Q What other publication goes out of CDC?

A That was the other article that we talked about yesterday from Clinical Infectious Diseases. That is also a publication.

Q Okay. That's that what I called a scholarly article that was published in a journal?

A Correct.

Q But out of CDC, it's these two documents?

A Well, so again, the MMWR has authors on it from Nevada, so it's not just CDC. It's also got authors from Nevada like the scholarly articles you said the Clinical Infectious Diseases article did.

Q Who publishes this MMWR?

A So it's -- it's through CDC. It's a CDC -- but you don't have to be a CDC employee to publish in the MMWR, I guess, is what I'm trying to say.

Q I'm not -- and the scholarly article --

A Yes, sir.

Q -- that's published in -- what journal accepted that?

A Clinical Infectious Diseases accepted that.

Q Okay. And that's a -- who reads that? I've never got a copy.

THE COURT: They don't sell it on the newsstands.

THE WITNESS: I understand. So, you know, I'd have

to look at their website to see, but see what they market themselves as. But it's clinical infectious diseases, so typically ID trained physicians, other physicians.

I mean, it's whoever wants to read it can access it, and if you have a particular topic you're looking for, like I said, you can look, you know, on the Internet for PubMed, find this article and, you know, if it meets whatever parameters you're looking for, read it and use it.

BY MR. WRIGHT:

Q It's like -- tell me if I'm wrong about this -- like when I'm done with this trial, okay, if I want to get together with Mr. Staudaher, Ms. Weckerly, maybe the judge, and we put together an article about this trial and the intricacies of it and submit it through Nevada State Bar Journal?

A I'm not familiar with that journal, but that's right. We -- you know, we went through the authors yesterday, wrote the article together and submitted it to a journal who ultimately was interested in it and published it.

Q Okay. I follow. So the CDC MMWR, May 16, 2008, right?

A Yes. The MMWR is May 16.

Q And the trip report May 15. And the -- the MMWR goes out to whom?

A It's freely accessible on the Internet.

Q Okay.

A So it's typically read by public health people, epidemiologists, health department people, but anybody can Google it and get it on the Internet.

Q Okay. It says weekly. I guess I'm -- I'm old school. I expected this to come out weekly in my mailbox or something. I mean, is it paper or --

A They do paper copies. They also send electronic copies if you're on their mailing list. I can't tell you the distribution or who's on that list. But yes, they do have paper copies and they also have electronic.

Q Okay. And the conclusions and information in MMWR is, the way I see it, the same as the trip report?

A Yeah. The conclusions are the same between the two.

Q Okay. Was there anything else different? This looked like to me it was the public synopsis of the trip report.

A I was just trying to verify if we had the -- because the CID article had more cases in it. I think the MMWR and the trip report have the same number of cases at that point in time, and the conclusions that we came to were the same.

Q Okay. Now, after May, the final trip report, did your individual conclusions ever change?

A My conclusions about how transmission --

Q Likely cause.

A -- occurred in the facility? No.

Q Okay. And so it wasn't something where a later report came out, this is it?

A This is it.

Q Okay. Now, I want to go back to the trip report. You talked about likely causes of the transmission. Okay. And without focusing on August -- July 25 or September 21, just combining it in general, you're there looking for hepatitis C, okay?

A Okay.

Q Cause of transmission.

A Okay.

Q The -- the likely causes you considered, let's just tick them off.

A So again, you know, confirming the diagnosis in these patients to confirm that transmission likely occurred in the facility, and then we're looking at, you know, the possible ways they could be exposed. So things that I think about are as we talked about before, it's a blood-borne pathogen, so blood to blood. So looking to see, you know, did they have any finger stick testing where you prick the finger to get blood.

Q And that -- the answer to that was no --

A Correct.

Q -- and that the finger stick testing is where they would prick someone's finger there in the clinic, and that just plain none whatsoever, they don't do that?

A Right. They did not do that testing.

Q Okay. Go ahead.

