. So one unit is a 15-minute interval. When you say unit, is that a billable type thing?
A. Yes, one billing unit.
Q. Are there any, do you start off with any certain number of units in a procedure or do you just bill the amount of time you did on a procedure?
A. Yeah, there is certain number units that is associated with the procedure.
Q. Do you know what the numbers are pertaining to upper endoscopies and colonoscopies?
A. These numbers used by my office are such that the upper endoscopy EGD I believe the code is 00740, and the units are five units.
Q. Is that for both of those procedures or are they different?
A. They're different. For colonoscopy the code is 00810 and the unit value is five units.
Q. So before you do anything to the patient you code that procedure, your upper endoscopy or colonoscopy, you get to start off with five units; is that what you're saying?
A. Yes.
Q. And then on top of that do you add the time for the units that you actually gave anesthesia?

A. Yes.
Q. So if you had a, and I'm trying to make sure I understand how this would go, if you had say a 14-minute procedure how many units would you bill for?
A. One unit.
Q. So you would have five plus one which would be six?
A. Yes.
Q. And if you had a procedure that was 16 minutes long, one minute past the 15-minute increment, how many units would you bill for?
A. I would bill for usually still one unit.
Q. How many could you bill for in that situation?
A. I could bill for two.
Q. Because you're in that next 15-minute increment?
A. Yes, but that's controversial so I just stay on the conservative side.
Q. If you went up to say 30 minutes or let's say in this case 31 minutes or 32 minutes, how many units could you potentially bill for?
A. Maximum three units.
Q. So your base unit of five plus a maximum of three would be eight?

A. Yes.
Q. Now depending on the number of units that you submit to the insurance company does that vary the amount of reimbursement you get back typically?
A. Yes.
Q. So if I -- and I don't want to make this too simple, I'm just trying to understand it. If I bill more units you get more money back, if you bill less units you get less money back?
A. Yes.
Q. Or fewer units you get less money back?
A. Yes.
Q. And the situation where you said you try to be conservative, do you ever just, you know, gosh, you got to 29 minutes so you just put it up to 30 so you could bill an extra unit?
A. No.
Q. Would that be an appropriate billing method for any individual?
A. No.
Q. Now I'm showing you what has been marked as Grand Jury Exhibit Number 28 and I want to ask you if you can tell me what that item is. First of all if you're familiar with it and then tell me what it is.
A. Yes, I'm familiar with this.

Q. What is it?
A. This is the federal law regarding the relation between CRNA nurse anesthetist and the supervision by physician.
Q. And I know we've got it there, it's an admitted exhibit. What does it tell us about that issue?
A. I'm not a lawyer but my reading of this tells me, it says a nurse anesthetist has to be supervised immediately by a physician. If the supervising doctor is not a MD anesthesiologist, if such a person is not available, then the burden of supervision falls on whichever operating physician or surgeon that happens to be there who required the service of the nurse anesthetist.
Q. To your knowledge is that the way it is in Nevada?
A. I believe it is.
Q. So either MD anesthesiologist or if that person isn't readily available a doctor, MD doctor who is doing the procedure?
A. Yes.
Q. Now with regard to the supervision issue again, and we're back to that, as a MD anesthesiologist is there a limit on the number of individual CRNAs that

you can supervise?
A. Again I'm not a lawyer but I was told Medicare rule limit the supervision to four CRNAs by one MD at any given time.
Q. And ladies and gentlemen of the Grand Jury, I'm going to caution you on the issue related to the hearsay. That's not offered for the truth of the matter asserted, just what his understanding and belief is about how many he could supervise.
And based on that, what you were told or what you believed the law was, would you supervise more than four individuals?
A. No.
Q. But you think you could supervise up to four individuals?
A. Yes.
Q. Now in supervising nurse anesthetists, would you be able to bill for their services?
A. Yes.
Q. So if you had let's say gone to the Endoscopy Center and were doing procedures for Dr. Desai and are supervising two or three nurse anesthetists at that time and they were all doing procedures, could you then take those face sheets or those insurance information, the anesthesia records, and bill for those

services?
A. Yes.
Q. If you were the one there doing supervision would Dr. Desai or any of his fellow physicians be able to bill for those services?
A. No.
Q. Would the CRNAs themselves be able to submit it as bills without you?
A. I believe not.
Q. And that's because you're the supervising physician I assume; correct?
A. Yes.
Q. Now at some point down the road you had said that, and I think it was 2001 or was it right around 2001 you thought that Dr. Desai was going to use nurse anesthetists?
A. Yes.
Q. Can you talk to us about that issue? What you know about it, were you involved in that at all?
A. I was not involved in the process.
Q. How did you know he was going to use them?
A. During one occasion when we work together he said he's planning on hiring nurse anesthetist.
Q. Did you ask him about that or talk to him about it?

A. He made that remark and I believe I mention to him that my understanding of the law is if you do not have a MD anesthesiologist there in the room supervising the nurse anesthetist then the surgeon or the operating physician would be the supervising doctor and they hold the responsibility.
Q. You actually told him that?
A. Yes, I explained to him my understanding of the law is the MD anesthesiologist is responsible for a CRNA if the MD anesthesiologist is in the operating suite, but without the MD anesthesiologist in the operating suite then whatever surgeon or operating physician happens to be there then they become the one assuming the responsibility.
Q. So beside that discussion with him, was that just a single discussion or did you have that on more than one occasion?
A. I think it was just one discussion.
Q. At some point down the road did you learn that he was using nurse anesthetists?
A. Yes.
Q. At the time that he started using them were you involved in any supervisory role with those nurse anesthetists?
A. No, never.

Q. At that time were you asked to potentially be involved with that supervisory or any supervision of those nurse anesthetists?
A. Yes, I was asked.
Q. At that time back in 2001 or 2002?
A. Yes, I was asked.
Q. By who?
A. By Dr. Desai.
Q. And did you agree to do that?
A. Yes, I agreed.
Q. Did you enter into some sort of agreement or start that process to do that supervisory work?
A. There was a letter of intent that if he called me, like he would, as any surgeon request system doctor would, if he called my office, asked me to perform the service which that would include supervising nurse anesthetist, then if that day I'm free I will go and perform the service.
Q. Now I'm going to show you what has been marked as Grand Jury Exhibit Number 27. And I'm also going to show you at the same time Grand Jury Exhibit Number 26. Are you familiar with those documents?
A. Yes.
Q. Have you seen these before?
A. Yes.

Q. What are they? I mean same type of document; correct?
A. They're similar.
Q. But there are differences between the two documents?
A. Yes, there is a very important difference.
Q. We'll get to that in just a second. But what types of documents are these again?
A. These are agreements or my understanding was letter of intent to supervise nurse anesthetist.
Q. Now they have different dates on them do they not?
A. Yes.
Q. What are -- let's look at Exhibit Number 26 first of all and tell me what the date is on that particular document.
A. The date is July 31, 2006.
Q. Okay. Does that document bear your signature?
A. Yes.
Q. Does that bear some additional handwriting on the document itself beside the typed portion?
A. Yes.
Q. Is that something you're familiar with? Do you know where that came from?

A. Yes.
Q. Where did it come from?
A. I wrote it.
Q. Now I'm showing you the next document down which is Grand Jury Exhibit 27 still entitled Supervising Physician Agreement; is that correct?
A. Yes.
Q. And even the typed portion of this is different than the one up here bearing your signature; correct?
A. Yes.
Q. Now on this corrected form does this bear at least a signature line for your name?
A. Yes, there is a line there.
Q. Now there is a signature there and a date. What is the date of that signature?
A. April 1st, 2002.
Q. So this second document, Exhibit 27, is earlier in time at least it appears than the document you signed above in 2006; correct?
A. Yes.
Q. And the signatures as I see them on this document appear to be different. The signature line on Exhibit 27, is that your signature?
A. The 27 is the '02. I'm not sure that's my

signature.
Q. Okay. Do you sign your name in different ways?
A. I sign my name similar to the one appearing on document Number 26.
Q. You say that you don't know that that's your signature. Do you recall ever signing this document?
A. I don't recall signing document Number 27.
Q. Did you, I mean I know that you say you signed the document above 26. Did you ever sign other documents like that for Dr. Desai?
A. I'm not sure. I think that these were the only two but there might have been other ones similar to document 26.
Q. Now let's talk about, let's start off with the one that's earlier in time and that would be Exhibit 27. Can you tell me what that document purports to be?
A. It says me in conjunction with Dr. Desai and Dr. Sharma agree to co-supervise and consult with CRNAs employed at the Gastro Center of Nevada, supervision and consultation service would be provided regarding the anesthesiology service provided by the Gastro Center of Nevada employees, it is agreed that I would be available by phone consultation in addition to

on-call premise consultation as necessary. And later it said the agreement shall include all ASA cases performed at the Endoscopy Center located at 700 Shadow Lane and the other center located at 4275 Burnham Avenue. And it's also agreed that the ASA4 cases will not be performed at either facility.
Q. What are ASA4 cases?
A. Those are the more critically ill patients.
Q. Now that particular physician agreement there, do you have any -- can you tell us about that, I mean your personal knowledge of this, what you did, and what you agreed or not agreed to the discussions you had about that with Dr. Desai?
A. I agreed to be called by him on certain days that he wanted my service and if I went responding to his call to go supervise cases then I would bill for all the cases that I supervised. For example, if I were to watch over the shoulders of one or two nurse anesthetist, at the end of the day I get to gather up all the anesthesia record, all the patients' insurance form and bring it back to my office and bill for all the cases done.
Q. So typically when you would actually go out to the facility just by yourself, I mean how many patients would you do procedures on in a day?

A. At the Endoscopy Center I could do up to 20 cases a day.
Q. By yourself?
A. By myself.
Q. So if you were out there supervising a couple of certified nurse anesthetists how many procedures could you potentially bring back and bill for?
A. I could probably bring back 40 to 50 cases to bill.
Q. And a typical reimbursement for anesthesia for a colonoscopy or upper endoscopy was roughly what?
A. Medicare pays the anesthesiologist ultimately probably a hundred dollars.
Q. What about private insurance companies, are they higher typically?
A. Yes, they're higher.
Q. So at least if you did the numbers that you're talking about it would be a hundred dollars or more times however many patients; correct?
A. Yes.
Q. That would be a significant amount of money I believe doing that work?
A. Yes.
Q. That supervisory work.

A. Yes.
Q. Now, and I think you've testified before but I just want to make sure I'm clear on this, if you had actually implemented that and done that work would that money have come to you or would it have gone to the clinic or Dr. Desai?
A. It would have come to me unless we reach other compensation agreement, but if I bill the insurance company will send the money to my office.
Q. If Dr. Desai didn't use you or people from his clinic didn't use you or any other anesthesiologist and took on the role as being the physician who was supervising as delineated in Exhibit 28 that you mentioned, would he be able to then bill for those services?
A. I imagine he could, but to my knowledge many insurance companies require that the doctor submitting the bill be a doctor on their panel. Insurance companies have a limited panel. For example, if they want to have cardiac surgeon providing service, not every cardiac surgeon in town can bill. Only the cardiac surgeons that insurance company have accepted can bill for the service provided.
Q. Now during this whole process when you're involved with sort of this agreement or the agreements

that you think you're initially involved with, did you talk to Dr. Desai about whether or not you could remotely supervise somebody or would agree to do that?
A. No. Supervision in anesthesia is different from so-called supervision in other lines of business. In anesthesiology supervision by a doctor has to be immediate, on-site, in the same physical vicinity, while in some other professions so-called supervision can be done where, with the supervisor being away from the person being supervised, but not so in anesthesia.
Q. This document though, and this is Grand Jury Exhibit 27, seems to indicate though that there would be some kind of remote or not on-site supervision; is that right?
A. Yeah, it indicated that there would be telephone consultation.
Q. Did you agree to do that with Dr. Desai?
A. I agreed to be called to answer questions if they ran into a complicated situation, but that is not supervision.
Q. So if I, just so I understand you correctly, somebody may call you up and ask you questions about what's going on, but you're not taking responsibility for the actual anesthesia work being done at the facility?

A. No, no. And it's not whether I would choose to take responsibility or not. My understanding is that by law I could not take responsibility because the responsibility is born by the nurse anesthetist himself and the operating physician in that room, nobody else, even if that person wants to, can take responsibility for that patient.
Q. Now did you inform Dr. Desai of this fact?
A. Yes.
Q. Before you entered into any potential agreement with him?
A. Yes.
Q. Now did he ever pay you, and I'm talking about ever, pay you a single penny or dime for doing any kind of work or supervisory, or hold a supervisory position at the clinic?
A. No, never paid.
Q. Did he ever call you for either consultation or to come out and do supervision of any CRNA?
A. Ever since he hired CRNAs he never called me.
Q. And when you signed the letter of intent that you're talking about -- well, you said this one you're not sure you actually signed, 27; correct?

A. Correct.
Q. Let's move to the one above which is actually dated 7/31/06 and you said does bear your signature; correct?
A. Yes.
Q. The handwriting is on that document, first of all the typed portion, what is the difference between these two documents?
A. The 2006 document listed the names of the nurse anesthetist.
Q. And it also bears some handwritten information on there as well; correct?
A. Yes.
Q. What kind of handwritten information did you add into that agreement there before you signed it?
A. I added that all supervisions by the MD anesthesiologist has to be on-site, other than that I will only agree to do chart review for quality assurance purpose.
Q. So chart review means what?
A. It means if the endoscopy clinic has had some negative incident involving the patient or anesthesia and they want an outside opinion to help them determine what caused the problem, they would submit a chart for a doctor such as myself to review to find out

the cause of the problem.
Q. Now as far as the handwriting portion I see off to the side of that there is a couple of lines and it appears to have some initials on at least one of the lines; is that correct?
A. Yes.
Q. And there is also a portion above where you have added the words CRNA who are under the off-site supervision and it's talking about, it's got initials there as well; is that correct?
A. Yes.
Q. Now why did you add the words off-site on that third paragraph?
A. Because the anesthesiology service that they wanted me to perform, my understanding was I need to be on-site, I need to be inside the facility for the supervision to take place. If they, if I'm not on-site in the facility my duty would be limited only to chart review and for quality assurance purpose if they ever submitted cases to me.
Q. Now as far as that's concerned, the handwritten statement, I mean do you talk to Dr. Desai about this?
A. Yes, that's something that I discussed with him from the very beginning when he proposed to hire

nurse anesthetist.
Q. Did you discuss it with him multiple times after that period?
A. I believe it was more than once but the purpose of the discussion was to emphasis my knowledge of the law that the nurse anesthetist has to be supervised by an MD anesthesiologist. Without such then all responsibility would fall on the shoulders of the surgeon or operating physician.
Q. Okay. Now I notice that your initials apparently appear on both of those handwritten portions; is that correct?
A. Yes.
Q. I don't see a corresponding by Dr. Desai or anyone else.
A. Yeah, I guess he refused to agree to this document.
Q. So when you, I mean how do you get this document back to him after he sends it to you?
A. He sent it to my office, I reviewed it, I put in the necessary addendum and then it was sent back to his office.
Q. Did you ever hear from him again?
A. No.
Q. Did you ever get this back?

A. No.
Q. Have you ever again get a penny of work or a penny of money in response to doing anything on that document?
A. No.
THE FOREPERSON: It's 10 'clock. At this point the jury would like to take a 15 minute break.
MR. STAUDAHER: What I'd like to do is to -- well, okay, we can do that, that's fine.
THE FOREPERSON: Okay. Thank you.
(Recess.)
THE FOREPERSON: Okay.
BY MR. STAUDAHER:
Q. Doctor, you're still under oath. We just returned from our break. I think when we were -- I can't remember what we'd actually talked about right before the break.
But as far as the document that we have up on the screen right now, the on-site off-site supervision, I notice that in the, I believe it is the third paragraph of that document, you have off-site supervision of the various CRNAs that are listed; correct?
A. Yes.
Q. That's something that you actually put in

there?
A. Yes.
Q. Now am I correct in what you said before, just for clarification, that paragraph then refers in some way to what you would do specifically for off-site supervision which would be just review of the charts for quality assurances purposes?
A. Yes, only for chart review. If there were any incidents that they are concerned about they could submit a chart to me for me to review to point out to them whether there was any quality problems by the nurse anesthetist.
Q. Now again were you ever called to do even that particular task, review charts or incidents or anything like that?
A. No, I was never called to review charts, I was never called to go into their facility to supervise CRNA, I never even met a CRNA, I have never even talked to the CRNA at any time.
Q. Now have you heard of obviously the differences between vials of propofol, the sizes of those propofol containers?
A. Yes.
Q. And the next few questions I am going to ask you I don't know if you will have specific knowledge

of but it is information that's been asked to be provided to the Grand Jury.
As far as the different types of propofol, are you aware of whether each one of the vials are multi or single use vials?
A. My understanding is that propofol should be single use.
Q. When you say single use, do you mean you use it just one time out of the bottle or just one bottle per patient?
A. One bottle per patient.
Q. In the bottles themselves are they marked in some way with some delineation to that effect?
A. I think and I remember seeing that on these bottles, it says single use only.
Q. Now as far as the different types of or sizes of propofol bottles, what kinds are out there that you know of?
A. I know of the 20CC bottles, I know of the 50CC bottles and I have seen 100CC bottles.
Q. Have you seen 10CC bottles as well?
A. I have not seen 10CC bottles.
Q. So if I understand you correctly you're at least aware that in the distribution you could order or get ahold of 100, 50 and 20CC bottles?

A. Yes.
Q. Have you used those different quantity bottles in your practice?
A. Yes, I have.
Q. Have you used hundreds?
A. Yes.
Q. Have you used 50s?
A. Yes.
Q. And 20s I assume?
A. Yes.
Q. For colonoscopy procedures, if you were to use either a hundred or a 50CC bottle, based on your prior testimony that would seem to exceed the amount which would normally be required for the procedure; correct?
A. Yes.
Q. At the end of the procedure what would you typically do with that additional propofol?
A. I would discard it.
Q. Would you ever use it on another patient?
A. No.
Q. Would you ever reuse a syringe on the same patient, meaning that you drew up some propofol, you injected a patient with it and then went back into that same vial to draw up some additional propofol for the

same patient, would you do that?
A. Yes, same patient, same case, it is perfectly acceptable to use the same syringe on the same patient.
Q. Would you ever use the same syringe or a syringe on a different patient after that?
A. No.
Q. Again the bottle itself once it has been opened, whether you use all of it or not, would you ever use additional propofol remaining on another patient?
A. No.
Q. Why would you not do that?
A. Because of the risk of contamination.
Q. When you say contamination what do you mean?
A. Propofol is a solution that can harbor bacteria growth so of course we would never put one patient's body fluid into the bottle and then draw it and give it to another patient. Not only that, once the bottle has been opened it begins to become a location where bacteria can grow so it has to be discarded right after the case.
Q. So regardless of whether or not it's contaminated by the patient itself, just bacteria getting into it could cause trouble?

A. Yes.
Q. Do you know about the aseptic technique used in ambulatory care centers regarding the use of propofol or other types of agents like that?
A. Yes, there's a general standard care among anesthesiologist.
Q. Can you explain what that is related to what we just discussed?
A. With propofol, for every patient I would open a new bottle and I would use a new syringe, new needle to draw the propofol from the bottle to give to the patient, at the end of the case I would throw away the bottle, the needle and the syringe.
Q. Is that the standard of care?
A. I think that's the standard care.
Q. Again have you ever seen another anesthesiologist or the few CRNAs that you supervised ever deviate from that practice?
A. No.
Q. Do you typically watch other doctors do their procedures?
A. No.
Q. Have you had occasion to do so however?
A. Many years ago when I was in training I would see other doctors do anesthesia and I would

observe their work.
Q. If you saw another doctor or CRNA or another person who would use a syringe or medication like propofol in an inappropriate way would that give you concern?
A. Yes.
Q. And when I say inappropriate way I'm talking about reusing the syringe on multiple patients or reusing the propofol on multiple patients.
A. Yes, it would give me concern.
Q. Is that because of the contamination potential that you discussed earlier?
A. Yes.
Q. Now by not hiring you, as these agreements that we talked about, which means that they didn't actually ever call you to do any of this stuff, right?
A. No, these letters of intent were never carried out. I was never paid, never called and I never went in.
Q. And as far as those letters of intent that you say were never carried out, did you assume any supervisory role at any time regardless of whether or not you had a signed agreement?
A. No, I've never met, spoken with or worked with the CRNAs hired by Dr. Desai.

Q. Did you ever tell Dr. Desai that if he didn't use you for example, or somebody like yourself, that he or whoever the doctor was doing the procedure would be responsible for the anesthesia if there was no MD there?
A. Yes.
Q. And when I say MD, I'm talking about MD anesthesiologist.
A. Yes.
Q. I know you said that you would not yourself reuse propofol or syringes or the like on successive patients, but in your role as an anesthesiologist or even a supervise, potentially supervising anesthesiologists for CRNAs, if a physician that you were working with -- and you work in a referral type position; correct?
A. Yes.
Q. -- knowing that if you make the referring physician unhappy that he may not or she may not ever ask you to do work for him or her again?
A. Yes.
Q. So knowing that, in the position you're in as a physician or supervisor, would you ever, if the doctor said to you hey, look, I want you to save that propofol and reuse it on the next patient because it's

expensive and I don't want to waste it, would you ever do that?
A. No.
Q. Why not?
A. Because it would put the patient in danger.
Q. Would you ever, same question except for syringes at this time, would you ever, even if the doctor that you were working with said look, I want to save money, or for whatever reason, I want you to reuse the syringes or needles or whatever on the next patient?
A. No, I would not do that.
Q. Do you think that would be at any time an appropriate procedural way of dealing with either propofol or syringes?
A. No, it's not appropriate.
Q. The one last question I think I have for you before I turn it over to the Grand Jury is can you tell us what the difference between supervising anesthesia for CRNAs versus supervising in other situations might be, is there a difference?
A. Yes.
Q. What is that difference and why?
A. Different terms mean different things in different walks of life. In anesthesia supervising means that the more senior doctor supervising the junior

doctor or MD anesthesiologist supervising the nurse anesthetist, they have to be at the same place at the same time. In other words, if a professor was supervising junior anesthesiologist, that professor has to be in the operating suite, perhaps walking among a number of rooms looking over the shoulders of the junior doctors. The same thing happens between the MD anesthesiologist and the nurse anesthetist. The MD anesthesiologist has to be in the operating suite walking among patients, walking say between two rooms staffed by two CRNAs and making himself immediately available to troubleshoot, to answer questions by the patient or by the nurse anesthetist. I believe this is the standard care in the country. And I also believe this is the law. Outside anesthesia, when we say supervising, for example you can have a lawyer being supervised by a senior member of the law firm, the senior member of, the senior partner does not have to sit in the office all day looking over the shoulder of the junior lawyer, the junior lawyer would do his work and maybe once every few works the senior lawyer would look over the accumulated work by the junior lawyer and that process can be called supervision. But that's absolutely not the case in anesthesia. There is no supervision unless the senior anesthesiologist or the MD

anesthesiologist is in the same room. The law backs that up because the Medicare will actually refuse to pay if the supervising anesthesiologist's name does not appear on the billing record.

Q. And one last question, I'm sorry, I said there was going to be only one but sometimes I have one additional one. In a situation where you have -- you understand what a capitated payment arrangement is with insurance companies; correct?

A. Yes.

Q. And just for the Grand Jury, just explain that if you could in general.

A. I've never been involved in such arrangement myself, but just as a piece of common information capitation is when an insurance company enters the contract with the group or a single physician and they, the insurance company will pay a set amount of money to that doctor or doctor's group every month regardless of how much work is done by that doctor or by the doctor's group.

Q. So in a situation where let's say the Endoscopy Center hypothetically had a capitated arrangement with an insurance company for colonoscopies, they would be paid in that particular situation a flat fee for doing a procedure on the patient; correct?

A. That's my general understanding of what capitation does.

Q. In a situation like that, if you were to go to the Endoscopy Center, or any other place for that matter, and the doctor that you're going to work with had a capitated arrangement with the insurance company, would that mean that you could not then bill the insurance company for your anesthesia services?

A. I've never been in that situation so I really don't know.

Q. Would you ever, I mean do you always bill for your anesthesia services regardless whether or not there is some arrangement with the doctor that referred you or was your referral source?

A. When I did the temporary work in California the company that hired me to go do temporary work paid me per day reimbursement, they paid me by the day, so I turned over the anesthesia record to them and they would do the billing and collection and get paid by the insurance company.

MR. STAUDAHER: I have nothing further for this witness.

THE FOREPERSON: Okay. Let's start with you.

BY A JUROR:

Q. Doctor, so my understanding is that if the operating physician has accepted that responsibility by not having been an MD anesthesiologist on-site ready to go, ready to supervise, he then becomes, you know, he's then responsible for the anesthesia going on in his particular, at his particular procedure. Does that also mean to your knowledge that he needs to know or is also responsible for what is going on in the anesthesia record?

A. He is the captain of the ship. When he's the only MD in the room my understanding is he is responsible for everything that takes place in that room.