A So we also look for any medications or injections that they received and the handling of those medications.

Q Okay. And we talked about propofol obviously, because that ended up the method of injection combined with propofol multi vial use ended up the likely cause of transmission, right?

A Right. Correct.

Q But we also had saline we looked at.

A We looked at, we -- go ahead.

Q And what's that other -- lidocaine. And we'll come back to the medications. I mean, any others that were like multi use and injected patient to patient?

A Well, so the other thing we talked about yesterday a little bit for medication handling is healthcare worker to patient transmission through theft of narcotics.

Q Okay.

A And we looked at what meds they use in the facility and the healthcare personnel ended up getting tested.

Q Okay. And so -- and on that, every healthcare person at the facility came in and was voluntarily tested, correct?

A That is my recollection.

Q Okay. And so they provided their blood and they were all tested and no one at the clinic had Hep C?

A None of the healthcare personnel did.

Q So that like -- that ruled out that.

A And also, you know, the patients didn't get fentanyl, and the narcotics that they had and were administered to patients, and they had security measures in place for those.

Q Okay. And go ahead and --

A So then other mechanisms for patient to patient, we looked at equipment use on patients, specifically the scopes and which scopes were used on which patients and how they're handled, and the biopsy equipment, I think, are the main --

Q Okay. And we've heard a lot here in the courtroom over the last few weeks about reuse of bed sheets.

A Okay.

Q Likely cause of transmission of Hep C?

A No.

Q Okay. So I mean, we can -- I mean, that isn't even something you would waste your time on, correct, for a

viral blood to blood infection?

A Right. You know, when we do these investigations, we're looking at the totality of care and trying to correct anything we see regardless of if we think it can result in transmission. That's why we looked at hand hygiene and other things. But you're correct, I'm not concerned about that as transmission in this situation.

Q And I -- a whole list of things I can go through. If the speed in which a colonoscopy is done?

A As far as transmitting and just focusing on the procedure itself, not the turnover time for reprocessing of instruments or the meds or anything?

Q Correct. Just by if I --

A I'm not concerned about that resulting in transmission of hepatitis.

Q Okay. And the issues like did I start -- I'm the physician, did I start to give a procedure before the person was fully asleep?

A Right. I'm not -- that's not going to be a mechanism of transmission.

Q Okay. And --

A Again, barring issues related to --

Q Oh, correct. We're going to get to the scope [inaudible], but I'm just saying --

A Okay. Yes, just focusing just on that, sure.

Q -- [unintelligible] a physician, you know, propofol's given and the person isn't under the influence of it yet and the procedure starts, that's going to have nothing to do with the transmission of hepatitis C?

A Not in isolation.

Q Okay. And the same thing if a patient is coming to at the end of the procedure and the physician says hold off, don't need -- don't need anymore propofol has nothing to do with transmission of hepatitis C?

A Right. You're not going to transmit from patient to patient in that situation.

Q Okay. Bite blocks --

A So --

Q -- reusing them. Taking the bite blocks, assume that they're single use hard plastic bite blocks and that the clinic was putting through the -- treating them just like scopes and recleaning them and reusing them.

A So they're doing some type of cleaning step --

Q Yes.

A -- then that is not -- I'm not concerned about that being a particular mechanism for transmission.

Q Okay. Being a cheapskate on the amount of tape you allow the staff to use in a facility?

A No.

Q Okay. Cutting Chux in half because you're a

cheapskate?

A No.

Q Now, on the equipment use, you'd be looking at the scopes, and you went through all of the proper cleaning, everything else. I mean, you look at all of that and then you looked at which scopes were used and the numbers and all of that was pretty much explained. Because you're doing two things as I follow reading what you all did. Number one, you're looking at all of it, observing it to verify that they are doing what they say they're doing --

A Correct.

Q -- is that fair?

A Correct.

Q I mean, you don't just like take their word for it. I mean, it's actually observation to see like the policies and procedures that are stated by the clinic are actually being implemented?

A That is our goal and intent, yes.

Q Okay. And you learned by talking to the people, whether it's GI techs, nurses, CRNAs, not only observing, but asking them questions, and you rely upon their answers?

A I rely on their answers and my observations and review of the records, yes.

Q Okay. Did you -- did you have any misrepresentations to you that you became aware of while you

were there?

A Can you -- can you specify a little? What do you mean?

Q A lie. They like said --

A Yes.

Q Okay. What was that?

A So I mean, Mr. Lakeman told me that they, you know, reused biopsy equipment, and that was not what was represented while I was in the facility and that was not what I observed while I was in the facility.

Q Okay. So your -- Mr. Lakeman told you biopsy equipment was reused?

A Correct.

Q And your observation when you were there, it wasn't being reused?

A I did not observe reuse of biopsy equipment while I was there, correct.

Q Okay. Who are you saying misrepresented, Mr. Lakeman?

A Well, so --

Q I mean, it could have been previous reuse.

A Right. But so I guess some of your question and information I have is stuff that, you know, I've heard from the health department calling since then, or in the newspaper since then. And so --

Q Well, I don't want any of that.

A So that's what I'm --

Q Okay.

A I don't know how to answer your question without addressing --

Q Well, you can't go --

A -- some of that.

Q -- there.

A Right. So it's hard --

Q Let me restate it. I mean, that's why I kind of made the parameters of May 15 and 16, you know, and then your conclusions didn't change. So I am dealing with your own personal knowledge, you know, and what happened when you were there. Okay.

A Right. So --

Q And my question was, did -- were you aware when you were there of any misrepresentations to you, you know, like someone said, hey, we do this and then you find out they do that?

A You know, I'm not recalling any specifics. I mean, we may have been looking into some inventory records for biopsy equipment while we were there, but I didn't observe it and I don't believe I was -- I don't recall being told at the time it was being reused. So nothing is jumping out for those nine or ten days that we were there.

Q Okay. Your perception when you left was they had been totally -- they, I'm talking about the clinic personnel you interacted with and Dr. Carrol, Tonya, the charge nurses, they had been fully cooperative --

A Yes.

Q -- in the efforts?

A Yes.

Q And you believed that that cooperation was genuine and sincere?

A Yes.

Q Now, on the equipment use, scopes, the -- your report indicates that the only lingering issue that needed to be corrected was the enzymatic detergent changing.

A Right. Correct.

Q And that's, I think the -- you saw the pictures --

A I did.

Q -- and the evidence has been they used blue buckets --

A Right.

Q -- at an early stage of the washing before going to the MediVator?

A Correct.

Q Okay. And the clinic, as I read your report and correct me if I'm wrong, they -- they stated they were

changing the enzymatic detergent every two scopes.

A Correct.

Q And the detergent said change it every single scope.

A Correct.

Q And this was one of the things that was brought to their attention and corrected?

A Correct.

Q So if -- if that was a -- of course that was their practice, meaning two scopes before changing.

A Right.

Q So we take that as a given that that was -- that practice went unchanged up until you got there, right?

A Sure. I -- I assume so, yes.

Q Okay. Well, I mean, that's the way -- you're there. You figure out what they're doing and then you ask have you changed anything lately.

A Right.

Q And basically they were saying, the they, everyone you talked to, that we're still doing things the way we've been doing things. We didn't change just because you walked in the door.

A Correct.

Q And in fact, when you all were there, they were doing 50 to 60 procedures a day, correct?

A That sounds accurate.

Q Okay. And that's what they said they had been doing in the past. And that was on the days in question it was like 60-something procedures.

A Okay.

Q And on your observation days it was -- they didn't cut their load in half or anything.

A Yeah. I didn't -- I don't -- we didn't -- I didn't count patients that day. But they didn't represent that they were cutting back because we were there, so that sounds right.

Q Okay. So taking it that they had been misusing the enzymatic detergent, that is something that would cause concern of are the scopes being cleaned properly?