Q. Okay.

THE FOREPERSON: Yes.

BY A JUROR:

Q. While you were in college and training was the procedures for the propofol handling using part of the training and education would you say?

A. During my residency, yes, we were taught that certain medications have certain potential of being contaminated and they have to be treated differently. And propofol was one such medication.

THE FOREPERSON: Are there any further

questions? Yes.
BY A JUROR:
Q. Doctor, using propofol, it comes in 20CCs, 50CCs and 100CCs. What is the maximum amount allowed to give to one patient?
A. It's actually, there is no limit. For example, in the intensive care unit when we induce intentional sedation or coma in a patient they could receive propofol for days.
Q. Thank you.
THE FOREPERSON: Yes.
BY A JUROR:
Q. Dr. Yee, in all your years of experience have you ever seen any patient go into convulsions from too much anesthesia?
A. No.
Q. Never?
A. Never.
Q. Thank you.
BY THE FOREPERSON:
Q. Is there a limit on the amount of propofol that can be given to a comatose patient to keep them in the coma?
A. If propofol is given in excessive amount it will suppress, reduce the blood pressure and can reduce

the heart rate so you could have, you could put a patient into that situation if you gave too much.
THE FOREPERSON: Okay. Thank you.
Yes.
BY A JUROR:
Q. Dr. Yee, to your knowledge was your name submitted as the supervising MD anesthesiologist on the CRNA records at the Endoscopy Center?
A. To my knowledge, no.
Q. Thank you.
THE FOREPERSON: Are there any further questions?
MR. STAUDAHER: I'll follow-up to that.
THE FOREPERSON: Okay.
BY MR. STAUDAHER:
Q. If that had been done was that under your approval?
A. No.
Q. Okay. Would you have approved that to be done without you being present on-site to supervise?
A. No. On the anesthesia record the space where we put in the anesthesiologist name, those people have to be physically present in order to have their names put down. And to put down someone that's not there I believe is illegal.

THE FOREPERSON: Any further questions? None.
By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: Yes.
THE FOREPERSON: Thank you. You may be excused now.
Please raise your right hand, sir. Thank you.
You do solemnly swear the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated.
You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.
Do you understand this advisement?
THE WITNESS: Could you repeat what you said please? And if you could speak a little louder please.
THE FOREPERSON: Okay.
You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.
Do you understand this advisement?
THE WITNESS: Okay. I do. But some of the meaning of some of the words you used I do not know so I don't know what to say.

THE FOREPERSON: I'm sure our deputy D.A. will explain them.

MR. STAUDAHER: I'll try to make it a little easier.

THE FOREPERSON: Could you please state your first and last name.

THE WITNESS: My first name is Satish, S-A-T-I-S-H, last name Sharma, S-H-A-R-M-A.

THE FOREPERSON: Thank you.

SATISH SHARMA,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. Dr. Sharma, before I get into your background or whatever, I want to clear up that issue. What the foreman of the Grand Jury was saying is she read off the charges that are facing the individuals that are being charged in this particular case and that you're here to give testimony in that case. Do you understand that?

A. Yeah, I understand that.

Q. And she's asking you to be truthful and all that.

A. Yes.

Q. So you don't have to necessarily understand the charges but just that you're here to give testimony in the Grand Jury proceeding related to those.

A. Okay.

Q. And those individuals.

A. Got it. Thanks.

Q. Now Doctor, what do you do for a living?

A. I am an anesthesiologist and a pain specialist so I practice pain management at the present time.

Q. And to get to where you are today where did you go to school and where did you do your residency, things like that?

A. I went to medical school in India, it was 1981, finished my medical schooling in '86. I did my anesthesia residency there for three years and practiced there for two years before I immigrated here in December of '92. After moving to this country I started, I passed my exam, required exams, and started my internship in internal medicine in '94 to '95 and then I did my anesthesia residency from '95 to '98 followed by one year of fellowship in pain medicine.

Q. Where did you actually get those different fellowships and so forth, where were they?

A. It was in Pittsburgh I did my internal med, internship and anesthesia residency at the West Penn Hospital or Western Pennsylvania Hospital in Pittsburgh, and fellowship was also in Pittsburgh at the Allegheny General Hospital.

Q. Now after you came out here to Las Vegas, and you said you came out in April of '06?

A. That is correct, sir.

Q. When you were out here did you come out for a job or did you come out looking for a job?

A. When I came here I started my pain management practice right away. And initially the way it works, pain management practice I started from one patient so obviously it takes time to grow your practice, and then on the side I was also practicing anesthesia.

Q. Now did you ever meet an individual by the name of Dipak Desai?

A. Yes, sir, I did.

Q. And how did you meet him and under what circumstances?

A. It was, it was I would guess end of October, we have this --

Q. Of what year?

A. Of '06. We have, he used to throw like party like you guys have your Christmas party, our kind of Christmas comes in either October, end of October or beginning of November, there is no fixed date like you have Christmas for 25th. So before that he used to throw a party and that party I was invited by one of his partner, his last name is also Sharma, Vishvinder Sharma. That's how I got to basically meet him.

Q. You meet him, it was a social setting; is that correct?

A. That's correct, it was a huge gathering, hundreds of people.

Q. Did you ever deal with him professionally? Did you ever provide services to him or his patients at any time?

A. No, never to his patient or to him personally, but I did work with his partner Dr. Vishvinder Sharma and few more, but most of the time it was that Vishvinder Sharma, I was providing anesthesia at the Spring Valley Hospital.

Q. So just hospitals or did you ever go to the clinics as well?

A. Never, just at the hospitals.

Q. And just to Vishvinder Sharma?

A. No. As I said most of the time it was Vishvinder Sharma. Very occasionally I will go to Southern Hills Hospital, there was another doctor, Dr. Weiss, and the same way rarely to Mountain View Hospital, there was one doctor, Faris, and sometimes it could be Summerlin Hospital, and I think one or two cases at the Valley Hospital. But it was all the hospitals.

Q. Okay. Now did you ever work at that time or prior to coming to Las Vegas with certified nurse anesthetists?

A. Could you repeat your question please?

Q. Before coming to Las Vegas have you ever worked with CRNAs, certified registered nurse anesthetists?

A. Indeed for almost eight years. For most of the time it was in Pittsburgh. I finished my pain fellowship in '99 and then for about, I don't know, eight to ten months maybe I got, I took my first job in Richmond, Virginia, then I moved back to the same program where I did my fellow, pain fellowship, and then from that point on I was there in that particular hospital, that's where I supervised CRNAs or residents or fellows.

Q. So when you supervised them was it a thing

where you actively, I mean supervised one or two or more than that, or how many did you do at a time?

A. It could be, it depends, like it could be either two of the CRNAs usually on an average, I use to supervise as part of the group policy two rooms. Now it could be two CRNAs or it could be one anesthesia resident and one CRNA, so on an average, or occasionally it could be three rooms.

Q. When you were supervising them were you ever in a situation where you would do that supervisory work from another building or another town or anything like that? I mean were you --

A. Never.

Q. Where were you specifically? I mean how close to the rooms where the CRNAs were working did you have to be typically?

A. We were accessible like most of the time, again nothing is hundred percent, most of the time it could be like there was this medical staff office where most of the doctors are sitting and the O.R. could be like from here to outside.

Q. So from here to outside this entire building?

A. No, not the building, maybe like couple of rooms from here.

Q. Thirty, 40 feet away, something like that?

A. Thirty, 40, or you can call it maybe even, yeah, 50 feet depending on, because it was a huge hospital.

Q. Same floor, same general area though?

A. Most of the time.

Q. Would there be times when you would be further away, like for example in a different part of the hospital supervising somebody?

A. No, it could be a different floor because there were, most of the operating rooms were on one floor, then if somebody having some special procedure, there's one case, you could go there, it could be, sometimes it could be different floors but it was the same building.

Q. So when a CRNA that you were supervising would start a procedure were you typically there for the beginning of it or nearby or how did that work?

A. When a patient goes to sleep we were there, when patient goes to sleep and when patient wakes up. And in between we could randomly go in there or if there's a problem the CRNA could call us.

Q. Did you have to be readily available to come if there was an emergency or some problem with an airway or something like that?

A. Yes, sir. Always.

Q. Have you ever been in a situation where you would let's say decide to go to lunch and just be available down the street at Applebee's or something?

A. No. In case we are going to go somewhere else for either the coverage of some other room on a different floor or we are going to cafeteria let's say because that's again two floor down, you always tell your partner hey, keep an eye on my rooms, I'm going to grab lunch.

Q. Another anesthesiologist?

A. Yes.

Q. So either you or somebody that you tell to supervise the CRNAs that you're working with; is that correct?

A. That is correct.

Q. Okay. Now that was back in another city before you came to Las Vegas?

A. That is correct.

Q. Was that pretty much the way the supervision went in your experience over that eight year period?

A. Yes, always like that.

Q. When you got out here to Las Vegas did you work with CRNAs?

A. No, never.
Q. You've never worked with CRNAs out here?
A. No, never.
Q. Now when you met Dr. Desai, you said you worked with some of the people who were in his practice in some of the hospitals; correct?
A. Yes.
Q. Did you ever work with Dr. Desai professionally from a medical type standpoint?
A. I did not.
Q. Did you ever talk to him or contemplate entering into a relationship with him to supervise CRNAs working with him?
A. I never did.
Q. Do you recall ever signing any paperwork or supervising sort of agreement, anything like that related to him?
A. I remember that.
Q. And how did that come about?
A. What happened was after that first meeting in the party I came here to just practice pain only, because in Pittsburgh I was practicing both, kind of 50/50 anesthesia and pain, and I relocated here with the mindset that I would practice pain only. But as I said earlier, pain practice takes time to grow before you

have certain number of patients where you find yourself comfortable to quit anesthesia. So when I met Dr. Desai he brought up this issue of doing pain procedures in this new surgery center he was building across, almost across the Spring Valley Hospital. Back then the name was Spanish Hills Surgery Center. It was under construction. And he said can you do your pain procedures in my, at this new surgery center, we are building a new surgery center. So after, you know, going back and forth I gave him my reasoning what is my loss because there are a lot of insurances, they encourage you to do pain procedures because these are kind of outpatient procedures, we can do it in the office like I'm doing right now, so a lot of insurance, including Medicare, they encourage you to do as much in the office as you can and they pay you almost three times as what I would get paid in the surgery center or the hospital. So I gave him this reasoning that, you know, I will be a loser if I do them at the surgery center. So anyway --
Q. You said you would be a loser. I assume you would lose money?
A. Financially, yeah. So then he came up with this idea that I'll make you medical director of the surgery center and I will also give you the ownership to

compensate you for your lost revenue for your pain procedures.
Q. So he wanted you to come into the facility and that was how he was going to do it?
A. Yes.
Q. So he was going to have you come in as medical director so to speak?
A. Right, that was his way of compensating me for my losses, financial losses, if I do my pain procedures there at the surgery center.
Q. Did you ever go into the center and do your pain procedures there?
A. No, it never started.
Q. It never started?
A. No.
Q. You said it was being built though?
A. It was being built but it was, first of all there was delay in construction as you know we see all the time and then also they did not have this Medicare certification. To best of my, I'm giving you best of my knowledge of what I know. They might know the details, they can tell you better about that. But that surgery center never started to my knowledge and we did not do any procedures, I did not do any pain procedures there.
Q. So if I understand you correctly you were

just going to do your pain procedures, no anesthesia procedures; is that right?
A. That is correct.
Q. And you were going to be the medical director but it never actually happened?
A. Yes, because we never came up, first of all it was not ready so there was no rush to really do the paperwork, secondly we never agreed upon the numbers like what would be my salary as a medical director or what would be my ownership, so we were going back and forth, so we were still in the middle of negotiations before this story kind of appeared in the newspaper.
Q. So after this endoscopy issue came up did that kind of fizzle away and not happen then?
A. It never happened, yeah.
Q. I'm showing you what's been marked as Grand Jury Exhibit Number 25 and I'm going to have you look at that and tell me if it looks familiar to you.
A. Yes, it is familiar, I remember this.
Q. What is this?
A. The is, obviously this is a supervising physician agreement. And it was brought to my office by one of Dr. Desai's girls.
Q. When you say girls are you talking about office people?

A. Office people. I was in the middle of my patients, seeing patients, and she came over, before that actually he did tell me that, you know, I, see for me to do the pain procedure at any facility, including this, what he was building, the new surgery center, I needed an X-ray machine, what we call a C-Arm, that costs almost $150,000. His argument was that well, I'm not comfortable until you kind of give me something in writing that you will bring your pain business to the surgery center. And that's when he just -- I said okay, that's reasonable, I'm compensated, I will do my pain procedures here, buy the C-Arm and that way whenever the office is ready or the surgery center is ready with certification and all that I will bring my pain patients there. So that's when I basically, all this started, this paperwork. Again we were in the middle of the negotiations, nothing was finalized, but this agreement, his employee brought it over, I just signed it and that was it.

Q. Did you really look at it?

A. No, I did not, unfortunately.

Q. Because before I ask you additional questions about this, were you ever asked by Dr. Desai to supervise CRNAs at the Endoscopy Center of Southern Nevada on Shadow Lane?

A. No, never.

Q. Did you ever go to that facility, even set foot in the facility?

A. I, I don't know how you will say go, I did go there to meet him a couple of times, but I did not enter in the working area where they see the patients or where they do their endoscopy, it was to his office and there was I guess one more office, it was upstairs somewhere.

Q. Again did he ever ask you to supervise CRNAs at any time?

A. He never did.

Q. Did you supervise any CRNAs at any time?

A. No, never.

Q. Did he ever pay you to do any supervisory work for anybody?

A. Not at all.

Q. Including CRNAs.

A. Not at all.

Q. As part of this thing that you signed here that says supervising physician agreement, did he ever pay you anything related to this?

A. Not at all.

Q. Have you ever received a dime of compensation from him for any purpose?

A. Never, not at all.

Q. Now on this I think you'll agree that it does say that you in conjunction with Dr. Desai and Vishvinder Sharma of the Gastroenterology Center of Southern Nevada agree to co-supervise and consult with CRNAs employed at the Gastroenterology Center of Nevada, supervision and consultation services will be provided regarding the anesthesia services provided by the Gastroenterology Center of Nevada employees, and it says here that it is agrees (sic) that MD, Satish MD will be available for phone consultations in addition to on-call premises consultations if necessary.

Do you see that?

A. Yes, I do.

Q. So all of this is related to the fact that there is at least an apparent agreement to do some supervisory work for the CRNAs; is that correct?

A. Not at all, that is incorrect.

Q. Then go ahead and explain.

A. It was -- first of all he never talked about supervising anybody and we never discussed anesthesia aspect ever. His only interest from me was that I should bring my pain business tc the surgery center so he can bill for the -- when we do, when you have a surgery performed there are two major components.

One is the professional component that a doctor bills, the other is the facility charges. So when you bill as a doctor, I will bill for the professional, and whoever owns the facility will bill for the facility charges. So his only interest was to bring my pain patients there so obviously he'll bill for the facility. We never talked about anesthesia ever, whether it was supervising or whether even I providing anesthesia to any of his patients. He did offer directorship and as I said -- first of all it had nothing to do with any of his other endoscopy centers or the surgery center, I do not know what you call them, we always talked about this Spanish Hills Surgery Center and that's where it always started and that's where it ended.

Q. So you signed this agreement that's sent over because you think he needs something in writing before the C-Arm is bought for the facility that you're going to do pain at?

A. That is correct. And actually I was interviewed by one detective and when he interviewed me -- first of all unfortunately I did not make a copy of this letter or agreement so I hope when detective called me I thought he might have the copy, he did not have either, and during that interview I did tell him that this particular letter agreement should contain

something about, okay, being medical director and this would be your, he just gave me like not definite numbers but anywhere from five to $10,000 per month being the medical director of Spanish Hills Surgery Center.

Q. When you're talking about he, are you talking about Dr. Desai?

A. Only Dr. Desai, I never talked to anybody else. So I told that's what it should contain, that letter. I did not make a copy. So when he interviewed me it was already after almost a year and a half after this incident.

Q. When you say he now you're talking about the detective?

A. The detective, yeah. So I forgot more like exactly what -- I did not read it and then but I thought it should contain what we talk, like me and Dr. Desai, about Spanish Hills Surgery Center, being the medical director of the Spanish Hills Surgery Center, and ownership and pain, that's it.

Q. If Dr. Desai had said to you that I'm going to send over an agreement that I want you to sign so that you can be a supervisor for the CRNAs doing anesthesia at any location, if you had realized that would you have signed the agreement?

A. No, never.

Q. Did you realize at any time that he wanted you to supervise any CRNAs at any time, he being Dr. Desai?

A. I'm sorry, repeat your question please.

Q. Bad question. Did you know at any time whether Dr. Desai wanted you to supervise CRNAs at any location?

A. He never expressed it. I do not know what was he thinking, but we never even talked about anesthesia so if he was thinking I would supervise I do not know, but we never talked about it.

Q. Okay. I'm going to move on to a little bit of a different area then. One of the reasons I provide this to the Grand Jury and I asked you the questions about it is because the State is under an affirmative obligation if we know anything that tends to show, point away from somebody's guilt or whatever we have to provide that information as well. So that's the purpose of this being offered at this point and to allow you to explain it. But I want to ask you some specifics about your own personal use of anesthesia, in anesthesia regarding equipment and supplies and things like that. Okay?

A. Okay.

Q. Have you ever reused syringes between

patients?

A. Never.

Q. Would you ever do that?

A. No.

Q. If a doctor that you worked with, a referring doctor that you worked with told you he wanted you, he or she wanted you to do that, would you do that?

A. No.

Q. Why not?

A. Because it's not standard of care. Even -- I don't know, it's beyond my imagination using a dirty syringe on somebody else.

Q. What about propofol, the drug propofol, are you familiar with that drug?

A. Yes, I am.

Q. Have you used it many times?

A. Thousands, hundreds and thousands of times.

Q. So over your career lots and lots of time?

A. Yes, sir.

Q. Single use or multi-use vials?

A. Single use.

Q. All of them?

A. Yes.

Q. What is the reason for that do you know?

A. It was availability in the operating room.

Usually they have those small vials and you use what is there in the operating room.

Q. Ever any issue of contamination of vials that you're concerned about?

A. No.

Q. Why not?

A. Because to begin with the whole vial is gone on one particular patient and secondly sometimes, you know, some patients need more, you may have to use two vials.

Q. What about in a situation where you had a big vial that you didn't use all of the propofol, what would you do with the rest of it?

A. Either you throw it or -- there are two ways. This question was asked earlier also. If you have a big vial you can, if you're drawing syringes again it has nothing to do with this particular case, it's common sense thing, you can draw like, let's say you have, what, 50CC vial, you can draw them in like two or three different syringes, and now all those syringes are clean, I can use one on you, I can use one on myself, because those, so it is not the size of vial, it is the aseptic technique that is important.

Q. Let's talk about aseptic technique for a moment. Is it standard of care or proper technique to

use a single syringe, use it, draw up out of the bottle of propofol, to use then that propofol to administer anesthesia to a patient and if you need more to go back into that bottle and use it on the same patient; can you do that?

A. Same patient you can use.

Q. Okay. Now same scenario except for at the end of the procedure the patient is wheeled away, you've gone into the bottle, this one bottle twice or three times and there is remaining propofol in the bottle, can you then take that bottle and use it on the next patient?

A. No, I would not.

Q. Why is that?

A. Because there is no, because of the blood, possibility of, I already went back in there in that vial with a, because I used the syringe, I needed more propofol, so with that particular syringe which I have already used on a patient I went back to that vial.

Q. Let's say that you even changed the needle in between but you used the same syringe.

A. Does not matter, syringe and needle, they go together.

Q. Okay.

A. So either it has to be a completely new

needle and a new syringe if you're accessing a clean vial. You cannot go back with a dirty needle or dirty syringe and then use it back and forth. Then you have to throw it.

Q. What if you were told to do that or it was policy to do that; would you follow it?

A. No, I would not.

Q. Is that because of this contamination concern?

A. Yeah. And also every physician does what they are, how they are trained and what they believe in. And that's beyond my imagination, I cannot do it, that's not how, I have trained a lot of resident doctors and fellows, we go by the books.

MR. STAUDAHER: I have nothing further for this witness, ladies and gentlemen.

THE FOREPERSON: Are there any questions from the jury? Yes.

BY A JUROR:

Q. Were you friends with Dr. Desai?

A. No, I was not friends, but I used to see him in get-togethers.

Q. Okay.

A. Not very often, but once a year, twice a year, something like that.

Q. Were you intimidated or in awe of him?

A. No.

Q. As a professional?

A. No. I was new. Back then I didn't even know that he was that powerful or big so I was not intimidated. I was not new out of medical school either, I practiced in Pittsburgh for eight years before I relocated here.

Q. That brings me to my next question. You obviously are a very intelligent person. Why would you sign a contract or a form without reading it completely especially if it's a one page letter, contract?

A. Because, because my understanding was that is not a contract because we were still in the middle of negotiations. Contract, I'm not an attorney and I do not know anything about the legal aspects of it, of any paper actually, but when you get contract, because I do sign contracts with insurance companies, with a lot of hospitals, you know, it's always, it's never like just few lines, it will define your role, it will define your responsibility, it will define how much you will be paid, it will define what are the terms of contract, like at what point we will terminate our relationship. So it was not a contract. And when -- because I don't sign contract without showing it to my attorney. I

didn't even care to take it to the attorney because I said yeah, we are in the middle of negotiations, all we needed just to move the process forward, because first you have to decide about the C-Arm, then you have to order it, it will come back whatever months it takes, so just to move the process forward I said okay, here you go, I signed it and I said, we were like okay, we'll talk, get to the numbers, final numbers later, but at least let's start the process. And moreover I thought, you know, it should have what we walked about. So it was basically signed in good faith. I wish I read it and I did not unfortunately.

THE FOREPERSON: Okay. Bianca.

BY A JUROR:

Q. I had actually the same follow-up as the previous Grand Juror. I understand you're saying that you signed it in good faith and you didn't consider it a contract. You never even read it and you just signed it?

A. Yes.

Q. In good faith?

A. Yes, ma'am.

Q. Would you do that again?

A. No, obviously not now. It's too late, but I would not do that now.

Q. Prior to doing that with him had you done that in the past?

A. No. That was a different story all together because here I started my new business together, I had no clue about the business or the legality of any paperwork. In Pittsburgh where I moved from it was a huge group, we were like almost 30 MDs and 75 nurse anesthetists or CRNAs and then maybe 20 resident doctors and some fellows, so it was a huge group and those groups have everything, you know, they take care of everything, they have their legal department, they have their everything, so they come to you with a flag, sign here and you sign, because you know there is somebody who will take care of it. Here I started out of no where, new, didn't know anything about business and that's how I kind of got stuck in it.

THE FOREPERSON: Steve.

BY A JUROR:

Q. Do you know of anybody, or you say of the medicine, of the propofol, have you ever seen anybody use propofol on two different people, one bottle?

A. I have not seen that. I have never seen that during my like residency and attending doctor when we were training resident doctors or when we were working with nurse anesthetist I didn't see it.

Q. So it's understood that one bottle goes to one patient and that's it?

A. That is correct, sir.

THE FOREPERSON: Constance.

BY A JUROR:

Q. Would you say is it legal or illegal to use propofol on more than one person?

MR. STAUDAHER: I'm going to ask that he not answer that question. I don't want him to get into anything that might call for a legal conclusion. You could ask him if he thinks --

A JUROR: I can revise the question.

MR. STAUDAHER: Yes. Okay.

BY A JUROR:

Q. In your training, going to school and in training, as far as policy and procedures, is that taught to you propofol is used only for one patient at a time?

A. Well, I, honestly -- you don't teach them like, you just see things around and then you practice that way. Nobody teaches you that hey, you cannot use this -- it is not about propofol. Let's take propofol out of the way. It could be any vial. They teach you aseptic technique, that you cannot have the possibility where you can transmit infection from one person to

another, that is aseptic technique. So nobody talks about particularly propofol. It could be anything. Because there are vials of, there are bottles and you can go and use them with a clean syringe and a clean needle and that's fine because everything is clean. So it's not regarding propofol. But you don't teach, I don't know, it's more of a hypothetical question. You just do what you see and what makes sense to you that yeah, this is a clean technique is what I'm doing, there is absolutely no possibility of transmitting infection from one person to another.

Q. So is it safe to say then, what I'm trying to get at is what you're saying it's the individual doctor thinking that it is a safe process?

A. Yeah, I would say so. Yes.

Q. Yeah. So in that case you're saying is this common sense or something that is trained in school? In general. We're not talking about propofol. We're talking about any type of needle and medicine that should be used only for one person and not reusing the same syringe or medication for another patient.

A. Yes, it is trained but not in direct words like okay, that's how, that's today's lesson, this is this, but yes, you're taught to use aseptic technique. You cannot use the needles or the dirty syringes on more

than one patient or the dirty vial. Once you have inject, you know, used a vial with a dirty needle, now it's a dirty vial, it's the same thing. So obviously, yeah, those are the things you are taught. But during the training we are taught more about the infections which are really kind of, how should I put it, like I'm a pain specialist and when we use, we do anything we do it with everything sterile, sterile gloves, everything sterile. So that's where you focus more. Because this injecting IV, it does not have to be like sterile gloves or anything, it has to be just clean. But there are certain procedures that have to be absolutely sterile and you have to have a mask on to do some things. When we go inside the spine, because you don't want to spread the infection from your own, like for example I'm putting a needle in, I'm coughing at the same time, the needle is going to get dirty too. So those are the things you train more your students or your teachers teach you more.

BY MR. STAUDAHER:

Q. I'm going to interrupt here for just a second. I want to make sure we have something defined. You mentioned this term a number of times and I think even I used it, aseptic technique. If we break that down, septic means infection; correct?

A. That is correct.
Q. And a means without or trying to prevent, or not have happen; correct?
A. That is correct.
Q. So aseptic means in a way to not promote or process or transfer infection; is that correct?
A. That is correct.
Q. When you say aseptic technique are you referring to specific techniques that are taught in your training and all of the training whereby you can handle things, whether they be drugs or other items, in a clean way that prevents infection from going from one patient to the other?
A. Yeah.
MR. STAUDAHER: Does that help a little bit?
THE FOREPERSON: Agnes, did you have a question?
BY A JUROR:
Q. I got one. Doc, you're talking about pain procedure. Can you tell us the difference between a pain procedure and anesthesia?
A. Yes, ma'am. It's like, it's completely different thing. Pain procedures we do for pain related symptoms mainly which are spine related issues, somebody

having low back pain, back pain, arm pain. Anesthesia -- so those procedures are performed with everything sterile, like completely untouched and packed in a way that are not exposed to air even. So you just open them, use them, throw them. So there you need really sterile technique. Versus anesthesia. Anesthesia has to be clean syringe. It could be sitting on the cart for last, doesn't matter, even 24 hours, as long as nobody has touched it it's still clean. The needle is still clean. Anesthesia when we put you to sleep we give medicine through the vein. And with the pain procedures we are going inside the spine that need a little more even really stricter aseptic technique.
THE FOREPERSON: Bianca.
THE WITNESS: I hope I'm answering your question.
A JUROR: I think I understood a little bit.
THE FOREPERSON: Bianca.
BY A JUROR:
Q. We've heard several different testimonies in regards to propofol and that single vial should be used one time. So when you say let's take propofol out of the picture, to the best of your knowledge is there no, is there any particular medication that cannot be

reused? So all medication to the best of your knowledge is only usable one time? Propofol is not the only anesthesia that you've used in your career; is that right?
A. That is correct.
Q. So when you say that this is nothing that was trained, because I've heard other testimony that they, that it was stated that was trained, they were trained in propofol is a single patient, single application. So when I listen to you and you said that it wasn't anything that was said to you out of anyone's mouth, it's just a procedure that you do and you're taught, you know, it's just common sense, my question now is every medication, since no one just specifies propofol to you, all medication, all anesthesia is a one dose application, one dosage per person, you cannot draw out of another, even with a clean syringe you cannot draw out of a different type of anesthesia or medication and submit to a new patient?
A. For most, yes, that is correct. But I remember in Pittsburgh before the propofol was introduced in the market, okay, it was early '90's I guess and it could be mid '90's, we used to use what we call Pentothal, okay, Pentothal bottle was this big, like this bottle of water.

MR. STAUDAHER: And for the record he's referring to a container that appears to be almost a quart in size.
THE WITNESS: Okay. So now you cannot use that whole bottle on one patient and you don't want to throw it either. So what they used to do, there are some connectors that you put on top of that bottle, so you come with your clean syringe, take how much you need, make like two or three syringes, whatever, and you go to your room. Now the other person, he could be working in the other room, he will come, he will draw his syringes, take it to his room. So for most part what you're saying and what other people you referred, they are correct, but it also depends on that it is nothing is like one hundred percent that's how it is because this particular bottle you cannot use, you need only 20CCs out of 500 ml.
BY A JUROR:
Q. And I understand that. And like I said it just poses confusion, you said they trained you on a procedure what was sanitary and not sanitary and I heard several different testimonies about when it came to propofol in their training they were trained and they were taught not to reuse that. And I also heard you say that you used to draw up syringes in order not to

contaminate it, that you can draw up that solution, if it was 100CCs of propofol you can draw multiple needles and have them to the side just like you said you could with the Pentothal. So that was why my question was, which you did answer, that there are some medications you can reuse, it depends on how you do it.

A. Medication we can reuse, let's be a little more specific, that particular bottle we can have access multiple times with clean syringes.

Q. Right.

A. Yes.

BY MR. STAUDAHER:

Q. Let me follow-up with that. If, whatever the medication is, in this case I'm going to use propofol, if you have a situation where you take a clean syringe and draw it up --

A. Uh-huh.

Q. -- and then use it on a patient, take the same syringe which is now technically, whether it is clean or not clean, it's considered not clean; correct?

A. That is correct.

Q. And you re-enter the bottle, do you then consider that bottle to be contaminated?

A. Yes.

Q. In that situation would you ever use that

potentially contaminated bottle on a second patient?

A. No, never.

Q. Even if it was the Pentothal bottle that was very large, 500 milliliters I think you said and you had done that same technique the same way that I just described, you would have to pitch that bottle; correct?

A. That is correct.

Q. So when you were describing this large bottle that people would come and get their drugs from, are you talking about them walking up with a clean, unused syringe, using an aseptic technique, drawing from that bottle and walking away and never coming back to use that contaminated syringe in that bottle?

A. That's correct. It's like early in the morning, 25 operating rooms, 25 people and everyone is filling their syringes going back to their rooms.

MR. STAUDAHER: Does that help?

A JUROR: Uh-huh.

THE FOREPERSON: Are there any further questions? Lisa.

BY A JUROR:

Q. Dr. Sharma, we saw an agreement where you signed as the MD anesthesiologist to supervise CRNAs. To your knowledge was your name ever used as the MD anesthesiologist supervising CRNAs on any records that

Dr. Desai submitted to insurance or that he kept for his office records?

A. Not to my knowledge. I didn't give anybody any permission and I was never involved with any of the CRNAs. I don't even know any of them. I know few of the doctors that were performing endoscopies because I was providing anesthesia for their cases as an independent anesthesiologist, but if he has used my name I'll be surprised myself.

Q. Okay. Did you ever earn any income off the practice of Dr. Desai?

A. Never.

Q. Thank you.

THE FOREPERSON: Any further questions. Anne.

BY A JUROR:

Q. Doctor, you talked about three draws where they set, they've gone sterile or aseptic procedures and drawn a number of syringes and needles for us.

A. Yes.

Q. How long are those kept? Are they gotten rid of at the end of the procedures, do they stay there all day?

A. That's a good important question in regard to propofol particularly. There are certain medications

which don't really matter, like for example when they draw normal saline syringes they draw it from a bag, when they are clean and they are sitting in a drawer you can go in and use them any time. But with propofol it's different. Propofol, what they recommend is that if you do not use it like in five or it could be six hours just throw it. Because propofol has something that promotes bacterial growth, what they use as a media for this, so that way this particular question pertains more to propofol than any of the medications because there is a possibility of bacterial growth so they do not recommend it, if you have opened the vial or if you had accessed the vial or if you have drawn it in the syringe, if you don't use it like about five hours or so pitch it.

Q. Thank you.

THE FOREPERSON: Are there any further questions? There are none.

BY A JUROR:

Q. I have just one more follow-up. So based off of what you just said about even in a clean syringe sitting around propofol could gather its own bacteria possibly?

A. Possibility. Because in air there are always bacteria. We are talking, coughing, everybody in the operating room or wherever it is, so yes, it is

recommended you throw it after five hours.

THE FOREPERSON: Okay. Any further questions? There are none.

By law, these proceedings are secret and you are prohibited from disclosing to anyone anything that has transpired before us, including evidence and statements presented to the Grand Jury, any event occurring or statement made in the presence of the Grand Jury, and information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this admonition?

THE WITNESS: Yes, ma'am.

THE FOREPERSON: Thank you. You can be excused.

MR. STAUDAHER: Thank you all.

(Proceedings adjourned, to reconvene at a later, undetermined time.)

--oo0oo--

REPORTER'S CERTIFICATE

STATE OF NEVADA)
: Ss
COUNTY OF CLARK)

I, Danette L. Antonacci, C.C.R. 222, do hereby certify that I took down in Shorthand (Stenotype) all of the proceedings had in the before-entitled matter at the time and place indicated and thereafter said shorthand notes were transcribed at and under my direction and supervision and that the foregoing transcript constitutes a full, true, and accurate record of the proceedings had.

Dated at Las Vegas, Nevada,
May 5, 2010.

Danette L. Antonacci, C.C.R. 222

AFFIRMATION

Pursuant to NRS 239B.030

The undersigned does hereby affirm that the preceding TRANSCRIPT filed in GRAND JURY CASE NUMBER 09BGJ049ABC:

_X_ Does not contain the social security number of any person,

-OR-

___ Contains the social security number of a person as required by:

A. A specific state or federal law, to-wit: NRS 656.250.

-OR-

B. For the administration of a public program or for an application for a federal or state grant.

Signature 5-5-10
Date

Danette L. Antonacci
Print Name

Official Court Reporter
Title

EIGHTH JUDICIAL DISTRICT COURT

CLARK COUNTY, NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID DISTRICT COURT

ORIGINAL

THE STATE OF NEVADA,

Plaintiff,

vs. CASE NO. 09BGJ049A-C

C268107

DIPAK KANTILAL DESAI,
RONALD ERNEST LAKEMAN,
KEITH H. MATHAHS,

Defendants.

_____/

Taken at Las Vegas, Nevada

Thursday, April 22, 2010

11:32 A.M.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

VOLUME 4-A

Reported by: MARCIA LEONARD, CCR 204

GRAND JURORS PRESENT ON THURSDAY, APRIL 22, 2010:

SVEN BRADLEY
CONSTANCE CABILES (Not present in P.M.)
LISA CAMP (Not present in P.M.)
CHRISTINE LYONAIS
AGNES PARKER (Not present after 3:00 P.M.)
YOLANDA PARKER
BIANCA ROBERSON
ROBERT ROSE
SHELLY SALAMANOPOULOS
STEVEN SHLUKER
ALICE SZURAN
MICHAEL THOMPSON
THOMAS UHRHAN
JOSEPH WILLOUGHBY
PAMELA YOUNG
ANNE ZARATE
LOUISE ZUNIGA

FILED

JUN 08 2010

CLERK OF COURT

Also present at the request of the Grand Jury:

MICHAEL V. STAUDAHER
Deputy District Attorney

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CE15

LAS VEGAS, NEVADA, THURSDAY, APRIL 22, 2010

* * * * * *

MARCIA J. LEONARD,

having been first duly sworn to faithfully and accurately transcribe the following proceedings to the best of her ability.

THE FOREPERSON: Okay. Please raise your right hand.

Do you solemnly swear that the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman, and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes.

THE FOREPERSON: Could you please state both your first and last names, spelling them for the record.

THE WITNESS: My name is Yereny, Y-E-R-E-N-Y, Dueñas, D-U-E-N tilde A-S.

A JUROR: I'm sorry. Can you just do the last name again? Sorry.

THE WITNESS: That's okay. D-U-E-N, with a tilde, A-S.

YERENY DUEÑAS,

having been first duly sworn by the Foreperson of the Grand Jury to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q. And how do you pronounce your last name, ma'am?

A. Dueñas.

Q. Dueñas.

Ms. Dueñas, what do you do for a living?

A. I am the claim team leader for ABPA, the

third-party administrator for the Culinary Health Fund.

Q. So the Culinary insurance, you do the third-party administration work?

A. We process their claims, administer their benefits, provide customer service, handle their eligibility, yes.

Q. So, in other words, do you receive claims from providers of care, health care?

A. Yes.

Q. And then make payments on those claims?

A. That is correct.

Q. Is that per the agreement that Culinary has with whoever the -- either the provider and/or the actual participant, plan member?

A. Correct.

Q. Okay. In your capacity as the claims -- claims leader I think —

A. Claims team leader.

Q. -- what kinds of things do you do in that capacity?

A. We process claims. We receive them. Either a hard copy, EDI. We pend for information from participants. Request additional information from providers if we need them. We process hospital claims.

Q. When you said EDI, what do you mean by

that?

A. Claims are submitted electronically through the system. We don't actually get a hard copy dropped. It's actually done all through the system. It's filed electronic.

Q. So when a provider sends in a claim form for some sort of service that's been provided to a plan member, is that a certain type of form?

A. Yes, it is a HICFA form.

Q. And does it have a particular number and type associated with it?

A. Yes, a HICFA 1500.

Q. Is that pretty standard that most claims come in under this HICFA 1500 designation?

A. Yes, for medical physicians. Hospitals use UB, UBs.

Q. Okay. And the particular case that I'm going to talk to you about today relates to a plan member, a Culinary plan member by the name of Sonia Alfaro-Orellana.

Are you familiar with the claim and the payment for the claim made by the Endoscopy Center of Southern Nevada related to that individual?

A. The anesthesia claim?

Q. Yes. Well, we'll get to that in a minute.

Some claims --
A. The claims submitted for her, yes.
Q. And I guess that was a poor question. I assume she may have had some other things as well, correct?
A. Yes, other claims.
Q. So let me define that a little more and make it a little easier for you.
A. Okay.
Q. My questions are going to be confined to procedures that were performed for colonoscopy and anesthesia related to colonoscopies on that particular plan member at the Gastroenterology Center of Southern Nevada by Dipak Desai's organization. Are you with me?
A. Yes.
Q. Okay. Did you, as part of your normal activities, do you have access to the records you've described, such as claim forms or electronic submission forms and payment information?
A. Yes, we do. Yes, I do.
Q. Did you look up or bring with you or provide at some point that type of information to the police and to this Grand Jury?
A. Yes, we did.
Q. Okay. I'm showing you what has been

marked as State's Exhibit 30B and ask you if you recognize that item?
A. Yes, this is the EDI screen, which is in our system claim fax, which mimics the hard copy of a HICFA 1500 in our HF screen when a claim is submitted electronically.
Q. Okay. I want you to thumb through all the pages and make sure you're familiar with them.
A. Okay.
Q. And I believe there are four pages to this particular exhibit document?
A. And a HICFA starts with Box 1, and Box 1 is there.
Q. On page 1 of that document, correct?
A. Yes. Page 1. Page 2.
Q. At this point, I just want you to flip through and see if you are familiar with them. Then we'll go through the documents.
A. Okay. Yes.
Q. Now, is this the claim actually that was submitted that we're talking about for Ms. Orellana regarding her -- the anesthesia portion of her procedure?
A. Yes, it is based on page 3.
Q. Based on page 3.

Okay. Let's start off with page 1.
A. Okay.
Q. Tell us what we're looking at and how you know that -- let's talk about the date, the type of procedure, whatever it is?
A. Okay. Based on page 1, is the -- Box 1A is the member's social security number.
Do I need to read anything out?
Q. No.
A. Okay.
Q. You don't have to read out the social security numbers. I'm just trying to find out when it happened, when the form was submitted --
A. Okay.
Q. -- and who it's related to.
A. Okay. The patient's name is Sonia Orellana-Alfaro. The insured's name is Sonia as well. Her address. Her date of birth.
Q. When was the claim submitted?
A. The claim is submitted -- let me see -- is not on this. It is not on this form.
Q. Okay. The form, not on that particular exhibit?
A. Yes.
Q. Do you have the information about when the

claim was submitted?
A. I would have to look and see what you've provided.
Q. Okay. This is the -- you need to look at Grand Jury Exhibit 30A to do so. You can do so at that time.
A. It was received 9/25 of 2007.
Q. So that's when the claim was actually submitted?
A. Correct.
Q. And you're looking at this time on the third page of Exhibit 30B, correct?
A. Correct.
Q. Now, are those documents, and I assume you looked through that one as well, is that something that is part of the records of the Culinary Union or at least the third party, your third party --
A. Yes.
Q. -- sort of entity?
A. Yes, sir.
Q. Now, let's talk about the procedure itself. Was this for an anesthesia procedure for a colonoscopy?
A. I would have to pull the other dates of service, the other services provided for this date of

service.
Q. But this is specifically for an anesthesia billing, correct?
A. Yes, yes.
Q. Now, on this particular — do you have any of those documents with you if you need to look at them?
A. I believe I do.
Q. Okay. And I have got some as well. If you need to refer to any documents of your own that you brought with you at any time, just let us know you're doing so and tell us what you're looking at. Okay?
A. Okay.
Q. But those are not going to be admitted necessarily as exhibits.
A. Okay.
Q. If you need to refer to any document you have at this time, go ahead and do so just to refresh to make sure we're talking about the right document. Okay?
A. Okay.
Q. Now, what were you just looking at just for the record?
A. I was looking at the copies that we had provided you and new printouts that I made this morning

of modifiers that are associated with the claim.
Q. Okay. So you're interpreting things on the exhibit based on your review of records in your business?
A. Yes.
Q. Okay. Did that help refresh your memory --
A. Yes.
Q. -- as to what those items were?
A. Yes, it did.
Q. Okay. Put that aside, if you would, what you brought with you.
And now if you could testify about what we're looking at here on Exhibit Number 30B?
A. Okay.
Q. And I think we're on the third page of the document.
A. That is correct.
Q. Okay.
A. Okay. So this basically tells us that we received a claim for date of service 9/21 of 2007, for place of service 24, which is an outpatient, outpatient facility, AC facility. For ASA code, which is an anesthesia code of 00810. Billed with three different modifiers, QZ, QS and P2, in the amount of $560 for 33

minutes.
Q. So if I understand you correctly, the dollar amount of the claim was $560; is that correct?
A. That is correct.
Q. So that's what they say, hey, look this is what it cost or what we're using as the cost for an anesthesia; is that correct?
A. That is what they're using as the billed charges.
Q. Billed charge? Okay. Sorry about that.
A. Billed charges.
Q. Now, you had mentioned that there was a time that was also submitted as well.
A. Correct.
Q. And you said --
A. Thirty-three minutes.
Q. -- 33. Is that -- now, that dollar amount and that minutes charge, that was actually submitted in the claim?
A. Yes.
Q. Go ahead.
A. Okay. So that's basically what this screen is telling me, that that is the code, the billed charges and the minutes billed by the doctor.
The doctor's name is on the second -- on

the last page, which is the fourth page, which is for Keith Mathahs.
Q. What's the address and the business?
A. The address is 700 Shadow Lane, 165A, Las Vegas, Nevada 89106. And the services were rendered at the Endoscopy Center of Southern Nevada, 700 Shadow Lane, 165, Las Vegas, Nevada 89106.
Q. Okay. Now, that document there talks -- is basically the information related to the claim itself being submitted by the Endocscopy Center, correct?
A. This is the claim for the anesthesia.
Q. The anesthesia portion of that procedure, correct?
A. Correct.
Q. Okay. Now, if you move on to the next document, which is 30A, can you tell us what this is?
A. Okay.
Q. And I think it's multi pages as well; is that correct?
A. Yes, it is three pages.
Q. Okay. Tell us what we're looking at on this particular document.
A. Okay. This document is the member explanation of benefits that lets the member know how

we process the claim.
Q. So in other words, is that called an EOB, then?
A. Yes, an EOB, explanation of benefits. It is in Spanish. The second page is -- it looks like it's -- this might have been submitted by the doctor's office.
Q. So the second page is not one of your documents itself?
A. Huh-huh.
Q. Okay. And then is it something you're familiar with or not?
A. Huh-huh.
Q. Okay. So just so we're clear, the second page of that particular exhibit is not something submitted or that you're testifying about today, correct?
A. Correct.
Q. Okay. And what is the last page?
A. The last page is the screen printout, it looks like, from our customer service desktop when providers or participants call to check the status of their claim on the website.
Q. Okay. Do any of those documents indicate how much money was actually paid on the claim

submitted?
A. Yes, it does.
Q. How much money was paid?
A. We paid $306.
Q. Was that paid back to the Endoscopy Center of Southern Nevada where the claim came from?
A. This claim was paid actually to Dr. Mathahs, the $306.
Q. At the location where he was working, correct?
A. Correct.
Q. Okay. And I just want to be clear. Even though you're the third-party administrator for Culinary, you're the ones that were responsible for receiving the claims and then paying the benefits on those claims for Culinary; is that correct?
A. That is correct.
And I just want to be clear that this claim is for Dr. Mathahs. The $306 were Dr. Mathahs, the anesthesiologist, CRNA, where he rendered the services at the Endoscopy Center.
Q. Got it.
Now, beside just coming and testifying about the records, the claim, and the submission of everything or the payment of the money on the claim, is

there any other item there of importance to you regarding what was done or handled in this particular case by your organization?
A. No.
Q. I think you mentioned the minute charges of being submitted as 33 minutes, correct?
A. That's correct.
Q. Now, hypothetically, if the minute charges had come in less than that, would the claim necessarily have been paid for a lesser amount?
A. Yes, it would have.
Q. So the number of minutes was significant as far as the dollar amount paid on the claim?
A. I'm sorry. Can you repeat the question?
Q. So the number of minutes was -- correlates to how much money was actually going to be paid?
A. Correct.
Q. If, in fact, you had received a bill that was down in the seven-minute range, would the payment have been less?
A. Yes, it would have.
MR. STAUDAHER: I have nothing further for this witness, ladies and gentlemen.
THE FOREPERSON: Are there any questions from the jury? There are none. Okay.

By law these proceedings are secret. And you are prohibited from disclosing to anyone anything that transpired before us, including evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury, or information obtained by the Grand Jury.
Failure to comply with this admonition is a gross misdemeanor punishable by a year in the Clark County Detention Center and a $2,000 fine. In addition, you may be held in contempt of court punishable by an additional $500 fine, and 25 days in the Clark County Detention Center.
Do you understand this admonition?
THE WITNESS: Yes, I do.
THE FOREPERSON: Okay. Thank you. You can be excused.
Please remain standing and raise your right hand.
Do you solemnly swear that the testimony you are about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: I do.
THE FOREPERSON: Thank you. You may be

seated.

You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property, criminal neglect of patients, insurance fraud, obtaining money under false pretenses, and racketeering, involving Dipak Kantilal Desai, Ronald Ernest Lakeman, and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Could you please state both your first and last names and spell them for the record?

THE WITNESS: First name is Anne, A-N-N-E. Last name is Yost, Y-O-S-T.

THE FOREPERSON: Thank you.

ANNE YOST,

having been first duly sworn by the Foreperson of the Grand Jury to tell the truth, the whole truth, and nothing but the truth, testified as follows:

/ / /

/ / /

EXAMINATION

BY MR. STAUDAHER:

Q. Ms. Yost, what do you do for a living?

A. I'm a registered nurse.

Q. How long have you been a nurse?

A. Two years.

Q. Where did you get your training and when did you graduate?

A. I want to correct that. It's three years. Three years.

I got my training at the Community College of Southern Nevada.

Q. And when did you graduate?

A. I graduated in May of 2007.

Q. Okay. What type of a nurse are you?

A. Currently, I am a psychiatric nurse.

Q. Are you an LPN, RN?

A. RN.

Q. RN. Okay.

And you're working at a psychiatric unit or building or facility?

A. City jail.

Q. City jail. Okay. I'm going to go back in time a little bit.

After you graduated, where did you go to

work?

A. After I graduated, I started working at the Endoscopy Center.

Q. Do you know when you started working at the Endocscopy Center?

A. Yes, it was July of 2007.

Q. Do you know the specific date?

A. I would say second, third and fifth of July.

Q. Okay. So over the Fourth of July period, right in that range?

A. Right.

Q. You described a three-day period. Is that all that you worked at that facility?

A. Right.

Q. Were you terminated from the facility?

A. No, I resigned my position.

Q. When you first went to work at the facility, who did you meet with to hire you or deal with?

A. Katie Maley was the director of nursing.

Q. So she was the one that interviewed you?

A. Yes.

Q. And just for the ease of the court reporter, and I'll try to do this, sometimes I make the

mistake as well, I'm going to ask you to let me finish my question, and then I'll try to let you finish your answer. Okay?

A. Okay.

Q. Because it's hard, if we talk over each other, for her to take down all the words.

A. Okay.

Q. Okay. So you're at — so Katie Maley is the one that interviews you. Does she hire you on the spot, or do you come back a couple weeks later? How did that go?

A. I believe it was a week later. Well, she hired me on the spot. I started about a week later.

Q. So when you come into the facility, what is the job that you're going to do?

A. I was in the procedure rooms where they perform the endoscopies.

Q. And what was your role in the procedure room?

A. Mainly charting and paperwork.

Q. So did you have hands-on patient activity at that point?

A. No, mainly talking to the patient about how they were feeling about the procedure and documenting the condition that they were in.