A Yes.

Q Okay. And the -- if we like go back to the -- you used the July 25 date, because that's simply a one source patient, one transmission to Mr. Washington. Okay. And each of them, one had an upper and one had a lower.

A Yes.

Q And so those scopes had to have been clean.

A Yes.

Q Okay. And if like those two were in the same blue bucket, you know, or one, the second one, however it works when they didn't change it out right, it -- what could

happen?

A Well, they're still -- that's the precleaning step. They're still getting rinsed and going through a high level disinfection step, so I wouldn't -- I wouldn't -- wouldn't see that as being a mechanism for transmission.

Two different scopes that are just mixed together in precleaning water or solution and then they still go through high level disinfection, I would not believe that transmission would occur through that.

Q Okay. So that's less likely?

A Yeah. I don't consider that within the realm of likelihood, yes.

Q Okay. Well, what the -- the -- what equipment -- as I read the trip report, you viewed the most likely cause of -- you, I'm meaning the report, the most likely cause of transmission was the propofol multi use coupled with syringe reuse?

A Yes, sir.

Q And then I read that less likely was equip -- equipment cause of transmission.

A Right.

Q Okay. And would that be including like the scopes?

A Yes.

Q Okay. And the cleaning problem, if there was

one?

A Yes.

Q Okay. And the -- if biopsy equipment, whatever you call it, the biopsy equipment was being reused when it's single use, that fell into the less likely?

A Yes.

Q And those are all lumped into the less likely portion of the trip report on equipment reuse?

A Yes. I mean, but again, while we were there and what was told to us is biopsy equipment was not reused and not everybody got biopsies amongst our cases and the source patient -- yes.

Q Okay. I understand. The -- but on July 25, the two patients had biopsies?

A Right. The source and then Mr. Washington, correct.

Q Okay. And then aside from the equipment possibility of transmission being less likely, you also had the -- when we go to the med -- back to the medication, we have saline injection practices being less likely?

A Yes.

Q Okay. And lidocaine injection practices being less likely?

A Yes.

Q Okay. Lidocaine, saline, both multi-use vials?

A Both labeled as multi use, yes.

Q Right. And being used multi use?

A Yes.

Q And like lidocaine, as I read the report, one multi-use vial like 30 cc brought out in the morning --

A Yes.

Q -- and then used all day and then, as I read it, discarded?

A I'd have to look back at the report to confirm, but I do know, and this would have been in the notes that I had, that they also would have prefilled syringes with 1 cc of lidocaine, and those can be sitting in a drawer overnight and not discarded or not put anywhere if they weren't used.

Q Okay. The lidocaine syringes that were prefilled -- and of course, just to refresh recollections, lidocaine 1 cc is put into the syringe, set aside, and then ultimately they're going to fill it all the way up with propofol.

A Correct.

Q Okay. And if there were any of those left over, it appears they were just left in the drawer --

A That was my understanding.

Q -- syringes with lidocaine only in them, and then like reused the next day -- or used?

A Then used.

Q Dangerous word that, reused.

A Right. Then used the next day.

Q Okay. And so on lidocaine, the -- it being multi-use vial 30 cc, it -- any re-entry of it, reuse of it or something could --

A No. The --

Q How's it work?

A No. The practice was that it was a one-time administration to a patient helps prevent the burning of propofol when it's going in and so there's no need, because then the patient's asleep, to give them more lidocaine. So it would be enter with a new needle and syringe, draw up, no need for re-entry or re-dosing for a patient.

Q Okay. In the ordinary course there wouldn't be, but if a mistake was made there would be?

A If they decided to re-dose and reuse a needle and syringe to enter?

Q Yes.

A And then what was the question?

Q Well, then that could be a possible -- I mean, mistakes are made, correct?

A Mistakes can be made, sure.

Q Okay. And so I'm trying to get to how the transmission could occur, I mean, because that was a -- that's a less likely probability. But there is a way it could occur,

correct?