Q. Okay. So pretty much just dealing with the chart and just verbally with the patient?
A. Right.
Q. Now, when you started working there, did they tell you that that was what you were going to be doing primarily?
A. Yes, they did.
Q. When you came into the facility, that's what you actually started doing then?
A. Right.
Q. Was there any kind of a training period for you to be able to chart, or did you learn that when you were in school?
A. The three days that I was there I learned their specific way of charting.
Q. Okay. And we'll get to that in a minute.
But as far as your job, was this the first job that you had after you graduated?
A. Yes, it was.
Q. After you left that facility, were you able to find another job?
A. Yes.
Q. How long after that three-day period did it take you to locate another position?
A. I started looking for a position right

away. I don't believe I was hired until a couple months later.
Q. So you started looking -- I mean, how soon after you actually start working did you start looking for a new position?
A. As soon as I had resigned, I started looking for another position.
Q. Okay. It didn't take you a long, long time, though, to find one?
A. No.
Q. Now, I'm going to start asking you about what you actually did and what the issues were, if any, that relate to why you left the facility. Okay?
A. Okay.
Q. Were there personal or professional reasons why you left the facility?
A. Yes, the professional reason was that they were encouraging me to pre-chart, and pre-charting is documenting on a patient before you've actually seen them.
Q. Now, when you say they encouraged you, was it one person, more than one person, how prevalent was this practice?
A. I was trained by two nurses, and both of them had encouraged the same thing.

Q. Okay. Did you see other persons do the same thing there?
A. Just primarily the two that had trained me, and then also in pre-op.
Q. Now, we're going to get into the specifics about how things work in the facility, but when that happened, when you had people come up to you and get you to try and do this, did that surprise you?
A. Yes, it did.
Q. Did it affect you in any way?
A. Yes, I felt -- I was appalled by it.
Q. Did you express at the time that this was something that you didn't agree with, you didn't want to do?
A. Yes. I told the nurses that were training me that I didn't want to document on a patient before I had actually seen them.
Q. When you talk about documentation, what kind of documentation are we talking about?
A. Basically, the condition of the patient, anxiety, let's see, if the person has a strange color to them, looks like they are having difficulty breathing.
Q. Did you ever -- when you saw -- I assume that you weren't the primary person dealing with the

person initially, correct?
A. Right.
Q. You're in the procedure room. Was there a room or a place that the patients went before they got to the procedure room?
A. Yes, pre-op.
Q. In the pre-op area, did you go out and do any charting or any work out there?
A. No, I didn't.
Q. When the patients came from the pre-op area to the procedure room, did they have paperwork with them?
A. Yes, they did.
Q. When you saw the paperwork coming, did at times you see anything unusual about that paperwork?
A. Sometimes the nurses from pre-op had completed the charting that would have been done in the procedure room. They would have started some of that charting ahead of time.
Q. For you?
A. For the -- yes, the procedure room.
Q. What about you, as far as if something had already been filled out for you, what did you do then?
A. I would ask why the paperwork was already filled out, and then the nurse training me would say

IN THE SUPREME COURT OF THE STATE OF NEVADA

KEITH MATHAHS, Petitioner, vs. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE VALERIE ADAIR, DISTRICT JUDGE Respondent, and THE STATE OF NEVADA, Real Party in Interest.	CASE NO: 61359 D.C. NO: C2654107

RESPONDENT'S APPENDIX
VOL. II

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CERTIFICATE OF SERVICE

I hereby certify and affirm that this document was filed electronically with the Nevada Supreme Court on September 20, 2012. Electronic Service of the foregoing document shall be made in accordance with the Master Service List as follows:

CATHERINE CORTEZ MASTO
Nevada Attorney General

MICHAEL V. CRISTALLI, ESQ.
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Counsels for Appellant

RYAN J. MACDONALD
Deputy District Attorney

I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage pre-paid, addressed to:

JUDGE VALERIE ADAIR
Eighth Judicial District Court, Dept. XXI
Regional Justice Center, 11th Fl.
200 Lewis Avenue
Las Vegas, Nevada 89101

/s/ eileen davis
Employee of the
Clark County District Attorney's Office

RJM//ed

EIGHTH JUDICIAL DISTRICT COURT

COUNTY OF CLARK, STATE OF NEVADA

BEFORE THE GRAND JURY IMPANELED BY THE AFORESAID DISTRICT COURT

ORIGINAL

STATE OF NEVADA

Plaintiff,

vs.

CASE NO. 09BGJ049A-C

C246107

DIPAK KANTILAL DESAI,
RONALD ERNEST LAKEMAN,
KEITH H. MATHAHS,

Defendants.

Taken at Las Vegas, Nevada

Thursday, April 15, 2010

1:50 p.m.

REPORTER'S TRANSCRIPT OF PROCEEDINGS

Volume 3A

Reported By: DONNA J. McCORD, C.C.R No. 337

GRAND JURORS PRESENT ON THURSDAY, APRIL 15, 2010:

FILED
JUN 08 2010
CLERK OF COURT

PAM YOUNG, Foreperson
JOSEPH WILLOUGHBY, Deputy Foreperson
LOUISE ZUNIGA, Secretary
SHELLEY SALAMANOUPOULUS, Assistant Secretary
SVEN BRADLEY
CONSTANCE CABILES
LISA CAMP
CHRISTINE LYONAIS
AGNES PARKER
YOLANDA PARKER
BIANCA ROBERSON
BOB ROSE
STEVE SHLUKER
ALICE SZURAN
MICHAEL THOMPSON
TOM UHRHAN
ANNE ZARATE

FILED
JUN 08 2010
CLERK OF COURT

ALSO PRESENT AT THE REQUEST OF THE GRAND JURY:

MICHAEL STAUDAHER, ESQ.,
Deputy District Attorney

Terry Coffing, Esq.
Suzanne Whitehead, DA intern

INDEX OF WITNESSES

INDEX OF EXHIBITS

CE15

LAS VEGAS, NEVADA, THURSDAY, APRIL 15, 2010

* * * * * *

DONNA J. McCORD,

having been first duly sworn to faithfully and accurately transcribe the following proceedings to the best of her ability.

MR. STAUDAHER: Ladies and gentlemen of the Grand Jury, we're going to go ahead and continue on with the presentation for today. The next witness will be Pat Armour.

THE FOREPERSON: Please raise your right hand, ma'am.

You do solemnly swear that the testimony you're about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated.

You are advised that you're here today to give testimony in the investigation pertaining to the offenses of performance of act in

reckless disregard of persons or property; criminal neglect of patients; insurance fraud, obtaining money under false pretenses; and racketeering involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: I do.

THE FOREPERSON: Could you please state your first and last name spelling both for the record?

THE WITNESS: Patricia, P-A-T-R-I-C-I-A, Armour, A-R-M-O-U-R.

THE FOREPERSON: Thank you.

PATRICIA ARMOUR,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q Is it Miss or Doctor?

A Miss.

Q Miss Armour -- before we get started I do want to put on the record that there is another

person accompanying Miss Armour. His name is Terry Coffing. He's the attorney for the Southern Nevada Health District. He will not be participating but he will be here to lend advice to his client if he needs to. And with that we'll go ahead and proceed.

Miss Armour, what do you do for a living?

A I'm the laboratory manager of the Southern Nevada Health District.

Q And what do you do as the laboratory manager?

A I oversee the operations -- I'm sorry, I misspoke. It's the Southern Nevada Public Health Laboratory which is affiliated with the Southern Nevada Health District.

Q Okay.

A I oversee the operations of the Southern Nevada Public Health Laboratory, and that includes the clinical testing that's performed there as well as the bio-terrorism testing for Southern Nevada and reportable disease isolate testing for Southern Nevada Health District.

Q In your capacity in the Health District do you ever get involved with the preparation, grouping, processing of samples that are sent off to

other laboratories, for example CDC?

A Yes, I do.

Q I'm going to direct your attention to January of this year. Geez, January not of this year, January of 2008. Were you involved in the preparation of samples or the collection of samples or both regarding an outbreak of hepatitis in Southern Nevada?

A Yes, I was.

Q And how did you become involved in that in the first place?

A As part of the outbreak investigation team which was set up with the Southern Nevada Health District, the laboratory was an integral component of the investigation into the Endoscopy Center. We participated in meetings with the CDC as well as collecting samples from employees of the facility and planning for the notification that would occur in February.

Q Now, did you know at the time that you started that you were going to actually be involving CDC?

A Not at the -- I did not know at the time that we started that CDC might be involved.

Q Okay. So at what point in this whole

process do you actually become part of this?
A The point in the process when I became part of this typically occurs when our office of epidemiology receives results of a positive test on a sample. And typically we're notified, our laboratory is notified by the epidemiology department to see if we can contact a commercial laboratory that performed the testing to see if we can get a sample of that, if we can get that sample shipped to us so that we can ship it to the CDC for additional testing.
Q Now, as far as samples that either come into the Southern Nevada Health District or are initiated in the form of blood draws or whatever by the Southern Nevada Health District, is your entity within that group part responsible for that kind of work?
A For collecting the –
Q Collecting the samples first of all. We'll take it piece by piece.
A Okay. So we collect samples at the request of the Southern Nevada Health District office of epidemiology. We are not open to the public and we don't do testing for other physicians. So if the office of epidemiology requests collection

of samples then we would be the entity that would collect them.
Q Did you do so in this case related to the outbreak?
A Yes, we did.
Q And then subsequent to that did you then process any of the samples that you yourself or your organization had processed?
A Yes, we did.
Q As far as samples that came into you that you obtained from other laboratories, was that something that went through your hands or your laboratory?
A Yes, it was.
Q When that happens, either if you initiate it or it comes in from another source, is there some way that you kind of keep track of what's going on?
A So every sample that comes into the laboratory is labeled with a unique identifier from the facility that it came from. So laboratories typically give unique identifiers for the sample. It's called an accession number for the samples that they collect. Those samples are labeled with that number. It's also typically labeled on the, or that's written on the test requisition form that

comes to us. Those samples, when they get shipped to us from the other laboratory, when they get to our facility those numbers are matched with the number and name that's on the tube, with the number and name that's on the requisition and then that information is placed into our laboratory information management system where it gets yet another number. And that unique number is part of the Southern Nevada Public Health Laboratory information system which it's called the LIMS.
Q Now, at any time do you, if you're interacting with an entity such as CDC, do you ever receive numbers or labels or information from them that you're going to use in the collection process?
A Yes, we can. In some instances they will give us an additional unique identifier that the other laboratory is requiring us to use.
Q So if I understand you correctly at this point, if you were doing that in general you might have multiple identifiers for one single sample?
A That's correct.
Q In the process of processing these, sending them out, receiving them, handling them, do all of those numbers have to match up to make sure that it's the same person and sample?

A That's correct.
Q In the particular case that we're talking about here, the Health District case that involved the hepatitis outbreak, did you involve yourself with the CDC in either obtaining that kind of material from them in order to produce the samples?
A Yes, I was in charge of that process.
Q Okay. Tell us what you did related to that.
A Related to getting the numbers from the CDC?
Q Yes. Tell us how that goes and what you receive from them and what you did with them.
A The outbreak investigation team, when we made the connection with the CDC, the CDC created a specific code for this investigation. It had three letters in front of it, NVC, and the numbers were sequentially numbered starting with number one. They sent us a sheet of pre-labeled, preprinted labels. The labels also had bar code numbers on them. And each patient sample, when the samples were collected if we were sending them to CDC, that label with the special NVC number was attached to the samples that were sent to the CDC as well as the test requisition forms as well as a sample log that

the CDC required that we send with the samples when we ship them to CDC.

Q In your position, do you have access to all of these records and logs and so forth that are done?

A Yes, I do.

Q Did you review those in preparation for coming in today?

A Yes, I did.

Q Did you actually produce some documents or copy some documents related to the, sort of the flow of these samples through your laboratory back to CDC?

A Yes, I did.

Q I'm going to start off by showing you a couple of exhibits. One is, it may be redundant but I just want to show it to you anyway, one is marked as Exhibit Number 12 and one is marked as Exhibit Number 18. Would you look over those documents and tell me if you're familiar with them?

A Yes. These were documents that we started in the beginning stages as well as when the investigation was going on that helped us to keep track of the patients that had been sent to CDC and keep track of all those numbers.

Q So do the names of the individuals that relate to a sample, do they correspond with these unique identifiers that you mentioned earlier?

A Yes, they do.

Q And does that include the unique identifiers from CDC, the NVC numbers?

A That's correct.

Q After the samples are put together, do you send the names along with the samples to CDC or just the numbers?

A No, the names are included as well.

Q Okay. So all that goes off to CDC; is that correct?

A That's correct.

Q So in this particular case on Exhibit Number, we'll start off with Exhibit Number 18, can you tell us what we're looking at here?

A So on this log you have the patient's name, their date of birth. We were trying to identify whether they were a patient to contact, an employee or a past employee. They're what's called an OOEMR number and that is another unique identifier that our office of epidemiology maintains for morbidity tracking.

If the sample was received from an

outside commercial laboratory, we identified where that came from, when the sample was collected, the special unique identifier for that commercial lab.

If the lab was collected at Southern Nevada Public Health Lab, the collection date for that with our unique identifier, the CDC study code number, the NVC number, the date the sample was shipped to CDC.

There's an additional number on here called a chart identifier which is another number the CDC utilized when they were on site, the results of the testing, when they were received by the lab, when they were received by Epi and also the procedure dates, who performed or collected the sample, any additional testing that was done and whether the sample is still stored in the laboratory freezer.

Q Okay. I'm going to go ahead and display this for the Grand Jury and I'm want to ask you a few questions about it. This is the first page of Grand Jury Exhibit 18. And I know it's very small but since you're close I'm going to stay up here for a moment and just ask you if, and I'm just going to pick one for example, but on the first and second page, does this depict all of the patients who were

either believed to be infected or source patients regarding this outbreak?

A That's correct.

Q Okay. So if we pick the very first one as an example, can you tell us who that was and what the information is across this page? And if you need to step up a little closer you can.

A Thank you. The first -- well, I'm going to look over here.

Q That's fine.

A The first --

Q And you can use your finger to direct and show --

A Thank you. So the first name on here is Rudolfo Meana. Date of birth 2-20-1935. This is the patient. The epidemiology medical record number is 30402. This sample came from a commercial laboratory which is Quest. The collection date is 12-27-2007. The accession number 490 -- did you want me to read all the numbers?

Q You don't have to read all of it, just tell us what those categories are.

A All right. So the assessment collection date, the accession number. So if the sample was collected at Southern Nevada Public Health Lab, the

specimen collection date for that, the accession number. This sample was the very first one in our study code so it's NVC-1, the date it was shipped to CDC, the chart identifier, the results of the testing at CDC, when we received them by at Southern Nevada Public Health Lab, when they were received by our office of epidemiology, when their procedure was. And this line that talks about CDC testing, this identifies that the sample that was tested at CDC was the Quest sample that was collected back on 12-27-2007. The sample was recollected at Southern Nevada Public Health Lab because we needed to test the patient for Hepatitis B as well as HIV.

Q Okay.

A And then the last column tells that the sample is still in storage at Southern Nevada Public Health Lab.

Q So just for the record, as we moved across that as you say each category, you were referring to a different column on the sheet; is that right?

A Correct.

Q And we just picked out one for an example?

A Correct.

Q Now, again this contains, this page and the following page on this particular exhibit lists

all of that kind of information for each one of the patients, either the source patients or the infected patients for both dates, the 25th of July of 2007 or the 21st of September of 2007?

A Correct.

Q Okay. That's fine. Now, and that document that's up there right now, is that one that you put together or had some hand in crafting?

A Yes, I assisted with the -- I started this spread sheet and then in conjunction with our office of epidemiology, both groups worked on putting in the data.

Q The data that's contained in this particular document, have you actually gone back and verified that it's accurate?

A Yes, I have.

Q Okay. You yourself did this?

A Yes, I did.

Q Now, as far as the other exhibits are concerned, I'm going to start off with -- I guess we'll just go in order. We've got 19 through -- 19, 20, 21, 22, 23 and 24. Can you tell us what those documents are?

A So each one of these documents represents the CDC shipping form, when the samples were shipped

to the CDC. They --

Q And as you talk, I'm going to go ahead and display one so that we can have that for the Grand Jury. I'm going to start off with, I'll put Exhibit 24 on the screen and you can describe for us what we're looking at. And I believe this one looks like it goes to Sharrieff Ziyad.

A Correct. This was a shipping form that the CDC provided to us at the beginning of the study. At the top of this you'll see that the NVC hepatitis reference study code is listed. It lists the date the samples were shipped. It lists a number in there to identify how many samples were included with the shipment. It lists the Fed-Ex air bill number for when the shipment was sent, where it came from. It lists our facility location, the person who completed the form and their signature, the date the form was completed and then it does list the shipping address to the CDC.

Q And that's on the first page; is that correct?

A Correct.

Q And then on the next page, what information is contained on that page?

A So on the next page is the listing of the

samples that were included in with the shipment. So there were three vials listed on the front page of the page, that was what was contained in the shipment, and there were three vials that were shipped.

Q Now, that's of the exhibit that you're actually looking at?

A Oh, I'm sorry, I'm on the wrong -- yes.

Q So the one that's up displayed for the jury right now, it's the same kind of thing for each one, this one only contains one but the one you were referring to which is Exhibit 23 actually has three separate samples that were sent; is that correct?

A That's correct.

Q Okay. Tell us what we're looking at there on the screen.

A So on the screen again where it says patient I.D., that is a label from our laboratory information management system. The number at the top, the 12839 I believe it says, is an accession number that's unique for that sample, lists the patient's first and last name. The second column which is the CDC study code --

Q Let me stop you there just for the record. Is this the number up here that you're referring to?

A That's correct.
Q So the top of the bar code to the left under the column patient I.D. for the record?
A That's correct.
Q Okay.
A The next column is the CDC study code and that this contains the preprinted labels that the CDC provided to us. And that is an NVC number that's listed on there that's unique to this sample.
Q Okay.
A The next column would be the date the sample was collected. The next column is the number of cryovials that were related to that sample. And then the diagnosis column actually identifies which tests that we performed at the CDC as part of this study.
Q So in this case it's -- does this stand for Hepatitis C, Hepatitis B and HIV?
A That's correct.
Q And that's a Human Immunodeficiency; is that correct?
A That's correct.
Q Now, as far as your handling of these samples, when all of them are sitting there I assume you send them out at different times; is that right?

A That's correct.
Q When you have more than one sample at a time, do you do them both together or how do you keep them categorized?
A So the samples are all handled individually. They are -- when we receive samples at the laboratory they come in a, what's called a biohazard bag. It's a zip-style bag. The sample is included in the zipped portion of the bag. There's a pocket at the front of the bag where any paperwork attached to that sample is put. They come in with a test requisition and then the samples are all labeled with the patient's name and information.
These come in. They're accessioned into our laboratory information management system which is where that preprinted label comes from. And then if any additional testing that needs to be done on these samples, they need to be centrifuged. Typically they come in as whole blood. They get placed in a centrifuge so that we can collect the liquid portion of the blood which is called serum. That is the material that is sent to the CDC or to the testing laboratory for testing. The CDC recommended that the samples, once they were collected, that they be centrifuged within a

specific period of time and that the sample, the serum portion be aliquoted off or taken off of the tube and placed into another vial that was frozen. And the vial that -- and that vial with the frozen serum is what gets sent to the CDC. Those frozen vials were labeled with the accession label that contains our unique identifier.
Q Now, do you send the entire sample off or do you retain any of it in the laboratory?
A So in this case when we collected these samples we were -- there was sufficient serum off of one tube of blood to split that so that we could maintain one sample of frozen serum at SNPHL as well as send one sample to CDC, and that was to ensure that if there was any problems during transit, we had situations where our boxes might be delayed by Federal Express, these are frozen samples, we want to maintain their integrity, we maintain a sample in our freezer to ensure that we could reship the sample if needed.
Q Did you maintain a sample in your freezer for all of the nine patients?
A That's correct.
Q Did you have any problems with shipping where you had to either reship out a sample or there

was some problem with a delay and the, you know, the sample warming up or something like that?
A We did not have any shipping problems.
Q Okay. Now, beside the issues that you've addressed, after the samples go to CDC and the testing is done, are you involved with any of the results that come back?
A Yes. The results, as the submitting laboratory, the results come back to Southern Nevada Public Health Laboratory. The test that was ordered in our laboratory information management system remains pending or open until we get the results back which enables us to track those. And then when the results come back we put the results in our system and then we print a report which is sent to our office of epidemiology.
Q Beside that process that you've described, were you involved in any interpretation of any of the results or any testing itself at the lab?
A At the CDC?
Q No. When stuff comes back, do you interpret the results or is that already done?
A No, that's already done and the testing laboratory provides the interpretation.
Q Okay. And then what do you do with that

after you get those results and as far as incorporating it or just giving it to your people internally?

A To the office of epidemiology?

Q Yes.

A So again those results are put into our laboratory information management system and then a report is printed that includes the CDC results. And then we also send a copy of the CDC report along with our report to the office of epidemiology.

Q Who was the local epidemiologist that was involved with this particular case?

A That would be Brian Labus.

Q So were these results made available to him then after they came back?

A Yes, they were.

Q Were you involved in the actual transfer of the information that came from CDC into your information lab or information data base, so to speak?

A Yes.

Q Okay. And you've checked that to make sure that there were no errors or inaccuracies in the transfer?

A Yes, I have.

MR. STAUDAHER: At this time I have nothing further for this witness if the Grand Jury has something.

THE FOREPERSON: Are there any questions from the jury? None?

By law these proceedings are secret and you are prohibited from disclosing to anyone anything that transpired before us including any evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury or any information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by one year in the Clark County Detention Center and a $2,000 fine. In addition you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Thank you. You may be excused.

THE WITNESS: Thank you.

MR. STAUDAHER: Stand right here.

THE FOREPERSON: Please remain standing and raise your right hand, sir.

You do solemnly swear that the testimony you're about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?

THE WITNESS: I do.

THE FOREPERSON: Thank you. You may be seated.

You're advised that you're here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property; criminal neglect of patients; insurance fraud; obtaining money under false pretenses; and racketeering involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Could you please state both your first and last name spelling them for the record?

THE WITNESS: Brian Labus, B-R-I-A-N L-A-B, as in boy, U-S, as in Steve.

THE FOREPERSON: Thank you.

BRIAN LABUS,

having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:

Q Mr. Labus, what do you do for a living?

A I'm the senior epidemiologist with the Southern Nevada Health District.

Q And how long have you been in that position?

A I've been the senior epidemiologist for seven years. I've been an epidemiologist for nine.

Q Prior to the time -- have all nine years been with the Southern Nevada Health District?

A Yes, they have.

Q When you were not the senior epidemiologist, what was the other role you had for those other two years?

A I was an epidemiologist. The same job basically, just a little lower on the totem pole.

Q In order to become an epidemiologist at

Southern Nevada in your case, what was your background and experience?

A I have a bachelor's degree in biology from Purdue University and I have a master's degree in infectious diseases from the School of Public Health at the University of California Berkeley.

Q Beside your education, have you been involved in any training seminars, publications, anything else things like the report which came from this particular case?

A Yes. I've been involved in numerous training seminars related to my profession. I also teach infectious disease epidemiology at the School of Public Health at UNLV.

Q I'm going to direct your attention back to January of 2008, actually maybe even before that a little bit, back into 2007. Did you at the Health District become aware and get involved with an outbreak of Hepatitis C cases related to the Endoscopy Center of Southern Nevada?

A Yes.

Q And how was it that you become involved with that?

A We had two cases of acute Hepatitis C reported to our office independently by the doctor

that diagnosed those cases. By law they're required to report those to our office so we can investigate them and try and identify links between the cases.

Q So this wasn't just something that a doctor has discretion to report, it's an obligation under law to do so?

A Yes. It's required that health care providers and laboratories report evidence of disease to the Health District for investigative purposes.

Q In a typical year do you get reports of Hepatitis C cases --

A Yes, we do.

Q -- that come to the lab? And just for ease of the court reporter, if you could allow me to finish my question before you answer. I'll try and allow you to finish your answer before I ask the next question if that's okay.

A Okay.

Q That being said, in that particular situation, I mean, how many do you on an average receive in a year's time?

A In an average year for the county we receive between two and four cases reported to us.

Q So what was the time frame by which you

received the first two reports from the same doctor you said?

A The two cases reported related to the same clinic is how we determined in our investigation, but the first one came in the beginning of December, 2007. The second one came in the middle of December, 2007.

Q Okay. Based on that information, was two in that short of time span kind of an unusual event?

A Having two cases closely linked together would have been a little unusual. It was unusual. We had our disease investigators do the investigation and find out that they both had gone to the same clinic.

Q Okay. So this was part of the record or part of the investigation that was done and typically in any case that comes in that you have to do some form of investigation?

A Yes, that's correct.

Q So you just can't say, gosh, this is a just a Hepatitis C case and, you know, if we get another one we might look into it?

A No. Each case is investigated according to our protocol. They ask about the major risk factors and then try and confirm the person actually

has that disease.

Q So when a case comes in do you initially get involved or is that a lower investigator level person?

A We have a disease investigation staff that does the individual case investigation.

Q So do they follow up with not only the person that supposedly has Hepatitis C but also look into other issues like risk factors and so forth?

A Yes. They get laboratory results, they will get medical records from the patient's provider and they will interview the patient to look for risk factors.

Q Now, are the cases that come in -- there's a difference between chronic and acute hepatitis, is there not?

A Yes, that's correct.

Q In the cases that came in, what were they classified as at the time?

A They were both classified as acute Hepatitis C.

Q And can you tell us about that? What is the difference between acute versus chronic hepatitis and how is it classified?

A Acute Hepatitis C is reportable in Nevada.

Chronic hepatitis is not. Acute disease refers to a person that develops symptoms. So they have a newly acquired infection, they develop the symptoms of hepatitis which include jaundice, nausea, abdominal pain, dark urine, light-colored stool. They have physical symptoms that are present.

A chronic case is a person who either went through that acute phase and the symptoms went away and they still have the virus present in their body doing damage at a level that they wouldn't notice unless they were tested. Or most people when they're newly infected go right into that chronic phase and never have the acute symptoms. So only about one in ten people actually develop that acute disease.

Q So even though that you had two individuals that presented with hepatitis, at least acute hepatitis, that could mean that there was up to 20 individuals out there that maybe had the similar thing happen to them but didn't essentially produce results or symptoms?

A I suppose that's possible. We don't make those sort of calculations. We just saw two closely-related cases and that was what started our investigation.

Q Fair enough. So at this point you've got one case that comes in and another case that comes in a couple of weeks later. Do your investigators or your investigative office, do they compare notes on cases that come in?

A Yes. Our investigators, we're talking about acute Hepatitis C cases that they had, the two investigators who were assigned those cases, and on December 28th they identified that there was a common risk factor among the two, that they had both undergone endoscopic procedures at the Endoscopy Center of Southern Nevada.

Q You know, when you're looking at something like that, do you have some sort of matrix that you follow as far as the things you're looking at; for example, whether or not somebody had blood transfusions or they engaged in risky social behavior, things like that?

A Yes, there's a number of risk factors that we ask about on every case, looking at the major risk factors for that disease. For Hepatitis C there are a number of them that we look at. They're standard across any case that would be reported which would include blood transfusions, organ transplants, intravenous drug use, sexual contact

with people that had hepatitis, medical procedures, dental procedures, tattoos, basically any type of situation where they could be exposed to blood or blood products.

Q So medical procedures were on your list of things to look at?

A Yes. And because of outbreaks that have occurred with other endoscopy centers nationwide, we specifically ask about that. We ask people about surgeries but they may not think of the endoscopic procedure in the same way. So we specifically ask about that as well.

Q Is that a line item that you actually ask the person, have you had an endoscopy or colonoscopy or something along those lines?

A Yes, it is.

Q So in this particular case were there any other risk factors that were associated or in common with the two except for the fact that they both had endoscopic procedures done at a local clinic?

A No. Those were the only risk factors identified, that endoscopic procedure in both of those cases.

Q So once that information comes to light, what is the next step that happens at the Health

District?

A We begin starting to look at what the common factors are. In this case having two Hepatitis C cases related to the same facility is very uncommon. So we contacted the CDC for some technical advice on which way to go with this investigation. The two cases we identified had procedures on different days so we didn't have two people on the same day. We had two people, one in late July and one in mid September. We didn't have the dates or the time, but we knew they were separated by about three months or so.

Q Later you got the dates?

A We got the dates later, but initially we knew they at least didn't have it around the same time period.

Q So I assume you call the CDC. Was that you? Do you get involved at this stage?

A Yes.

Q Okay. So once you have two sort of cases from your investigators, do you get assigned to the case?

A Yes. Basically I'm responsible for the outbreak investigation. So that's one of my normal job duties is to get involved in the sort of

clusters or reports of common links.
Q So you're the one that picks up the phone, dials CDC and talks to them?
A Me and my boss. We had several people actually contacting CDC at that point. We kind of work as a team on most things.
Q Now, based upon your contact with CDC what happened?
A Well, as we were discussing with CDC what we should do and where we should go with the investigation, we identified a third case. So basically as we're emailing and talking to CDC a third case was reported of acute Hepatitis C. It was assigned to an investigator. They made it a high priority. They managed to get ahold of the person right away. And that person had a procedure at the Endoscopy Center of Southern Nevada on the same day as one of the other two cases. So now we basically had the dates down. We knew there was one case on July 25th and two people who had procedures on September 21st.
Q So was this a red flag to you at this point?
A Yes. The three cases basically are what we'd expect for the entire county for the year and

now we've got them linked to the same clinic, two of them on the same day.
Q Okay. And they come in to you within a period of about a month it sounds like?
A Yes, that's correct.
Q So do you relay this information to the CDC as well?
A Yes.
Q Do they agree to help you?
A Yes. We started the process then of asking for their assistance for them to come out and provide what's called an Epi aid. It's a process set up where the CDC can provide technical expertise and send their people out to assist in outbreak investigations in state and local health departments.
Q And I just want to interrupt for just a second.
Is everybody hearing what he's saying?
A JUROR: Yes.
A JUROR: Yes.
MR. STAUDAHER: Okay. I wanted to make sure.
///

BY MR. STAUDAHER:
Q I assume that that happens then?
A Yes, we made the official request. That actually comes from our state epidemiologist. So we made an informal request to CDC and then we asked our state epidemiologist to make the formal request, send the letter, do the paperwork and all that sort of thing.
Q And who is the state epidemiologist or was at that time?
A At that time and still the state epidemiologist is Dr. Ihsan Assam.
Q Now, once that sort of formal request goes out, does CDC then immediately come out or do they set up a time to come out? How does it work?
A We started talking to CDC on January 2nd. They were able to get there the following week and they arrived on January 9th.
Q Did they meet with you when they came out?
A Yes.
Q Okay. But before meeting with them on the 9th, had you made contact with the clinic involved?
A No, we had not.
Q So you decided at that point when you meet with them to then make contact with the clinic?

A Yes. We didn't want to have the clinic start to change their practices before we went in and did the investigation. So we waited until we were out there in the field and could observe what was actually going on.
Q Now, the clinic in question was which clinic and where was it located?
A It was the Endoscopy Center of Southern Nevada located at 700 Shadow Lane. It was right across the street from the Health District. It may be a little confusing for some people, but it was a little more confusing because they had two actual clinics in the building. There's an endoscopy center where they do the surgical procedures and they have a gastrointestinal, basically a doctor's office right next door to that. They're linked together. They share a number of staff. But it was the Endoscopy Center at 700 Shadow Lane.
Q When you say surgical procedures, I assume you're talking about upper endoscopies and colonoscopies?
A Yes, that's correct.
Q Do they do any kind of other procedure there?
A There were a couple other procedures they

did related to that, placing of a PH probe I think was one of those and there was one other procedure they did occasionally. But they were, you know, one or two a month maybe.

Q Gastrostomy tube placements?

A I believe that was one of the other ones as well.

Q Beside those things, that's what they did there essentially?

A Yes.

Q Okay. And then there was an associated medical type gastroenterology clinic with that group?

A Correct.

Q Separate entities within the same building I think?

A They were right next door to each other. They had a back door that connected the two offices.

Q So different buildings?

A It was the same building, it was just two office suites within the same building and shared some staff between the two offices as well.

Q Now, when you meet with the CDC when they come out here, I mean, who's coming out to meet with you?

A We had two people come out from the CDC to assist us, Dr. Melissa Schaefer and Dr. Gayle Fischer. They both came out to assist. They were EIS officers assigned to this particular investigation.

Q And EIS is what?

A Epidemic Investigation Services I believe.

Q So they come out and meet with you. Is it just you or do you have anybody else working with you?

A No. When we conduct an outbreak investigation we have a large team. We have our outbreak investigation team assembled with all the people we need from the different disciplines related to this investigation. So it was a meeting of, there were probably 20 or 25 people in the room in the initial meeting.

Q Now, all 25 people don't go over to the clinic, do they?

A No.

Q Who goes over to the clinic?

A The clinic, it was the two people from CDC, myself and we had a concurrent investigation done by what was called the Bureau of Licensing and Certification at the time. They've changed their

name since then. They were with the State Health Division and they're responsible for licensing that clinic. So the five of us were the ones that made the initial contact with the clinic and made the initial visit.

Q Now, when you make the initial contact, is that by telephone first or do you just so show up at the door?

A We called and said we were coming over, we want to meet and see if they can get their people together so we gave them a little warning we were coming over. But we were right down the street so within a half hour we were over at the clinic meeting with them.

Q Who did you talk to when you first called over to the clinic, if you recall?

A We spoke to a few people. We called the main line first. I think we got one of their, I think it was the director of patient relations who then referred us to the administrator Tonya Rushing and she set up the meeting for that day.

Q So they know you're coming over and who you are?

A Yes.

Q Did you tell anybody either before you got

over there or once you did get over there that it was not just the Health District but the CDC as well?

A I don't know if we told them in advance but we did explain who everybody was, what their roles were in the investigation and what each person was doing there basically.

Q Once you got there?

A I believe so. We may have said something in advance, but we basically said we're coming over to talk to you about this cluster we've identified.

Q So you arrive on site, there's about five of you you said?

A Yes.

Q Some from the Bureau of Licensing and Certification, CDC and yourself?

A Yes.

Q Anybody else from the Southern Nevada Health District besides you?

A For the initial meeting, no, just me.

Q You go into the facility. What do you do?

A We sat down with Tonya Rushing and Dr. Cliff Carrol and explained basically what we had identified, that we had three cases. We talked about what information we had on the cases that we

could share, that they were acute cases, they were confirmed by our case definition and that they all reported undergoing procedures at the clinic, the dates of the procedures, some just basic information, explaining we would be doing an investigation to look for a common source if there was one.

Q How long did the meeting last?

A Forty-five minutes, an hour maybe.

Q Now, after either talking to them -- and you made it clear as to who all you were, all the players?

A Yes.

Q After that meeting did you get up and leave or what did you do?

A They took us downstairs and gave us a quick walk through of the clinic just to get kind of the overview of how things were set up.

Q And then?

A That was late in the day so it was basically we had the meeting with them, got a quick overview. The clinic was -- I think when we went in they were seeing their last patient of the day so there wasn't anything to observe. Most of the people were starting to go home.

Q Did you start any chart review or anything like that on that day?

A On that day, no.

Q So did you make arrangements to come back the following day?

A Yes, we did.

Q Was that in the morning, afternoon, evening?

A First thing in the morning.

Q So you show up. Who shows up on the second visit?

A The second visit it was the same people from that initial meeting as well as a couple of additional investigators from my office. We were going to do chart reviews so we needed some help just going through lots and lots of documents.

Q What kind of charts did you look at?

A Basically anything that they had related to those procedures. So they had procedure charts related to how each procedure was performed that particular day. In some cases they also had medical charts relating to the gastro clinic next door of a patient's overall health. So we requested all the charts from the days where we had known transmission as well as I believe two or three days prior.

Q Okay. So that's your group that you're looking at?

A That was the big first group. We also asked for a number of other documents in the clinic; their protocols and procedures, cleaning logs, a number of other things from them. But the big focus the first day was the charts and looking at those procedure charts.

Q Now, when you say the first day, the first day that you actually did chart review?

A Right, the first full day of investigation.

Q So this would have been the second day?

A This would have been Thursday, the 10th of January.

Q So when you go back and start the chart review, is that pretty much all you do the whole day or do you go in and start watching and observing procedures, things like that?

A For that day it was basically chart review. We didn't go and observe anything that day. We wanted to look at what information was in the chart to help focus where we were going to do our observations.

Q How long did CDC and you go do this on a

daily basis?

A CDC was in town for a week. They arrived on Wednesday and they left the following Wednesday. So we were out there the three days of that week, Wednesday, Thursday, Friday, and then I think Monday and Tuesday of the following week and then they left on Wednesday.

Q After CDC leaves do you go back to the clinic at any time or --

A Yes.

Q And what was the purpose of you going back?

A I was following up on different documents. There was additional information I wanted to collect so I went back a few times over the next two or three weeks.

Q Now, during the time that you are doing the chart review, I assume you look at a bunch of charts?

A Yes.

Q Did that chart review continue on over those period of days that CDC was present?

A Yes, they did. We were doing chart review pretty much everyday that we were at the clinic.

Q At some point do you start reviewing or

watching procedures and, you know, how they handle things within the clinic?
A Yes.
Q Did that come on the third day then?
A Yes, that would have been the third day, the 11th of January.
Q Is that only a partial day or is that a full day; some people watching procedures all day, other people doing chart review?
A It was the way you described, some watching procedures, some doing chart review. It was basically continuing the chart review from that Thursday and then starting to do observation in the clinic as well.
Q We'll get back to the chart review in a little bit, but I would like to move to your review of the procedures. Were you parented up with somebody or partnered up rather with somebody as far as the observational part of it or were you by yourself looking at various aspects of the practice?
A I was with Dr. Schaefer in the procedure room on the right.
Q So there were how many procedure rooms?
A There were two procedures rooms. They weren't labeled A or B. They just had two rooms.

So we were in the one on the right and Dr. Fischer was in the one on the left.
Q When you were doing the chart review, and I'll go back to that periodically probably, but when you were looking at the charts for those days and since they have two rooms going, initially could you tell, I mean, were they designated as room A or B or first room, second room, anything like that?
A No, there was no indication on the chart as to which room the procedure occurred in.
Q Later on were you able to make a determination of what room was what on at least the day of the 21st?
A On the 21st, yes, we were able to do that.
Q And we'll get to that down the road in a little bit but back to the procedure issue. When you first go with I think you said Dr. Schaefer; is that correct?
A Yes.
Q What about Gayle Fischer at the time?
A She was observing in the other procedure room at the same time.
Q And her name has subsequently changed to Gayle Langley; is that correct?
A Yes.

Q Now, I'll probably refer to her as Fischer and Langley but just so you know who I'm talking about. She's in another room and you're in a room with Dr. Schaefer?
A Correct.
Q Where are the other people in the clinic? Are they looking around at charts at this point, doing things like that?
A The other people that were with us, they were doing the chart review. There was a conference room across the hall that they had set us up in and they were in that room doing the chart review. People from BLC, I don't know what they were doing in their investigation. They were doing their own separate parallel investigation so they may have been in and out or a different place so I'm not really sure about them.
Q When you came back to the clinic on the subsequent days, I know the BLC is there, I know the CDC is there and I know you're there. How many of your people did you bring along with you to help you with the chart review and the observation?
A The most we ever had from my office were three people including me.
Q Okay. On average was it three or two or

one or --
A It kind of varied depending on what was going on that day. Some days it was just me, other days there were three people.
Q So where do you start your observation?
A Basically standing in the back of the room watching as they bring in a patient and seeing what happens basically and how the patient flows, how the staff moves around the room, that sort of thing.
Q And you're talking about being actually in the procedure room itself at this point, correct?
A Yes, that's correct.
Q Did you go out and observe any pre-anesthesia areas, post-anesthesia areas or, not preparation, but cleaning areas at any time?
A We did eventually. At first we just went into the procedure rooms. That was our first stop basically.
Q What happened in the procedure room of note?
A We observed several procedures. Linda Hubbard was the CRNA in the room that I was observing. There were some infection control issues we identified. She was only wearing one glove, not two. There were some hand washing issues and the

way they'd wipe the bottles and some minor things like that that weren't thought to be a major problem for an outbreak, an infection control issue but not for the outbreak that we're interested in.

So we watched several procedures. The first procedure, the patient got the anesthesia and when it was done there was leftover propofol in the vial and the vial went on the tray that was set up in front of the CRNA Linda Hubbard.

Q And the vials that you were seeing used at that time, what size vials were -- I mean, I know you're familiar with the different sizes, correct?

A Yes.

Q What size bottles were they using?

A The vials we saw that day were all 20CC vials.

Q So there was some remaining after the first patient or the patient you observed that day?

A Correct.

Q What happened next?

A Another patient came in. She took a new vial, clean needle, clean syringe, drew up the anesthesia and sedated the patient. And when that procedure ended there was a little left in the vial and that one sat on the table. So this happened for

several patients and there were several vials lined up. And then we observed her draw a couple of syringes from the multiple vials, basically use up whatever remaining amount there was in those vials.

Q Now, as far as that process, was there a concern about that at the time?

A There was a concern that they weren't using the product in accordance with the manufacturer's label. It's labeled for single patient use only. If the vial is reused on somebody else and that vial were to be contaminated, that would have been a major problem. We didn't observe any contamination, we just saw the reuse of the vials. But that's one piece that was a major issue for us.

Q Now, after that day or at least that observation, did you have a chance to speak with Gayle Fischer or Langley at that time regarding what she had observed in the other room?

A Yes. We sat down that afternoon and had a discussion about what we observed during the procedures.

Q Now, the purpose of these discussions I assume is so that you can formulate your outbreak information and try and prevent any issues that

arise to make sure that you are correcting any problems that are out there?

A Yes, that's correct.

Q Did you also interview staff at that time?

A Yes, we interviewed staff at that time and for the next several weeks.

Q Did you ever come across the impression that what you had observed was a common occurrence within the practice?

A Yes.

Q Was it a common occurrence?

A It's what we observed in both rooms. And we reviewed the number of vials of propofol that were checked out on the days so we knew how many patients there were, we knew how many vials they used and it was clear that there wasn't one vial at least for each patient.

Q So you're saying you were able to go back to the days of the 25th or 21st and look and see how many actual vials had been checked out for those days?

A Yes, that's correct.

Q And how many patients they had and compare the two?

A Yes, that's correct.

Q What was the -- I mean, how many -- let's use the 21st if you know and remember. Do you know what the differences were between the number of patients and vials that were used on that day?

A Off the top of my head, no, but I can find it in the report. That's why I brought this with me.

Q Before you go there let's do this right now. I'm showing you what's been marked as Grand Jury Exhibit Number 13 and ask you just to flip through that. I think you're probably familiar with it. Just tell us what it is.

A This is the final report that I wrote for our investigation.

Q Okay. Now, in this report, I know you were about ready to refer to a document, I've got the copy here that is going to be a Grand Jury exhibit. What I'm going to ask is that if you go to a page that you're referring to a chart or a diagram or any kind of information, that you just refer me to that page and then I will go ahead and display it for the Grand Jury as well.

A Okay. Let me find the page. I have the number of vials they had that day so let me find it.

Q And unless it's a chart or something we

probably won't display it if it's just something you need to refresh your memory. Go ahead and look at the document and then you can tell me about it after you do so.

A Okay. On September 21st there were a total of 64 procedures performed on 63 patients. That's on page 22 of the report. One patient had two procedures so there was one more procedure than patients. On that day they used a total of 24, 50CC vials and they checked out four, 20CC vials and returned all four. So there were 63 patients and they used 24 vials on September 21st.

Q Okay. So based on what you had observed on subsequent days and talking to patients and so forth, not patients but the staff about how to use propofol, was it consistent with what you were seeing there is multiple uses of a single vial on multiple patients?

A Yes.

Q Was that a potential concern for you as a possible mode of transmission of this disease process?

A Yes, it was.

Q Now, one of the other issues that arose, did it have to do with syringe reuse?

A Yes.

Q Did you also look into that?

A Yes, we did.

Q Was there evidence in your investigation, at least during your observational period, that syringes were being reused at the clinic?

A Yes, there was.

Q Did you do a similar kind of thing where you looked at syringe amounts and all that kind of stuff as part of the investigation?

A We did not evaluate the number of syringes and needles used related to the vials. That came through observation of what was actually going on in the clinic. Dr. Fischer was observing Keith Mathahs in the other procedure room and observed him use a clean needle, clean syringe, draw propofol, sedate the patient. The patient needed a second dose of propofol. He took the needle off the syringe, disposed of the needle, put a new needle on the syringe and went back into the vial to draw a second dose of propofol.

Q Now, what you just described for us is not something you personally observed, is it?

A Correct.

Q That information, however, is contained in

this report that you have presented to us today or that is marked as Grand Jury Exhibit Number 13; is that correct?

A Yes, that's correct.

Q And this is a public document that anybody can download off the Internet or go to your website and review or anything like that?

A Yes, that's correct.

Q And that information was I assume used as part of your investigation to come up with your determination as to what actually was happening at the clinic?

A Yes, that's correct.

Q Was that consistent with some of the other information that you received along the way during the process of your investigation?

A Yes. In interviewing other CRNAs we identified that that was a practice that some either admitted to doing or said they were directed to do but didn't do. And it was really expressed as kind of the way they wanted things done at the clinic. Not everyone necessarily followed it but enough that we knew it was going on at the clinic.

Q Okay. Now, after you observed what you did in that room, I assume you have your meeting

with Dr. Fischer?

A Yes.

Q Did you then go to the clinic staff and tell them what you had observed?

A Yes. Everyday when we got done with our observations in the clinic we met with the clinic management and told them what we found that day and kept them up to date on what was going on in the investigation.

Q Now, beside the issue of syringe reuse and propofol reuse, were there other areas that you looked at as possible sources of an infectious transmission?

A Yes. There were a number of different areas that we looked at.

Q What were the areas that you looked at?

A For this one I'll refer you to one of the tables because I laid out -- it's table 20-1 on page 76.

Q And that's a table?

A Yes, that's a table. It basically goes through the different modes of transmission that we considered during our investigation.

Q Okay. Now, I'm going to display that for the Grand Jury. I know you've got your copy in

front of you so I know that's again difficult to read but we'll have you give us some information. As a matter of fact, I'll zoom in on that and move it up and down as we need to.

So what's displayed goes down to the word endoscope and the column entitled transmission mode slash source. Go ahead and tell us what you looked at and if you were able to confirm, rule it out and why.

A The first item on the list was staff to patient transmission. There's always a concern that a provider could be infected with Hepatitis C and through their actions spread it to patients. In order to evaluate that we tested all of the people that worked at the clinic. Let me see how many people we tested.

From page 28 we collected specimens from 36 employees including the physicians who were working at the facility at the time of the investigation and had them tested for Hepatitis C, Hepatitis B and HIV. All 36 staff members we tested were negative so there was nobody that we identified as being positive for these diseases that could have transmitted it to a patient.

Q Okay. Go ahead.

A We also through the genetic testing, which I assume we'll get into a lot more, identified source patients and the people who were infected and had genetic matches on them, additionally ruling out that it came from a staff member from the clinic.

Q And in fact I think, and we've already had fairly extensive testimony on the genetic aspects of this, but sufficit to say that you had two different days with two different genetic matches for patients on those days, correct?

A Yes, that's correct.

Q Go ahead.

A The second item on here was the physician so one of the concerns was it was a common staff member, something they were doing that allowed the transmission to occur. Let's see, so on page 22 now we basically did a test to look if any these things were statistically significant. And those next three items on there, the physician, the CRNA and the technician, we were all able to rule out. There was no common person for all the procedures. So it wasn't like there was one person involved in the procedures of everyone who was infected. So it was a mix of providers and a mix of CRNAs and technicians.

Q So, in other words, there wasn't a single provider on each and every person. You might have a CRNA on one, a different CRNA on another, a doctor on one, a different doctor on another, that kind of thing?

A That's correct. And on September 22nd there were only two CRNAs working in the clinic so there was some overlap there. But the patients had gone to -- had seen both CRNAs so it wasn't all linked to one CRNA.

Q You said September 22nd.

A I'm sorry, September 21st.

Q Okay. So as far as that's concerned, go ahead. What was the next thing?

A So all three of those things we were able to rule out. There was no statistically significant association.

Q Now, I'm going to move this back and move this up so the Grand Jury can see from the equipment, the biopsy equipment in that same column down to I believe the end.

A Okay.

Q Continue.

A So the next item is the biopsy equipment and it actually links to the item three lines down,

the reuse of the bite blocks. Basically looking at disposable equipment being used by the clinic to see if it was being reused and there was a common source with that. We ruled out both of those two items because not all infected patients had a biopsy. So there was the biopsy equipment. There was no way someone would have gotten it from it because they didn't have a biopsy. The same is true with the bite blocks. Those were only used for the EGDs, the upper endoscopies. And so if you only had a colonoscopy you wouldn't have used a bite block. So neither of those two items were brought up as the likely source of this outbreak.

Q What was the issue of the bite blocks?

A We had staff members report that bite blocks were being reused from patient to patient. We had one staff member report they were only allowed to use four bite blocks per room per day. The bite block is placed in the mouth and there's a hole in it and that's where they feed the tube down so the patient basically bites down on it. If they bite down in the middle of the procedure they're not biting through the equipment. But it was a concern of the reuse of that particular piece of equipment as a potential source. But we're talking about

something that went in the mouth and something that wasn't used on every single person. So that wasn't found to be a source of this outbreak.

Q So that was why you were able to rule that out as a possible source?

A Yes.

Q Okay. So there were things that came up like the bite blocks based on information you received through your investigation that said, hey, this is a possible source and then you looked into it?

A Yes, that's correct.

Q Okay. Go ahead.

A Okay. So the next item on there would be the endoscope. Actually looking at the piece of equipment used, concerns that it was the way it was cleaned that would have allowed transmission, if it wasn't cleaned properly. We had different scopes used on the patients and they were different scopes than the ones that were used on the source patients. One record reported that two back-to-back patients had the same scope number which they looked into and found there was a clerical error and they had it recorded differently in a different place and that it wasn't the same scope. But the scope used on the

source patient was different than that used on the patients who were infected. So there's no way it would have gone from that source patient to the infected people. We ruled that out.

Q And again the determination of the source patient and infected patients came from the genetic analysis that was done later?

A Yes. At the time of the investigation the clinic, part of the pre-anesthesia interview is asking people if they have hepatitis and a number of other health conditions. And so we had several patients who reported to be Hepatitis C positive which is what we'd expect on each day. So we had identified potential source patients very early on. We didn't have the genetic testing until much later, but even looking at those potential source patients we weren't able to have those sort of links between the patients by scope.

Q Now, we'll get into the timing issues there, but is it sufficit to say there were issues regarding timing of procedures and the recording of those various times?

A Yes, there were.

Q Significant time issues?

A Yes. There were major issues in figuring

out which times were appropriate and accurate in order to put the procedures in order.

Q The person who was determined to be the source patient on both days, the 25th of July of 2007 and 21st of September of 2007, according to your review did that person appear before the infected patients in the schedule?

A Yes. On both days the infected patients' procedure started prior to the -- or the source patients' procedure started prior to the infected patients' procedures.

Q In review of those source patients, were they documented as being Hepatitis C positive at the outset?

A Yes, they were.

Q So both patients were identified by the personnel in the facility as being Hepatitis C positive prior to their procedure?

A Yes, that's correct.

Q In the chart?

A Yes.

Q Now, in fact was one or more of those individuals being treated by physicians within the practice itself?

A I believe one of them was. I'm not

positive but I think that's right.

Q Okay. As far as the procedures and policies and things, you said you asked for additional information from the clinic; is that right?

A Yes.

Q Did you review any policies and procedures that related to, you know, when a patient should be -- that might have an infectious disease, when they should be placed on the schedule?

A No, I did not review any policies like that.

Q Go ahead and go forward then.

A The next item was the procedure type. This is related to the bite blocks and the endoscope as well. It wasn't a common type of procedure. It wasn't all upper endoscopies or all colonoscopies. It was a mix of both. So that one was ruled out pretty easily. They use different equipment for the two so it kind of goes along with the other pieces of equipment, that it's not linked because they didn't have the same types of procedures obviously.

Q So the same scope that goes in the mouth doesn't go in the bottom and vice versa?

A It can but generally it doesn't. They're

two different length scopes. You can use the lower scope to do an upper endoscopic procedure if you need to, but the scope they use for an upper endoscopy just isn't long enough to make its way through the colon. Generally though they use certain ones for upper and certain ones for lower.

Q In this case they had them separated into two separate groups; is that right?

A Yes, that's correct.

Q Go ahead.

A The last two items on here, the first one -- they both have to do with the injection safety issues and the way they handle needles, syringes and medications. The first one was the placement of the IV lines when a patient came into the clinic. We evaluated that because it was, obviously there was a needle puncture in the skin and we were concerned that there was improper use of injection equipment. We observed or the CDC staff observed the IV set-up procedure. They weren't observed to be reflushing the syringes so there was no way to contaminate a common vial. They would place the IV line and they would flush it once. There wasn't a need to flush it again so that needle and syringe never needed to go back into that common

saline vial which was actually labeled for multiple patient use.

Q Now, during the time you were all there in the ten days or eight days or whatever it was that you were there, was there any observation of any kind of reuse or double dipping of the syringe related to the IV flush?

A No, there was not.

Q Okay. In any of your investigation did you ever come across information that corroborated or gave you pause to think that that was actually happening?

A No.

Q Did you actually ask questions and look into that specifically?

A Yes, we did.

Q And found nothing to that effect that would show that that was being done?

A Correct. And in addition on July 25th, the source patient didn't set foot in the IV prep room. They were one of the first patients of the day, the first few patients. They just start in the procedure rooms because they can move into the clinic faster that way. So they never would have set foot in the IV prep room; therefore, there could

have been no contaminations from that vial. So on July 25th there's no way it could have even possibly occurred that way because the person never went into the IV prep room.

Q I see. Go on.

A The final item was the sedation injection practices, the items I've already talked about; the reuse of the vials and the reuse of the syringes. We had observed that they were being reused, both vials and syringes. We had staff members admit to those sort of things into the records. We could clearly show that they were reusing vials of propofol between patients. We were able to rule out everything else. That was our likely source of infection and one that had been identified in a number of other outbreaks as well throughout the country.

Q So this was something that in the past had been done, issues related to that specific issue?

A Yes, that's correct. Nationwide but not that we identified in Southern Nevada up to this point.

Q Okay. So you're kind of left with that and that's what you actually observed happening and it was corroborated by the investigation itself?

A Yes, that's correct.

Q Was there any other source that you could see as a possible infectious, you know, mechanism?

A The only other potential source was brought to us by Dr. Carrol, one of the clinic doctors, who was presenting as if somebody did it intentionally. He met with me a couple weeks after our investigation completed and before we made the public announcement and thought that maybe one of the staff members, a disgruntled staff member was intentionally spreading hepatitis in the clinic. We had no evidence to corroborate that.

During the conversation I had with him, he kept referring to it as a female CRNA basically and there's only one female CRNA working there, Linda Hubbard, and she wasn't working on the days when these things happened.

Q So she's ruled out as being the possible person when he in fact is thinking that that's the likely source?

A Right. And we had no other evidence that any other person did anything intentionally. There was no person reporting anything to us. There was nothing we found that would even remotely point in that direction.

MR. STAUDAHER: And that last portion, ladies and gentlemen of the Grand Jury, I'm going to admonish you at least that that was not offered for the truth of the matter, it was a statement made by another person to him which related to his investigation. It only goes to show what he did in his investigation, how he arrived at his decisions and what he did actually investigate as a result of that. So it's not offered for the truth of the matter at this point.

BY MR. STAUDAHER:

Q Go ahead.

A That was the last thing we looked at. Nothing else stuck out as a potential risk factor. I guess there was one other thing. It was related to the processing of the endoscopes. Different scopes were used with the people. We also looked at the manner in which they reprocessed the scopes, how they cleaned and sterilized those scopes. We found some potential small issues with that cleaning process but not ones that would explain an outbreak and not ones that were likely to spread infection from patient to patient. So we ruled that one out as well.

Q Okay. Now, I want to go back just a

moment to the potential intentional use issue. I know at least the person that you were directed to as being a concern for the clinic wasn't working on those days, but did that prevent someone else from going in and trying to do this?

A No, it didn't.

Q Okay. So did you look into the possibility of that as being a mechanism of transfer?

A Yes, that's a consideration really in any outbreak investigation that somebody may have done something on purpose. But at no time during our investigation did we find any evidence that pointed in that direction.

Q In fact, in reviewing both the genetic analysis on the 25th of July and the 21st of September, did you come to a conclusion that that probably had not happened?

A I don't think the genetic evidence really said anything either way about it. It didn't show that that was a source. Basically showed we had a different source patient on both days, but we had observed all sorts of infection control or injection safety issues with the way they handled the propofol. That was the likely source of infection.

There was no other evidence that something was intentional. So we had a very good and very likely source versus something that was brought up as a possibility and there was no evidence that that actually occurred.

Q On the two separate days though, and although you had different source patients, you also had very divergence of virus sort of groupings; is that right?

A They all group together in the genetic analysis so they did cluster together. They aren't a hundred percent matches because of the mutation rate of the virus which is exactly what we would expect, but they did cluster together and showed a close relationship on that genetic analysis.

Q For each day of the --

A Right.

Q But when you compare one day to the other there was a difference, correct?

A Correct. The virus on July 25th was different than the one on September 21st.

Q So if there had been somebody intentionally going around and doing this, they would have had to have gotten -- since none of the clinic members had the virus on board, they would

have had to have gotten a source of virus from two different potential sources on two different days and done this; is that right?

A Yes, that's correct.

Q Did that seem likely or unlikely at the time?

A It seemed unlikely.

Q Okay. Now, I'm going to take down that chart for the moment and let's center for just a second on the issue of the actual injection practice. I know that you kind of described that. Was there any kind of diagram or anything that you put together regarding that whole process that might make it easier to visualize for the jury?

A Yes. There's two diagrams on page 74 and 75.

Q And I'll show the one on page 74. And again, this is all coming from Exhibit Number 13 which is the report that you were involved with the authorship of this report; is that correct?

A Yes, it is.

Q Entitled the "Outbreak of Hepatitis C at Outpatient Surgical Centers"?

A Yes, that's correct.

Q Start off with page 74. Let me zoom out a

little bit and get this in. Can you tell us what we're looking at in that particular diagram?

A This diagram explains how the contamination of the vials occurred.

Q From what you observed and the information you obtained, correct?

A Yes, that's correct.

Q Go ahead. Walk us through it.

A So number one at the upper left we have a --

Q And while you're sitting there I'm just going to use my finger to point to this portion of it as you get there. But number one is up here?

A Yes.

Q Okay.

A So you have a clean vial of propofol, a new vial of propofol, clean needle and a clean syringe. The syringe is a plastic piece, the needle is the metal piece that attaches to the syringe and goes into the skin. Propofol was drawn up into that injection apparatus. And in number two there it's administered into a patient.

Q And that's this area right here?

A Yes.

Q Now, in this particular diagram you just

got a needle going straight into a vein; is that correct?

A Yes.

Q But in most of the instances there was an actual heplock device which was an IV access port to that vein?

A Yes, that's correct. But it's basically considered part of the veinous system then at that point. It's no different than going into a vein for purposes of disease transmission.

Q Okay. Go ahead.

A When the syringe is put in you can get back flow of blood into the syringe and needle. So you can get contamination of that injection equipment as that injection is actually occurring.

Q So if in fact that actually happens your arrow here pointing backward on two for the record would potentially cause mixing of that solution here with contaminated virus; is that right, or virus contamination?

A It would allow for blood to make its way into the syringe. If that blood were contaminated with a virus then the virus would move there but not every patient was infected obviously.

Q Sure. Go ahead.

A So now you have a contaminated syringe. Now, on number three on the right side here, the normal practice is to discard the needle and syringe right into a Sharps container.

Q So is that what's depicted in the very first syringe, that you just take that and throw it right into the garbage?

A What's depicted in the first piece there is the removal of the needle and the reuse of the syringe which is not the typical practice that should be used. This is what Dr. Fischer observed going on in that procedure room and what other staff members reported was what they were directed to do and what some had admitted to doing.

Q So we've got a syringe that's potentially contaminated. For this particular diagram we assume that it's contaminated at this stage and the needle is removed and thrown away.

A Yes, that's correct.

Q So the next syringe over, a new needle -- is that showing the new needle being placed on that syringe?

A Yes. The new needle is being placed on the contaminated syringe.

Q Okay. And then the next syringe over?

A That contaminated syringe with the new needle is being used to access a vial of propofol and in doing so passing on the contamination into that particular vial.

Q So now causing contamination in the entire vial because whatever was in the syringe, at least some of it got into that vial?

A Yes, that's correct.

Q Okay. And then the last picture on four?

A Now you have a contaminated vial in the clinic. So you have a contaminated vial of medication that could be used to potentially transmit disease to other people.

Q So in the situation where you observed, for example, Linda Hubbard on that day with all those open vials, if one or more of those had been contaminated, you might have a patient or two that come in and don't, if she's holding off using that as a sort of a grouping together, you might have a couple of intervening patients that don't get contaminated at all?

A Yes, that's correct. You would have patients that didn't get propofol from those contaminated vials or prefilled syringes potentially.

Q And is it also possible for someone to be injected with a contaminated vial of propofol and to not succumb to Hepatitis C?
A Yes.
Q Okay. It's not a hundred percent, there's not a single like of infectious dose meaning one viral particle causes the disease kind of thing?
A There are known infectious doses for Hepatitis C and known risks of transmission. We couldn't establish that number though because first of all you would have to have a patient with Hepatitis C, you would have to know how much virus was in their blood and then you have to know how much propofol was left in the vial basically to get a concentration of virus in that vial. There's no way to make those sort of calculations and determine how much virus people were potentially exposed to.
Q If this process that you have depicted on page, I believe it's 75 or --
A 74.
Q 74, I'm sorry. On page 74 of that exhibit, if that had been done over and over again, would it be possible to continue on with a number of patients continually infecting the next vial, the next vial, the next vial?

A Yes. And I have that depicted on page 75 in figure 20-2.
Q And I'll move to that then. So walk us through what we're seeing here on number one first.
A So number one, this was the practice we observed with Linda Hubbard. You could have several syringes drawn from that one contaminated vial. And so you could have basically prefilled syringes sitting out used for the next patients, sitting there not used for ten patients later. Just a number of contaminated prefilled syringes basically waiting for patients to come in.
And then on number two you could have the same problem happen. Say you drew half a syringe from a contaminated vial and the other half from an uncontaminated vial, now you've contaminated that second uncontaminated vial. Now you have another vial that can be used, and basically the cycle can keep repeating with transmission the same way as initially happened.
Q And in number three here, what do we have here?
A So basically you have a patient being injected with contaminated propofol, essentially being injected with the virus and having

transmission of disease.
Q And then the next one here, number four?
A Additional syringe reuse just as before where you have a contaminated syringe and needle, you throw out the needle, you still have the contaminated syringe, you contaminate another vial of propofol.
Q And it just cycles over and over again?
A Potentially. The challenge with that is over time there's going to be less and less virus as it goes on, but it doesn't have to go through 30 or 40 vials. You could have the contamination occur in just one or two vials. And the calculations I did, and I think we had, let me find the page on that, we had sufficient propofol -- I believe in one vial, the way the injections were given, that it all could have potentially come from one vial. It wasn't as likely but just mathematically that was possible.
Q Are we talking about strictly a delusional effect as you go on?
A Yes. But given the amount of propofol that was required with the transmission, it could have come from one 50CC vial given if they were just getting 5CC doses at a time or something like that. That's probably not the likely way it occurred. It

seems unlikely that one vial just moved all over the clinic and just went to those patients. But one or two vials would have been sufficient to infect everybody.
Q Now, I want to go back to your analysis, and I'm talking about not necessarily during the initial phase when CDC was there but later on. Did you become aware through your investigation of a way to determine what room was used in which instance and specifically the 21st, September 21st date?
A Yes, we did.
Q And so were you able to categorize those rooms based on that information?
A Yes, we were.
Q What was the glitch or what was the issue that allowed you to do that?
A On September 21st for some reason the computer system in one room was set to say it was August 21st and not September 21st. And so in the printed reports from the clinic, some of the charts said September 21st and the other one said August 21st and it would have been different according to the two rooms.
Q When you matched all those up, did it look like a relatively even number of patients in both

rooms?
A Yes, it did.
Q So fairly confident that that was an accurate way of determining the rooms?
A Yes.
Q When you looked at those rooms did you see that, for example, the patient that was the source patient was obviously in just one room, correct?
A Yes, that's correct.
Q Did the infections result to the other patients all from that same room?
A No. And I have a figure 7-2 explains this particular piece of --
Q And 7-2 is on what page?
A 7-2 is on page 61, bottom of page 61.
Q All right. Do you want the first part or the second part? Why don't you tell us what's at the top first.
A The first part is a graph of the anesthesia times for September 21st. So it's not really in which procedure room, it has to do with the duration of anesthesia recorded on the patient charts. There were a total of 63 patients. The average for this was 32 minutes and over 90 percent of them fell between 31 and 33 minutes.

Q So there's one outlier here in the 25-minute range?
A Yes.
Q So everyone except for that single patient was at 31 minutes or more?
A Yes, that's correct.
Q Now I will zoom back out.
A And let me add that that's basically relevant to the public health investigation because of trying to put the patients in order. And so on this bottom graph here, figure 7-2, we tried to put the patients in order based on the many different times that were actually listed on a patient chart. The times on that top graph were the anesthesia times written down by the CRNA. And we found a lot of issues with using those particular pieces of time. They didn't seem to have any basis in reality.
Q Okay. What was significant about that?
A We had staff members tell us that they were basically billing for 31 minutes of anesthesia because anesthesia is billed in 15-minute units.
MR. STAUDAHER: And I'm going to caution this witness at this time. And the Grand Jury, I would like them to disregard that particular

information from this witness at this time because it's hearsay at this stage.
BY MR. STAUDAHER:
Q Now, was that information necessary for your investigation?
A The reason behind it, why it happened, it just goes to show that there was a potential reason that the times were recorded incorrectly and we couldn't really trust those times. For my purposes that's why it was relevant.
(At this time, Mr. Coffing exited the Grand Jury room.)
Q So what was relevant to you was not necessarily the actual time listed but there was inaccuracy in the time and that gave a reason to not trust those?
A Yes, that's correct.
Q Okay. Go ahead and continue on.
A So we had a number of different times on the chart. Let's see, it will just take me a second to find it here.
Q Okay.
A Okay. So we have a number of different times and it's listed on page 21 in the report. There were a lot of different times recorded on the

charts. And in order to put a figure together like this of the order of the patients, we had to use the times that best told us when that patient was in procedurally. The types of times they had in there were the anesthesia time that I already mentioned. Basically it was a time recorded by the CRNA as to the start time and the end time of the anesthesia. We had a time recorded by the nurse as the start and end time of the procedure. There was a nurse in the back of the room charting the procedure. We had two vital sign monitors that were used. One was used in the procedure room and it produced a tape with the blood pressure and EKG and it had a start and end time on it. They had an additional one that was used in the recovery room. So we had tapes with time stamps on those basically. And then we had the reports that were generated at the end of the procedure. There was a time that everything was initiated which basically was when stuff got set up and then when the doctor signed off on it and finished his notes, clicked done and put a time stamp on there.
And so for this particular chart we used the nurse's log time start, start time because when we were observing it basically the nurse looked

at the clock and wrote down this is the time the procedure started. So that gave us our beginning time. The end time was taken from the earlier of when the nurse signed off and said the procedure was done or when the doctor time stamped that chart and said they were done charting it. So basically it gave us an idea when that patient was actually in that procedure room as best we could tell.

Q Did the times that you determined, that you actually used, did those match up when comparing them to the actual recording anesthesia times and the anesthesia sheets, did they match up?

A Within a half hour, yes. I mean, it gave us the right time period of the day. The anesthesia times sometimes overlapped, sometimes were way off and so they weren't reliable in any manner. And we just couldn't use those times because they didn't really mean anything to us.

Q And did you find out whether or not the times, based on your review and determining the length of procedures and things like that, if they were remotely accurate based on what you were reviewing in the charts?

A They seemed close. It was sufficient for us to put the patients in order basically to figure

out when they were in and out of there, but it still left us with a lot of questions when we produced this type of figure.

Q Okay. And that's based on the most reliable time that you thought you could figure out based on the charts?

A Yes, that's correct.

Q So go ahead and tell us what we're seeing.

A Okay. So there's three lines here. The top group is basically all the patients together regardless of CRNA. The line down the middle just splits the two procedure rooms. So the top line is the first procedure room there and then the bottom line is the second procedure room. And then the two other graphs, I split it by CRNAs. So you can see where CRNA one was or CRNA four was at that particular time.

Q So this is CRNA one and CRNA four?

A Yes. And so the dark box all the way to the left there, I started this with the beginning of the source patient's procedure.

Q Okay.

A And then all the shaded boxes are when people were infected.

Q So let's start off with this top portion.

So we've got source patient in room A?

A Uh-huh.

Q And then what is this box in room B, what is that?

A That indicates the first person who was infected after the source patient.

Q So that's a different room?

A Yes, that's correct.

Q Okay. And then we've got infections proceeding in that second room; is that correct?

A Yes, it is.

Q And is the shaded area an infected patient?

A Yes, it is.

Q Now, what's the indication of the lengths here of this box, of those boxes? What does that mean?

A The size of the boxes related to the time of the procedure. So a very small box is a very short procedure, a very long box is a longer procedure. It's kind of hard to see the lines on here. You can see the markings. Those are one hour differences. So that's plus one hour, plus two hours, plus three hours.

Q So did you have any explanation for how

the infection went from one room to another?

A When we spoke with staff there they said the CRNAs were generally assigned to one room although they would cover for each other as needed, if somebody needed to take a break, use the bathroom, whatever. So having people move from room to room wasn't a common thing but it wasn't an uncommon thing either. The CRNAs generally stayed with their room but they would move between rooms as needed.

Q So at least there was a mechanism to get somebody that was contaminated or something that was contaminated in one room to another room possibly?

A Yes.

Q And you actually see that happen here?

A Yes. And if you look at the middle lines there, that's CRNA one and you can see --

Q This one here?

A Yes.

Q Okay.

A You can see two procedures in the first room and then over to the second room and then back to the first room and then there's a break.

Q Oh, so if I understand you correctly, we've got CRNA one in the first room and CRNA one in

the second room?
A Yes.
Q So we know that they did -- that CRNA one did procedures in both rooms on that day?
A Yes, that's correct. You don't see the same thing as much for CRNA four, but you also see a couple of gaps on both of these. The longer gaps, they are likely to be the lunch periods. It was right around lunch time when those things happened. But the gap at the beginning there for CRNA four, there was a patient in the second room that the CRNA didn't treat for some reason. So he left the room for whatever reason and CRNA one had to run over to the other room and cover for that person. So right around the time when the first infections happened, you had a CRNA moving back and forth between the room where the source patient was.
Q And from that point forward the second room has infections proceeding in it?
A Yes.
Q I see. Now, beside that diagram, was there another diagram regarding timing that you found significant?
A Are you talking about -- yes, this was a diagram, 6-2 on page 60. And this just goes back to

how we selected the different times. This is basically the most egregious example we found of confusing times on that particular day starting with the beginning of everything and seeing kind of what order the times were actually listed to see if any of these times actually made sense to us.
Q So walk me through what we're seeing here.
A At the top of the graph we have the report start. That is the time on the computer system. So basically it's when they plug the scope in, when they got the computer up and running, waiting for the doctor to come in. All of this was done through an automated system. It's a camera and so they're snapping photos and doing all those things as they're doing the procedure. It's just their normal equipment.
And so four minutes later we have the first monitor and we have the nurse both start their times which is the beginning of that particular procedure. Ten minutes later it was recorded that the anesthesia actually started even though it appears as though the procedure had been going on for ten minutes already. Two minutes after that we have the nurse and the monitor both say that the procedure basically ended. Two minutes after that

that's the computer system when the doctor signed off on it. It was taking just a couple minutes to do their notes so that's basically what's expected from what we observed. Three minutes after that the monitor was started in the recovery room. Two minutes after that the physician was reported to be at the bedside.
There was an issue with that because we were told they were always told to record it, I believe it was seven minutes after the end of the procedure whether the physician was there or not. That wasn't a time we were using for anything. There was another one that was suspect of all the times we had. Monitor two ended 36 minutes after the whole thing started.
Q What does that mean?
A So that was when they stopped monitoring basically doing the vital signs and all that in the recovery room. So the person was kind of finished with their initial recovery.
Q Okay.
A And then roughly ten minutes after that we see, or 11 minutes after that the anesthesia was reported to end. So after the person is already off all the equipment, there's nothing else going on,

there's still another ten minutes before the anesthesia was reported to end and an additional seven minutes after that -- at the bottom of the anesthesia charts they would check off the blood pressure and the heart rate. And the graph that had that information went on for an additional eight minutes after they said the anesthesia was done.
So we had an anesthesia time that started which looked like at the end of the procedure. It went on for roughly a half an hour and then there were check boxes passed when they said the anesthesia ended but they were still monitoring things but it wasn't written as part of the anesthesia.
Q So according to this it says when the patient is out of the room, physician is supposedly at the bedside and they even -- this is the end of monitoring in the recovery room, yet supposedly anesthesia is still being recorded and vital signs are still being recorded?
A Yes.
THE FOREPERSON: We would like to call a ten-minute break, please.
MR. STAUDAHER: Certainly.
(Recess.)

MR. STAUDAHER: Ladies and gentlemen, we're going to get started now after our break. The intern from our office, Suzanne Whitehead, has returned. And Terry Coffing, the attorney with the Southern Nevada Health District, is no longer in the room.

BY MR. STAUDAHER:

Q Continuing on with the questioning, let me hit one thing right off the bat that I want to get to. In the report as well as some of the things that we've seen on the diagrams, you have designated CRNA one, CRNA two, different people as sort of a generic identifier. Can you tell us who -- give us a list of all the people that you identified as a generic identifier in your report and tell us who the person matches up to, please.

A Sure. CRNA one is Keith Mathahs. CRNA two is Linda Hubbard. CRNA three is Vincent Leone. CRNA four is Ronald Lakeman. CRNA five is Ralph McDowell. I list two RNs. RN one is Lynette Campbell. RN two is Jeff Kruger. And then I list four physicians. Physician A is Dr. Clifford Carrol, physician B is Dr. Dipak Desai. Physician C is Dr. Eladio Carrera. And physician D is Dr. Ranadev Mukherjee.

Q So those are the individuals that are contained within the report itself; is that correct?

A Yes, it is.

Q Okay. At some point after you go through all this process, you're doing the timing, you've done the analysis or you're in the process of doing that, I know that you've got there, you got your results at the end, but how do you go through that process? How do you go through the epidemiologic sort of investigation? What kind of information do you use? Why is it different from other kinds of investigations?

A The public health investigation is focused on understanding kind of the big picture. Our goal is not to identify every single infected case during this -- that was ever infected by the clinic. It's not to try and find the source patient for all those people. It's trying to identify the overall public health concern.

Now, as part of this investigation we were able to identify a number of people and where their source was, but we didn't have to do this for every single person who was a patient with the clinic to get an understanding of what happened there in a broad general sense and then take the

steps we would in a public health investigation.

So it's very different than a criminal investigation. We're not trying to find exactly who's responsible for what things but really trying to understand exactly what happened in the big picture and make the appropriate public health recommendations. We don't penalize people for anything. We're not there to figure out who's responsible for some of the things. We want to know what happened and what we need to do to protect public health.

Q Now, in the process of doing that I assume you would then say since this isn't a criminal type investigation, I know it eventually became one, but your investigation initially is not really you're the police, you're the DA's office or anything else, correct?

A That's correct.

Q And you're not charged either in the Health District or personally with trying to be an investigator for the police?

A That's correct.

Q Which I assume means you're not a surrogate in any way for the police?

A That's correct.

Q As far as the investigation is concerned, it is I assume your intention in doing your investigation to make public or at least make available to other health care providers the information that you determine and receive as part of your investigative process?

A Yes, that's correct.

Q And I know that we have a large report here that was entitled, that was the public health investigation report that you helped author or did author, but there were also other publications like the MMWR that came out as well as the Trip report and things from CDC that were meant to go to individuals to assess and help them prevent this kind of thing from happening in the future?

A Yes, that's correct.

Q All of these documents eventually become public; is that correct?

A Yes, that's correct. The end result of our investigations are typically some sort of public reporting, kind of how we spent your tax dollars basically. This is what we found in the investigation but these are the public health findings and what we need to do to protect public health, how we can prevent these things in the

future or what people who have been exposed need to do to take care of their own individual health issues.

Q And all of the reports and documents and things that went into all this, including the report itself I assume, is part of the business records of the Health District, correct?

A Yes, that's correct.

Q And you have access to all of those things in your investigation?

A Yes, I do.

Q Now, as far as the cases themselves, I think we talked about some of them in the discussion we had today, how did you find out about all these cases?

A The initial three cases we've already discussed, the ones that led us to the investigation in the clinic. There were a total of six cases identified from the September 21st cluster and there's only one case identified on July 25th. So we did not identify any other people who had procedures on July 25th and were infected. We identified a source patient on that day through the genetic testing. On September 21st we identified the source patient through the genetic testing later

on, but it came down to the different methods we used to identify cases.

So we went in there with two cases from September 21st and within a couple hours we found an additional case. We had a list of all the patients from September 21st and we also had a list of all the hepatitis results that were reported to the Health District. And basically by cross referencing the names we found somebody on both lists and investigated that and found the third case.

The fourth case was found two or three days later. It was reported to our office as an acute Hepatitis C case. When we called and tried to interview the person they were really sick, hung up on us and didn't want to talk to the Health District. We saw their name on the list, reinitiated an interview and were able to complete the interview at that time and identify one additional case.

Another case was found in talking to the doctors later on. They were trying to present some of the information they had about it and they listed a number of people who they thought were acute cases and there was a name that we had not

previously identified.

Q So one of those cases actually came from the physicians in the practice?

A Yes. When Dr. Carrol brought his information to me about his theory of the intentional transmission, he had done some work on his own and listed out a number of patients who he thought were acute cases. And one of the names that he had listed on his list was one I hadn't seen before. And so I was able to identify one additional case that way.

The final case we identified never developed acute Hepatitis C. That person was identified through the laboratory testing that we put in place for that particular purpose. So when we made the public announcement, at the same time we started calling all the patients that we had contact information for from July 25th and September 21st to get them to come into the Health District for a blood draw because then we could do the testing for them and if it was positive, send it to off to CDC and do the genetic matching. And we identified one case through that process that we were able to genetically match but who did not have acute symptoms.

There was one additional person who was found to be positive from that day, but in sending the stuff off to CDC there wasn't sufficient quantity of the virus in the blood to be able to do the genetic testing. So it may be related, it may be unrelated, we couldn't make a determination on that particular case.

Q So possibly one other patient but not enough stuff to find out why?

A Right. We were unable to make that determination either way.

Q So that kind of lets how you got each one of the patients in your study as positive infected patients from the source individuals?

A Yes. So in the end we had six patients, five of whom were acute and one who was a non-acute case from September 21st and one new patient from July 25th plus the source patients on those two days.

Q And I want to be clear that I think you've already testified but I just want to make sure that it is certainly possible that even if there was, you know, a contaminated sample of propofol or whatever that had gone into a patient and the person had gotten the virus introduced into their system, that

they may not have succumbed to the virus or shown symptoms or anything else?

A Yes, that's correct.

Q Do you have any idea what the percentage of that happening is in the population?

A There's no way to really know that because we don't know exactly what happened with the propofol, how much was used from which vials. There's really no way for us to say. It's something you could theoretically come up with but we didn't have any of the numbers to be able to fill in that kind of equation. We don't know how much virus was in that person, how much propofol there was, who got how much propofol from which vials. There's no way to really to calculate those things. We can kind of explain how it happened and how we do the calculation but the numbers are all unknown. There's no way to figure that out.

Q And you're not aware of any study that's gone into that I assume?

A Well, I'm sure there have been studies that looked at the amount of virus it would take to actually infect somebody and so those kind of things. They evaluated can the virus survive in propofol and they found that it can. Looking at how

long the virus can survive and it very easily can survive the entire day in a clinic. That's not a problem. But in terms of this exact situation, I don't think there's any way you can model it or study it or figure out those sort of pieces.

Q One last thing related to just what you mentioned about surviving the entire day in a clinic. Did you ever get any indication or observe the propofol that had been used on one day that was left over was used the following day?

A No, we did not observe that. The propofol is labeled that it has to be used within four hours and all the people we talked to were aware of that particular issue. Propofol doesn't have the chemicals in it to prohibit bacterial growth and so it's not something that can sit around for multiple days. It has to be thrown out within four hours. Everybody seemed to be well aware of that issue. I can't say how long some of those vials sat around, but we did not observe any propofol being reused the next day.

There was one thing we did observe being reused. They would prefill the syringes with 1CC of lidocaine which is given with the propofol because it burns when it goes in. They would

prefill a bunch of syringes with lidocaine and put them in a drawer. They weren't labeled. They didn't have a time on them. Those syringes would have been around the next day. But the lidocaine, it wasn't that sort of issue where it would have gone bad after four hours or something like that.

Q I see. As far as the genetic information that came back from the CDC, what did you do with it when it came back and how did you use it?

A Well, we got different information at different times. Initially the first information we got from CDC is that they were all genotype 1A. It's the most common genotype in the United States and so it didn't tell us anything. It would have been nice if we had a different genotype. It could have given us some information. It just told us that they were genotype 1A and we couldn't figure out anything about the connection or the cluster or relationship in any of those cases.

After that we got the cluster analysis from the CDC, the final genetic analysis. And from that we could show which one of the potential source patients was the actual source patient. We could show which people were infected and put together the diagram we showed earlier

looking at the timing of it and try and understand how it went through the clinic and looking at how those cases are connected and did that actually make sense.

If we looked at it and said, well, the source patient was after all of the infected patients that wouldn't have made any sense. But it matched up with everything that we had believed all along, everything that we had found all along. It just confirmed our findings. It clearly showed that there were two different transmission occurrences, one on July 25th, one on September 21st, and that just kind of was in line with everything that we had believed up to that point.

Q Did you ever come across any evidence comparing the genetic stuff with the infield investigation, with the review of charts, anything that started to say, you know what, our conclusions are wrong, we made some mistakes here?

A No, we have not found anything that made us think it was anything other than the unsafe injection practices that led to the transmission of disease in this outbreak.

Q I think the last thing I want to go over, there's an item on page 23 regarding, I think it was

relation or relative risk that you mention in your report. I would like you to describe and tell us about that and what that means.

A One of the things you can calculate in epidemiology is called relative risk and you hear about these things on the news all the time. People who smoke are ten times more likely to get lung cancer than those who don't smoke. We were able to do the same sort of calculation comparing people who had procedures at the clinic after the source patient to everybody else who didn't have procedures at the clinic on that day, and we found that the clinic patients were over 31 million times more likely than the non-clinic patients to be infected with acute Hepatitis C.

MR. STAUDAHER: I have no further questions for this witness.

THE FOREPERSON: Are there any questions from the jury?

BY A JUROR:

Q You mentioned a lot about a Linda Hubbard. It appears that you found that she had made a lot of errors. Was that through visual observations or was that through reviewing the doctors' notes, the nurses' notes?

A Those were the observations we had when we were in the procedure room. They are considered general infection control issues and those were addressed with her.

Q And she was a CNA?

A She was a CRNA.

Q CRNA. Thank you.

THE FOREPERSON: Are there any other questions?

BY A JUROR:

Q We're talking about two days now where we had clusters of cases. Has any other cases come up yet on other days?

A The challenge we had was actually trying to make a strong link between the cases and the procedures at the clinic. In our report we list 115 people who are likely infected because of procedures at the clinic. We only have the genetic testing on the seven people that we've talked about today. The other people had developed -- they were positive on their testing. They reported that they had no other risk factors but we don't have the same genetic testing. In order to do that we would need to have a potential source patient and we would need to have kind of what happened on that day. We had a lot of

trouble figuring out a list of all the patients from certain days so we couldn't find the source patient, couldn't even do that genetic testing.

But in a public health investigation we're not trying to find every one of those. A couple of clusters showing us what happened for the outbreak is sufficient for our purposes to notify the public and to take the steps we need in public health to prevent more ongoing disease transmission.

THE FOREPERSON: Okay. Bob.

BY A JUROR:

Q Now, you said there were unsafe practices going on quite regularly, apparently anyway. How come only those two days? Why don't we see a cluster of more of these incidents throughout the time frame?

A There may have been other clusters that we just weren't notified of. Acute Hepatitis C is a little bit of a challenge for doctors to diagnose. And assuming they even can diagnose it correctly, even though they are supposed to report by law they don't. So a lot of times cases occur and we don't hear about them. So there may have been clusters that we missed.

The challenges, the majority of

people infected with Hepatitis C, a new infection, will have no outward symptoms. If they never seek medical care they would never know they were infected. So there wasn't a big red flag. It was just this background transmission that occurred.

Think of it like an HIV infection. If you get HIV you're not going to know it for years down the road until you have really serious health problems. That's the way Hepatitis C typically occurs. You wouldn't know it so there's not a whole bunch of people showing up at a doctor's office and we can find it. We just happen to have, for whatever reason, more acute disease happen on this day which put up that red flag and allowed us to find it. But that disease transmission is generally just going to go under the radar and we're not going to be able to identify it.

BY THE FOREPERSON:

Q The CRNAs that moved from room to room on those occasions when they did, did they take the tray that held the vials of propofol with them to the next room or did they leave it behind for the CRNA coming in to use?

A We didn't observe anybody moving from room to room like that so I can't say what typically they

were doing. There's a lot of ways we think it could have moved from room to room but we didn't observe directly somebody moving it doing those sorts of things.

Q Thank you.

Are there any further questions?

Yes.

MR. STAUDAHER: And I have one after you.

A JUROR: Go ahead.

MR. STAUDAHER: No, go ahead, please.

BY A JUROR:

Q So is Hepatitis C diagnosed with a blood test?

A Yes.

Q And at some point your organization sent out a public announcement that if you were at this business come and have your blood tested; is that correct?

A Yes, that's correct.

Q Were anymore cases discovered when you did the general testing among patients that stepped forward?

A Well, the 115 cases that I mentioned total, so that would have been an additional 105 or so, in that range, that we found from the testing.

A majority of the people who tested positive, we really couldn't match them up because the list we got from the clinic didn't have a date of birth. And so you have a name but without a date of birth you can't really match the people. We also had an incomplete list from the clinic and so we can't really say how many people were actually infected.

It was a big a challenge for us when we say they were possibly associated with the clinic because we had enough information to say they're Hepatitis C positive now, there was no report that they were positive before their procedure, they may have been but they didn't know it at least, and they report that they didn't have any of the major risk factors. And so it's kind of a fuzzy connection to the clinic. The only real strong connections we have is that genetic test and we can show it absolutely occurred on those days, went from this person to these people.

Q So the other you said 105 --

A Well, there were 115 total.

Q So the other 105 you couldn't genetically link to those two source patients from those two days?

A These were patients on different days over

a four-year period so they weren't on those same days. They weren't on September 21st or July 25th. We basically have somebody with a chronic Hepatitis C case who had a procedure there but we don't even have a potential source patient to match them against. So there was no way we could do any of that sort of analysis or testing.

Q Okay. So, I'm sorry, so the other 105, they weren't genetically linked within that 105? They could say these ten are similar and had the same source?

A The ones that are genetically linked we can say had the same source. The other 105 people or so, we can't say exactly what their source is. They're not genetically linked to somebody, we just know that they are Hepatitis C positive now, don't report any major risk factors and didn't know they were at least Hep C positive before they went in. So they likely got it at the clinic but we can't say that for certain.

Q Because before they said that like if it was within two percent, you know, then they could say somebody had the same source. And so you couldn't say like the other 105 weren't within two percent?

A I understand what you're talking about. This is completely separate and none of that testing was done on any of these people. And so we don't even have those kind of results. The two percent means nothing because that testing was not done on the people. The only testing done on those people was a laboratory test to indicate the presence of Hepatitis C. There was no additional testing beyond that so the two percent doesn't even factor into it. It's just we know these people are positive for Hep C and then that's it.

THE FOREPERSON: Any further questions from the jury?

MR. STAUDAHER: I have -- well, go ahead.

THE FOREPERSON: None? Okay.

MR. STAUDAHER: Just a couple.

BY MR. STAUDAHER:

Q And follow up to that, what is the background incidence of Hep C in the population?

A Well, the background incidence of Hep C in the population is roughly four percent. If you look at the population as a whole, we age adjusted that because the clinic population, the average age was 55. You tell people to get a colonoscopy at 50 and that's what most of their business was. So it was

an older population. We tend to see higher rates of Hepatitis C in the older population. So for the clinic population we expect around at most a six percent background of Hepatitis C patients walking in the door infected before they ever set foot anywhere near the clinic.

Q Okay. And as far as the questions that were asked by the Grand Jury member about other testing and so forth, I mean, I assume you looked for other clusters in some areas; is that correct?

A Yes, we did.

Q And were you able to find any other ones or what did you do in that regard?

A We were trying to find additional clusters, we just didn't have sufficient information to do so. The majority of the cases wound up getting lawyers as soon as they were found out to be positive and didn't want to talk to us. So we didn't know most of the people who were infected. The ones we did know, some had their procedure dates, some had a bill they got from the clinic that had a date. Other ones we knew roughly when they got it because on the clinic list it didn't have their procedure date, it had the date they went into the computer system. So it was within a week of

their procedure generally but we couldn't say they were all on the same day or not on the same day.

Finding the clusters though really wasn't a huge priority for us because we had these two clusters and that was sufficient to figure out what allowed the transmission to occur and identify the unsafe injection practice.

Q And that was your primary role, was it not?

A Right. We weren't trying to find every single person who was infected at the clinic. It was trying to figure out what happened and make sure it doesn't happen again.

Q Of those patients that were infected at the clinic or tested positive, beside the two source patients who were known Hepatitis patients when they first arrived on site, were the other patients, did they have -- was there some way to determine whether or not in the recent past prior to their getting the colonoscopy or endoscopy that they were positive or negative for hepatitis?

A We do have a list of all the hepatitis results that have been reported to us, so for some people we can look it up and say that they had a positive result in our system. But it doesn't cover

all the labs and it doesn't cover somebody who would have been tested out of state and recently moved here and things like that. So in some ways we could find people with prior positives, and we did that for anybody that we identified as a case, tried to find any previous positive on that person. The fact that we didn't have a positive doesn't mean one didn't exist, we just couldn't find it.

Q But you did look at that particular issue in that population of individuals?

A Yes, we did.

Q After this whole clinic thing happened, and I know the clinic gets shut down as a result of this, correct?

A Yes, but not by the Health District. I wasn't involved in that.

Q I know. I'm not saying you did. I wasn't implying that whatsoever. But it does get shut down?

A Yes, that's correct.

Q The background level that you had said was in the Las Vegas Valley was around three to four per year and this incident, all of a sudden you're getting this cluster of nine cases. Before I ask that question, I want to ask you, related to the

acute cases which you said everyone was except for one was a chronic case, correct?

A Yes.

Q Of the infected patients?

A Yes, that is correct.

Q What is the typical incubation time for an acute phase infection.

A The maximum incubation period is six months, the minimum is somewhere around a month. Typically about two months after the person's procedure is when we'll start to see symptoms. So two to three months, in that range. In the acute cases we found were typically in that two to three month range.

Q So another reason to believe that the acute infections came from that source?

A Yes.

Q Related to my question where I was going with this, after this whole process was done and the clinic was shut down, did the rates of reported Hepatitis C infections in the Las Vegas Valley return to their previous baseline?

A It took a while. They're closer down to that range now. In having 60 plus thousand people get tested, we identified a lot more of background

disease, people who would have normally not known they were infected with Hep C. As a result of that they are now being treated, managed and as part of their ongoing care lab testing is part of it. So Hep C testing is up just because we did a better job identifying all the background cases here in Southern Nevada. It's basically like a big screening program that we put in. And so we never really expected to go back to the background level because we picked up all these, I guess the number of people we know about now is probably closer to the truer number than it was before. And so that's just going to involve a lot more work for all the providers who now have to manage patients with Hep C.

Q But from the time the clinic is shut down six months afterward and beyond, because that would be the incubation period, did you see at least a decrease in that level of back -- or closer to the baseline that you originally had?

A Let's see, I have a figure on this testing. Could you bring up figure 13-1?

Q On page what?

A On page 65. I guess 13-2 as well. 65 and 66 as well. So this is figure 13-1. This is

basically looking at how many tests were ordered above normal. We know on a typical week how many Hepatitis B and Hepatitis C and HIV tests we expect to get on a weekly basis, basically how many people are tested both positive and negative. This line across the middle here below the graph is the baseline. So it's a one to one ratio, kind of our normal range. That next line is ten times above normal. So within two to three weeks we were getting ten times as many tests coming into us, positive and negative, as we did prior. This goes through basically near the end of May and at that point it's still a little above normal but by that time it had pretty much gone back down and all those people had been tested initially. The second graph that I have, 13-2, this goes to looking at chronic versus newly identified cases. The dark line is the number of initial positives we had and this is the ratio again of one and then there's ten at the top. The dark line is the first time we have a lab test for those people. The gray line is a subsequent test for those people. And so we saw a lot more subsequent testing after our announcements in April, May, June as people started to get in the care system and got retested. So we were still finding

initial positives but we had a lot more follow-up testing. So the overall number of results are way up but the number of new cases basically went back down to baseline. We're finding a lot of people are being retested. Part of your Hepatitis C management is looking at your viral load over time, how much Hepatitis C is in your blood. And so anybody that's got it will continue to have these tests over time, and because we've identified all these new cases there's just a lot more people being repeatedly retested.

Q And for the record that was from page 66 of the report.

I have nothing further.

THE FOREPERSON: Tom.

A JUROR: Yes.

BY A JUROR:

Q Do you know in a manufacturing process of the syringes and the needles, is that a common practice to provide this with replacement needles or is it just --

A I know they exist but I'm not an expert in that area. I couldn't tell you how common it is.

Q I was just wondering if you had any experiences. Is this acceptable, you know --

A I know you can purchase them separately. As an undergraduate I worked in a research laboratory and you can buy needles and you can buy syringes separately. You'll use syringes a lot of times without a needle in different settings so they do sell them separately. In terms of what they typically do in a medical clinic I can't really say.

Q Thank you.

THE FOREPERSON: Are there any further questions? None?

By law these proceedings are secret and you are prohibited from disclosing to anyone anything that transpired before us including any evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury or any information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by one year in the Clark County Detention Center and a $2,000 fine. In addition you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this advisement?

THE WITNESS: Yes, I do.
THE FOREPERSON: Thank you. You may be excused now.
THE WITNESS: Thank you.
THE FOREPERSON: You're welcome.
Sir, could you please raise your right hand? Thank you.
You do solemnly swear that the testimony you're about to give upon the investigation now pending before this Grand Jury shall be the truth, the whole truth, and nothing but the truth, so help you God?
THE WITNESS: I do.
THE FOREPERSON: Thank you. You may be seated.
You are advised that you are here today to give testimony in the investigation pertaining to the offenses of performance of act in reckless disregard of persons or property; criminal neglect of patients; insurance fraud; obtaining money under false pretenses; and racketeering involving Dipak Kantilal Desai, Ronald Ernest Lakeman and Keith H. Mathahs.
Do you understand this advisement?
THE WITNESS: Yes.

THE FOREPERSON: Could you please state both your first and last names spelling them for the record?
THE WITNESS: Melvin, M-E-L-V-I-N, Hawkins, H-A-W-K-I-N-S.

MELVIN HAWKINS,
having been first duly sworn by the Foreperson of the Grand Jury to testify to the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. STAUDAHER:
Q Mr. Hawkins, what do you do for a living?
A I'm retired.
Q How long have you been retired?
A Over a year.
Q I'm going to direct your attention back to January -- well, actually did you ever work in the past for the Endoscopy Center of Southern Nevada?
A Yes.
Q What were the years that you worked for that entity?
A August, 2003 through March, end of March, 2006.

Q You're aware of the hepatitis outbreak that occurred at the clinic?
A Yes.
Q At the time that that occurred, the dates in 2007, July of 2007 and September of 2007, were you associated in any way with the clinic?
A No.
Q Okay. When you had worked at the clinic what was your job at that location?
A I was a GI tech.
Q During the time that you were a GI tech, did you have interaction with Dr. Desai and some of the other physicians and CRNAs at the facility?
A Yes.
Q Specifically did you work with Dr. Desai prior to coming to the endoscopy center?
A Yes.
Q And how did you know or work with him in that situation?
A I was the GI tech at Southwest Medical from 1995 to 2003.
Q Now, as far as Dr. Desai, I want to ask you some specific questions about him. Speed of procedures, was he pretty fast?
A Yes.

Q In comparison with other doctors in general, was he faster, medium or slower than those doctors?
A Faster.
Q When you say fast, how long would it take him to do a typical colonoscopy on average over the time that you were with him?
A Three to five minutes when we were at Southwest Medical. Sometimes he had been known to do them faster, depends on the obstructions he would have going in or if the patient was prepped out enough.
Q So anywhere from three to five minutes you think?
A Yeah.
Q Okay. As far as procedures that for Dr. Desai lasted say, and I'm talking about colonoscopies, 30 minutes or more, how many of those kind of procedures did you observe of Dr. Desai over the time you worked with him?
A None.
Q So they were always much shorter than that?
A Yes.
Q Now, the kinds of things you talked about

that related to causing a slowing of the process, did that seem to slow Dr. Desai up much past this five-minute range that you talked about?

A With certain patients it did.

Q And what kind of patients are we talking about?

A If they failed to take their prep so you had poor visibility, you couldn't see, you couldn't flush them out enough. That was usually the main thing. Every once in a while you would have a patient with angulation. You couldn't get all the way to the cecum. Because of the angulation of the colon you couldn't curve the scope around. Or if the person was too elderly, especially females, elderly females or if they had diverticulitis are prone to have blowouts of the diverticulum, the little blips in the gut so you can't put a lot of air in them.

Q Okay. Did you ever see him do procedures in the two to three-minute range?

A Every -- yeah, every once in a while he would speed up. He'd have one that wouldn't take long. Depends on, you know, what tech was with him, if anesthesia was ready, patient's in the proper position.

Q Did you ever have a situation where you thought he held a record for speed of procedures in like an EGD?

A Yeah. I think he had one at Southwest that was supposedly under a minute.

Q So pretty fast at what he did, huh?

A Yeah, but an EGD is just a straight shot.

Q Straight down. Yeah, I guess we should clarify what that is. Colonoscopy is from the anus going up?

A EGD is from the mouth going down into the stomach and part of the, first part of the large bowel. Small bowel, I'm sorry.

Q And you've been -- you've done this kind of stuff for a long time; is that right?

A Yes.

Q And I'm talking about when you were working back then.

A Yes.

Q When you were working at Southwest Medical before you came to the Endoscopy Center of Southern Nevada, you said you worked with Dr. Desai during that time?

A I worked with Dr. Desai and all the doctors in his group.

Q Did you work with Dr. Desai during that period?

A Yes. He would usually be the first one in and then if he had to go somewhere he would send another doctor in.

Q In your experience, not Dr. Desai, in whatever the industry standard that you know of and the experience that you have, what's the average time or how long should a procedure last?

A According to the books in a training situation like where they learn it in school and fellowships and stuff, they do like ten cases a day. So they're taking 20, 30 minutes a patient then you have to clean up the room and that can be another 20 minutes. I know Nellis is the same way, it takes them like 20 minutes to turn over a room.

Q Well, when you came to the Endoscopy Center was the room turnover a lot faster?

A Yeah. Well, at Southwest when I was there I was the only tech there so we ran one room and we could still turn over in less than ten minutes. But that's between the nurse, the tech, and anesthesia would bring their own patient and the IV is already started. Southwest was set up different. It was a different set-up. It was more -- you had people at

each station. At D's it was a smaller thing but it was sometimes faster.

Q As far as the numbers of patients that you were doing in a day when you were at the Endoscopy Center, what -- first of all what clinic did you work at, what facility?

A I worked at the Shadow Lane clinic primarily.

Q Did you ever work at other clinics?

A Yes, I worked at the one over behind Desert Springs Hospital. If they had a problem or something they would send somebody over there.

Q Is that the Burnham clinic?

A Yes.

Q Was there a difference between the two clinics as far as patients that were going into them and the rate of procedures, things like that?

A Yes. Burnham had a lot slower pace. They couldn't keep up with us at Desert.

Q Was Dr. Desai out at the Burnham clinic?

A No. He would go over there every once in a while if they were having a problem but he usually didn't go over there and everything was at a nice calm pace.

Q When Dr. Desai came to the Burnham clinic,

were you ever there before he arrived at the Burnham clinic?

A Yes.

Q What was the staff's demeanor or how did it change when they realized that Dr. Desai would be coming over that day?

A One word, panic.

Q And why was that?

A Because they were afraid of Dr. Desai. If you couldn't -- if you weren't doing -- he'd walk through. If you were in doing records you had to be doing the records, you couldn't be sitting there, you couldn't be talking to anybody or you couldn't be drinking a drink. Or even in the lounge he would, you know, he would monitor how much time you were in the lounge. And when he would come it would be like a wildfire starting. You know, word would come D is on his way, because everybody called him D, and people were just like ah.

Q So typically over at the Burnham clinic how many patients were coming through in a day?

A Oh, they were in the teens. They were only doing like -- my last count with them I don't even think they got up to 20. A bad day was 20 for them.

Q Is that one room or two rooms?

A That's one room. They had -- well, when they moved -- that was when they were upstairs. When they moved to the new place downstairs I don't know how many rooms they had there. I never went to the new clinic.

Q But your observation was in the teens to low 20s?

A Yeah, for one room.

Q Okay. Now, over at the Shadow Lane clinic where you also worked with Dr. Desai, what were the patient loads over there?

A When I first started we had one room and we ran -- we got up to 50 patients a month.

Q In one room?

A Yeah.

Q A month or a day?

A In a day. No, in a day.

Q Okay.

A Then when we got the two rooms he had assured us, because he gave us a dinner for all the employees, that we would never go over 75. Then we got to 75. Then he assured us that we would never go over a hundred. Then we hit a hundred.

Q So there were times at the Shadow Lane

clinic that you were seeing a hundred patients in a day?

A They would book a hundred. Sometimes, you know, you'd have people that don't show and stuff so they were averaging like 85 patients a day.

Q And is that actually patients that are being done or patients that are just scheduled?

A That's patients being done on the endo side. There are also patients on the other side, new patients coming in. And I know like one Saturday, we worked a Saturday, we did -- we had to have at least 20 patients because we only worked half a day. So we started at 7:30 and we had to be out by 12. We'd have 20 patients and then I found out later on he was also doing new patients over on the other side. He had the other staff in. And he would see maybe 15 or 20 patients in between. He would jostle them. So if there was anything slow down in the room then he would go over and see new patients because they're easy to turn over because he didn't -- I don't know. I never went in the room with him for a new patient, I don't know what it was, but he was fast with them.

Q Were there any patients that he would slow down for or take a little extra time with?

A Yes. Usually he was afraid of frail little old ladies which most of them are. We did a lot of, what we used to call in the military, dignitaries. We did a lot of lawyers, other doctors, government officials, entertainers.

Q Any celebrities?

A Oh, yeah. BB King, a couple other people, Flavor Flav.

Q So those people he took a little extra time with them?

A They came in on Saturday. They were like on a one-on-one basis and that was a select crew that usually came in for them. Usually a nurse anesthetist, they'd have -- last one I heard about was just the charge nurse came in and I don't even know if they used a tech or not. If they did it wasn't me so I have no idea who it was.

Q Is it fair to say that over the time you were, not just at that clinic but in your general practice where you did this kind of thing for other doctors at other locations, that you got a feel for how long it took patients to recover from these kind of procedures, things like that, after they were done?

A Yes.

Q Typically when a patient had a procedure done, and I'm talking about a colonoscopy type procedure, how long did they typically recover out in the recovery area before they were discharged or let out of the facility?
A About ten to fifteen minutes.
Q Is that on average?
A Yeah.
Q How about with Dr. Desai's group?
A Oh, you mean -- oh, at other -- at Southwest you wait 30 minutes before you're discharged. You have to wait 30 minutes.
Q Why is that?
A It's just their degree of standard.
Q So is that because they had been given medication or something along those lines?
A You've been given medication and they let you wake up, you know, you throw the medication off because everybody takes different amounts of propofol so everybody wakes up differently. But I had a colonoscopy done at Southwest Medical by Southwest Medical Group after I started with Dr. Desai and I was in there 30 minutes so --
Q Was that the way it was at Dr. Desai's Shadow Lane clinic?

A No, that was about ten to fifteen minutes and then they were getting you up.
Q So the patient leaves the room after the procedure and within ten or fifteen minutes they're heading for the door?
A Patient leaves the room, he goes out to a recovery area, they put on a BP cuff, monitor him, take his blood pressure, and I think it was three blood pressures, and once his blood pressure was normal they had it recorded, the majority of patients were then put into their clothes and they had whoever was taking them home was brought out and they explained to them what happened. And it was a nurse that explained everything that had happened to them and talked to them so --
Q Ever an issue with that that you felt that it was going too quickly, that they should have been sticking around a little longer?
A There was one where because of the way the medication acts in different individuals and some of the individuals that we did at D's were, I mean, they were borderline coming in because you don't know if they didn't eat or didn't drink. Some of them were -- one time we saw a guy after the procedure drinking alcohol so -- but there was one

man that left, he just walked out of the building because it was so many people in there, it was a busy day, and he walked out and he was walking down the street looking to catch the bus. I mean, he had his clothes on but you're supposed to sit there until the nurse releases you, the release nurse. And he decided to get up and walk out the door. So I don't even know if he knew that he had a colonoscopy because the propofol acts differently on everybody.
Q As far as the people that were, you know, coming out of the recovery and so forth after the procedures were done, did the doctors follow them out and administer to them at the bedside?
A No.
Q Did the nurse anesthetist follow them out and take care of them while they were in the recovery room?
A No, they were too busy. They were getting the next patient into the room and getting set to go.
Q Was there a nurse or somebody that was supposed to be out in the recovery area to help --
A The RN in the recovery room.
Q Was she pretty much the only one that

dealt with the patients in the recovery room?
A We had an RN and sometimes they put a tech out there. Usually they'd keep a tech, maybe two techs depending on how busy it was so they could -- because when we got up to that hundred stage, I mean, it was like they were like flying. So they would have like two techs and you'd go out and you'd have to monitor their blood pressure and help them put their clothes on. A lot of times they were disoriented. They don't know where they're at or what had happened but that's because of the medication.
Q It's still get them out the door?
A Once they talked to them and, yeah, it's up to the nurse to decide if they were safe to go.
Q Did you ever experience or see Dr. Desai ever start a procedure before somebody put anesthesia on a patient or given anesthesia to a patient?
A No, not unless the patient had requested not to have anesthesia.
Q What about an incident in which there was a person who was having I think an upper endoscopy and the nurse anesthetist was getting ready to give the anesthesia and it didn't actually happen before

Desai was --
A That was at Southwest Medical, yeah. They had a new nurse anesthetist and he wasn't used to Dr. Desai's speed so he was just, you know, doing his thing but he was a lot slower than everybody was. And by the time he turned around and started to do the procedure because the patient was already in place and had the bite block in and, you know, IV's already running because they start those on the outside and bring them in, D thought the patient had had the anesthesia so he put the scope down and we did the EGD. It didn't hurt him but --
Q Patient react to it at all?
A Their eyes got a little bit big. But that was just my job to calm them down so, you know, you talk to them and tell them to breathe, just breathe, because they have the feeling that -- you have the feeling that you're suffocating, you can't breathe. And then once you found out that you can actually breathe through your nose then it's fine. And you just take deep breaths, you tell them when to breathe, to take a deep breath, don't hold your breath. And you'll say, okay, when we're going to do biopsies you're going to feel a tug but you won't feel any pain. And you say, okay, we're taking it

now. And sometimes you let them look at the monitor and they can watch it and they thought it was pretty neat.
Q Okay. So that happens on some patients that actually prefer to have no anesthesia?
A Yeah, you have patients that didn't want to take anesthesia because they didn't have a person to take them home. You always had to have someone to take you home and you couldn't let them go on the bus, you couldn't let them go in a taxi because of, I guess it was something with Medicare. Most of the people that -- these were like Medicare, Medicaid and stuff.
Q With respect to the difference between the Burnham and the Shadow Lane clinics, was there a preference in the staff as to which place they liked to or wanted to work at?
A Yeah. The Burnham staff were -- they were at the slower pace. They loved their clinic, they loved their doctors because they had the same doctors all the time. We had Desai always in the morning and then you'd have -- another doctor would start, you know, like 8:00 o'clock or 9:00 o'clock coming from the hospital or something. And then you would just run all the way through until you

finished. And usually in the afternoon it would be either Dr. Carrol or Dr. Carrera finishing it up.
Q And as far as supplies are concerned, and I'll start off with things like biopsy forceps, did Dr. Desai ever tell you to reuse those things at any time?
A Yes.
Q Okay.
A But that was because we would run out and he asked could we reuse them and I said yes as long as -- the thing with the biopsy forceps is that the company only guarantees them for one bite. That's all they guarantee the jaws for when you do that. But they work more than that because some patients you have to take three or four biopsies or five or six biopsies depending on the doctor.
But to clean them you have to know the person who's cleaning it because the forcep has a little sharp tooth in it, a little spear, so they have to know how to definitely how to clean it, make sure there's no tissue in these two jaws that are there, the alligator jaws, because they've got cuffs in them so you have to make sure there's no tissue in them. And then you put them in the sanitizer with the scopes and you can clean them and then you

can reuse them. But usually you only do that if it was an emergency, we couldn't get anybody to deliver. But usually with Dr. Desai you call somebody up and somebody would be delivering or else we would go to like Southwest and borrow a box of forceps or two boxes or forceps and you pay them back when you got your supply order in.
Q But he did at least at times tell you to reuse that stuff?
A Yes.
Q As far as that was concerned, you had said you left I think the clinic in August or rather March 31st of '06, correct?
A Yes.
Q Never went back to the clinic?
A No.
Q You have fairly extensive training in your background in doing this kind of work; is that correct?
A Yeah, with that. I trained in that and I've been in medical since 1965. I'm a retired chief hospital corpsman, served most of my time with, 16 years with Marines, three tours of combat, four, went through a DEA. I'm a shooter.
Q Well, as far as your medical background

and training, where did you get that?
A Naval Hospital in San Diego, OR school. I was an OR tech. I was a navy transplant tech. I was an independent duty tech. I was a field medical tech. Independent duty means that I can go somewhere with X number of marines with a combat load without a doctor and I did that numerous times.
Q And then you worked in endoscopy clinics in --
A I worked in endoscopy after I got out of the service. I had cancer surgery in 1996 so when I came back from -- I was on light duty and it was limited light duty. So they said the only place you can really work would be the endo room. So I had already worked with the company doctor. I was still at Southwest. And so I learned all of the endo and I was one of the few techs that, you know, I could look at the scope and I could monitor and I could tell the doctor what part of the colon we were in. I got really good at it so pretty soon I was the only one and at one point I was -- just before I left I was up to like 400 cases a month as the only tech.
Q So as far as your job at Southwest, or not at Southwest, but when you went to the Shadow Lane

clinic, did Dr. Desai recruit you to that clinic?
A Yes.
Q When you went to work for him what was your job role there initially?
A It was supposed to be, I was supposed to help instruct these younger kids because they were getting people in from administration, the girls that were working over there, they were training them. They weren't getting the OR techs in. There was an OR tech school in town but their turn-out of people was marginal, if anything. Most of their techs never got OR jobs, they got endo jobs because you can train anybody to be an endo tech. So I was supposed to train the people to be endo techs and train them about sterility and how to run the sanitizer machines and the one sterilizer we had. But I was never given the opportunity to do it.
Q Why was that?
A Because when we would have the meetings the charge nurse never allowed me to do it.
Q So if I understand you correctly, you have the experience and you would have done that role as far as a training person's concerned?
A Yes.
Q In the source of persons that they were

actually using for their techs came from administration, you mean like clerical people?
A Uh-huh.
Q Had they had any background or training in doing the kind of work that you did?
A No.
Q And now you said as far as like even the reuse of biopsy forceps it was important to be at least cognizant enough to look to certain portions of this forcep, make sure it was clean and so forth if you were going to do that, right?
A Yes.
Q Was that a concern of yours that these people didn't have the training or knowledge or experience to be able to appreciate that and do it?
A Yes.
Q Did you voice this to anyone there?
A Yes.
Q What was the result of that?
A I was told that I was not in charge of training, they had a nurse in charge of training and they would take care of it because I had already trained a couple people that were there and they were competent.
Q Did you ever have discussions with Desai

about any of this stuff?
A No, because he never had time to talk to me about it.
Q At some point you said you're not just in the room cleaning scopes, initially aren't you working somewhere else in the clinic?
A Initially I was there to work in the room with the patient, with the doctor. And then I had a disagreement with Dr. Desai so we weren't talking literally. And so I became the clean tech so I was cleaning the scopes. So you had a room on each side and you had a clean room in the middle. And you clean the scopes and then you put them in the sanitizers and the one sterilizer and, well, actually it was a sanitizer, not a sterilizer, and you process them. So I was the process guy so that worked out pretty good. And if they needed me because of my ability to manipulate scopes from the outside from pressing on a patient's stomach because, you know, I knew where to press, if they needed me they would call me into a room.
Q Now, as far as your, and I want to specifically ask you about Dr. Desai at this point, when you were with him in a room and you said you were, and I'm not talking about as the clean tech,

but when you were doing the procedures --
A Uh-huh.
Q -- these three to five-minute procedures that he was doing, when he would get to the end and the scopes would come out, was he ready to have that scope come out?
A You had to be prepared for him to have the scope out because he was there and he was moving at the same time, he was moving away from the patient, and he would just hand it off and almost drop it. So you had to catch the scope because he would have it out. And sometimes he would -- when you do the last six inches of actually the rectum they pull the scope out and they come all the way to the anus and they push back in, they invert the scope so they can look back towards the anus to make sure they don't have any cancerous growths there or internal hemorrhoids, then they straighten the scope back out and then they can bring it back out. And so when he would bring it back out sometimes he would bring it out with about a little bit of speed so you had to know that he was bringing it out and you had to be prepared to catch the scope.
Q Okay. Ever miss the scope?
A I didn't, no.

Q Did others?
A I've heard other people did, yes.
Q Did you hear any yelling from Dr. Desai when something like that would happen?
A Yes, because that's a $24,000 scope.
Q Okay.
A And that's the business end of it. The main end of it is the distal end.
Q Now, I want to ask you about some or talk to you about the reuse of biopsy forceps, things like that. Did Dr. Desai ever get upset about people using too many of anything; for example, like alcohol pads or too much lubricant, things like that?
A Yeah. He was -- he had a meeting and they said that, I guess they were doing their, you know, cost analysis and all of a sudden he come up with this thing about overusing lubricant, overusing -- he had them cutting the Chux up. Instead of being one big size he had them cutting them in half.
Q And the Chux are the things --
A Yeah.
Q The protective plastic barrier?
A Yes, it goes underneath the patient. And what else did he have them doing? He had them

doing -- you're supposed to wear gowns when you leave to go outside or like doctor coats. But he had the paper ones but he didn't want you to throw them away, you had to use them or reuse them.
Q So if they were stained with any kind of debris, would that be a concern to him that --
A Yeah. Sometimes he would come and look at them to see if they were hanging up. If they was hanging like in one room and he would look to see if they were, you know, if people were getting rid of them or too many masks or using too many gloves or --
Q Did you in fact have to hide some gloves of your own?
A Oh, yes.
Q Why was that?
A Because the biggest thing with cleaning the scopes is to protect yourself against hepatitis and HIV because the patients don't tell you if they've got it. So you need to put a serious barrier between yourself and the scopes that you're cleaning because you're dealing with contaminated scopes. So I would wear surgical gloves and then I would wear two sets of exam gloves and that way when I finished one part I could take the exam glove off

and then go to carry it to another station and then take that glove off and put two more gloves on and then start back doing what I was doing. But I always keep on the inner gloves unless they got wet. Then I would have to take those off. That was because I was an OR tech. The rest of the techs didn't really know anything about that.
Q So what was the issue then with the gloves?
A He said we were using too many gloves. We're using too many -- one time I was training a tech and we were using -- we both have extra large hands so we were using, instead of using my usual box and a half or two boxes a day I guess we got down to like four or five boxes and he was upset about that. I don't know how he found out we were using them but somebody was telling him. It wasn't us.
Q So he was at least involved at the level of the supplies and so forth to even be worried about how many gloves you were using and things like that?
A He was involved in all levels.
Q Now, as far as that you mentioned the gloves, the lubricant. What about the -- you

mentioned the Chux which are those plastic, I think you said plastic lined pads?

A That go underneath the patients, yes.

Q And what's the purpose of one of those things?

A The purpose of that is to keep them from soiling the gurney, soiling the sheet underneath them. If something happens, they do have an accident you can just contain it on that and take that out and put another one under them so you have a contained area.

Q You mentioned those, you mentioned the -- were they gowns or were they some sort of coat kind of thing that we're talking about?

A They were paper coats, paper -- they're disposable. They use them in contaminated rooms. When you go in and visit a person you have the yellow ones or sometimes you have white ones. They have different colors. They're real thin but it's just to protect your outer garments against people breathing on you and stuff. They don't really work in a wet environment but --

Q What about anything that might have gotten fecal material on it or anything else?

A Yeah, then you were supposed to change out

but most of the time the techs in the room don't wear -- they wore scrubs. They didn't wear -- they didn't wear gowns. What they wore in the room, you wore a rubber apron but they were hot. So it's an actual apron, it's rubber and it ties behind. And it's a hundred percent impervious so nothing can go through it. So that's what people would actually wear in the room. But the people on the -- and in the clean room you have to wear that if you don't want to get wet so --

Q Tell me about the issue regarding the lubrication that you had mentioned. You said that there was an issue of using too much. Did he institute any kind of policy or plan regarding that?

A Yeah, when he was in the room he would monitor how much -- you had a four-by-four sitting there for him to lube the scope up with and he would look at the size of the dollop of lubricant you put on and he would say that's too much or, you know, that's okay. And then he would, you know, give you this little spiel about using too much.

Q Was there anything about putting certain types of tubes that were partially used into rooms so that there couldn't be too much lubricant used?

A No, I don't remember anything about that.

Most of the surgical lubricant, I mean, that was like, that's like pencils and papers. You go through so much of that a day. I mean, it's for the patients and it helps the doctor. I mean, some doctors actually use a whole big tube of lubricant per patient because they want it to be slipping and slide. And then there's other doctors that only need a little bit. So it's up to the doctor and where they learn that.

Q Do you remember giving a statement to the police at one point during this whole investigation?

A Yeah.

Q And that was taped and you've actually -- have you had a chance to review that statement before today?

A Yeah.

Q Do you recall being asked about the issue of the lubricant that I just talked about and saying that you had to make sure that the tubes were basically empty when you put them in the room so that the other doctors wouldn't use too much lubricant?

A No, not empty when you put them in the room, you had to make sure they were empty before they were discarded.

Q Okay. So there was an issue with not throwing partial tubes away then?

A Yeah. He wanted -- we went as far as to get, you had these tube rollers that you put on toothpaste and stuff and you take them and you can roll them so you can get the last little bit out of the tube. And we had those and we'd put them on so you would roll them up. And he would ask you where's your tube roller.

Q And what about alcohol pads, was there any issue about that?

A See, alcohol pads I didn't have anything to do with them. That was in the nursing anesthetist field because I didn't give shots or anything.

Q What about the four-by-fours you mentioned and things like that?

A Four-by-fours, yeah. He wanted you to -- I mean, it's up to the tech to, you know, which doctor it is and what he feels comfortable with. So you know that if he gets -- he's going to use -- hold the scope with two four-by-fours and then if they get dirty then you change them out and you get two more and, you know, you throw those in the bin. But he didn't want you putting all those on the fill

(sic) and one reason was that once you put them on the fill you can't use them for anybody else. They have to go, stay with that patient. So he only wanted you to get a minimal amount and then if you saw that he needed more or the doctor needed more, usually it was just him, then you would have to go back or have the nurse hand you more four-by-fours.

Q And as far as the glove issue, did you ever hide any gloves so you could use them so he didn't know about it?

A Yeah, all the time.

Q As far as the scopes and how they were handled and after you moved to the clean room area, are you with me now?

A Yes.

Q When you left the facility did you have any concern that the people that were in the clean room area were not trained sufficiently enough to do the things that you were doing?

A Well, the people they put in there, I didn't know them so I had no idea what training they had and I found out through hearsay --

Q And I don't want you to get into what was hearsay.

A I don't know what training they had.

Q Okay. The things that you observed when you were there as far as patients coming, or not patients but people coming from administration into the clean room area to start doing work and you not being allowed to train them, that issue, do you remember that?

A Yeah. You can only -- instead of having them for a week you would only get them for like a day. And then this is somebody who has, you know, they don't even have a first aid card so they have to learn all this about different solutions, when to change the solutions in the machine, when to change the water in the tub that they're washing the scopes with, how much soap that goes in there to clean the scopes and stuff because you had do to a hand cleaning first and then you put them in the sanitizing machine. But it was only one or two people that I got to train and then the rest of them would be in there like a half a day and then that was it. And then they would take them out and actually use them the majority of the time for recovery. But then at a later date I heard they were coming, you know, they were back cleaning so I don't know.

Q Okay.

And again I'm going to have the, as far as that last comment --

A Take that out.

Q -- I'm going to have the Grand Jury disregard that. It's a hearsay statement.

I have nothing further for this witness, ladies and gentlemen.

THE FOREPERSON: Are there any questions from the jury? None?

Okay. By law these proceedings are secret and you are prohibited from disclosing to anyone anything that transpired before us including any evidence presented to the Grand Jury, any event occurring or a statement made in the presence of the Grand Jury or any information obtained by the Grand Jury.

Failure to comply with this admonition is a gross misdemeanor punishable by one year in the Clark County Detention Center and a $2,000 fine. In addition you may be held in contempt of court punishable by an additional $500 fine and 25 days in the Clark County Detention Center.

Do you understand this advisement?

THE WITNESS: Yes, I do.

THE FOREPERSON: Thank you. You may be excused now.

THE WITNESS: Thank you.

THE FOREPERSON: You're welcome.

MR. STAUDAHER: Ladies and gentlemen of the Grand Jury, that concludes the presentation for today. Are there any questions regarding any of the law or issues pertaining to bias that have come up since the presentation started this morning?

THE FOREPERSON: No.

MR. STAUDAHER: And I see that no Grand Jury has said or indicated that there's any issues regarding bias at this point. And as far as the witnesses are concerned we'll just resume next Thursday. And that concludes the presentation. Thank you.

A JUROR: Thank you.

{Proceedings concluded.}

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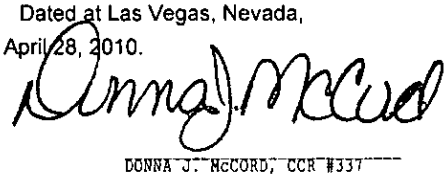
REPORTER'S CERTIFICATE

STATE OF NEVADA)
: ss
COUNTY OF CLARK)

I, Donna J. McCord, CCR #337, do hereby certify that I took down in Shorthand (Stenotype) all of the proceedings had in the before-entitled matter at the time and place indicated and thereafter said shorthand notes were transcribed at and under my direction and supervision and that the foregoing transcript constitutes a full, true, and accurate record of the proceedings had.

Dated at Las Vegas, Nevada, Wednesday, April 28, 2010.



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