A Nothing I saw or heard supported that as far as re-administering lidocaine or re-entering vials. But if there was re-entry with a used syringe into a lidocaine vial and that was used for multiple patients, that could be a source of transmission.

Q Okay. And the same with the saline solution or saline flush, whatever you call it?

A Right. So I again, the same with lidocaine, there was not reported or observed any need for reflushing patients' line, we didn't observe that. So we didn't see the potential for reuse of needles and syringes. But if somebody uses a syringe on a patient and uses that to go back into the vial, the vial can become contaminated and a source of transmission.

Q Okay. And if when using like saline vial solution in the preop area, all it would take is one single mistake?

A Yes. It could be a mistake and, you know, again, going back to the why it was less likely, you know, on the July date, the source patient didn't get a saline flush. And so for that to have been the mechanism, he would have had -- he or she would have had to have the saline flush, had the contaminated syringe to go in to then have the flush be used on Mr. Washington.

Q Okay. And you're concluding that the source patient did not get a saline flush on July 25, because the CRNA started the -- did the heplock?

A My under -- from what was reported to us, when the CRNAs placed IVs, there wasn't a need for a heplock because they were putting it in to start the procedure to use propofol. But you're correct, that's how I'm coming to that conclusion.

Q Okay. When they -- when they started the IV, they didn't flush --

A That was my --

Q -- they being the --

A That was what we were told. That was my understanding.

Q Okay. They being the CRNA?

A Correct.

Q Okay. But if there was evidence that CRNAs on occasion helped when the nurses couldn't get -- couldn't hit the vein right after two or three times, then the CRNA did it to start it?

MR. STAUDAHER: Objection. Foundation as to location where this would happen.

MR. WRIGHT: Well, it was a hypothetical. So I'll say in a preop room or --

MR. STAUDAHER: Say evidence showed or something to

that effect.

MR. WRIGHT: Well, it's a hypothetical.

THE COURT: Well, state your question.

BY MR. WRIGHT:

Q Okay. If there were evidence that sometimes nurses had difficulty with the [inaudible], or whatever the difficulty is in starting the heplock, and then the CRNA would start it for them.

A Okay.

Q Okay. Then we don't know in those situations whether that would be flushed or not flushed, correct?

A I can't answer -- I can't answer that. But again, in order for the saline flush to have been the source, there would have had to have been contamination of that vial through use of syringes and re-entry.

Q Right. Right. I didn't mean just by starting it.

A So, yeah.

Q I'm just saying there could be situations where the CRNA started the IV, but there was still a saline flush.

A There could be, sure.

Q Okay. And saline, the evidence has been, was used other than just for flushing the IVs, but was also used out of the saline vials for pushing the propofol.

A Okay. I hadn't heard that before.

Q Okay. But if that was taking place at this clinic, I mean, that -- that compounds the opportunity for more use of the saline and more possibility of an accident than you were aware of?

A I don't know that I -- that's not anything that I observed as a practice, and all I can continue to say is if you reuse a syringe from a patient to enter any vial and then use contents from that vial on another patient, that can be a mechanism for transmission.

Q Anything else? I mean, we had the medication other than propofol being a less likely cause, and we had the equipment being less likely.

A Yes, sir.

Q Was there anything I've overlooked --

A I don't think so.

Q -- as a possible?

A I think --

Q I mean, we've excluded others as just not a chance.

A Right.

Q Meaning coming from a healthcare worker.

A Well, there's always a chance. But in this instance, right, we ruled that out.

Q Okay. And the -- did you rule out what we in the courtroom have talked about, a rogue employee? I mean an

intent, someone doing something purposefully bad.

A That was not -- no one -- with intent to harm some --

Q Correct.

THE COURT: An intentional malicious act.

THE WITNESS: I never heard that from -- while we were there.

BY MR. WRIGHT:

Q Okay. And you saw no evidence of any such thing?

A No.

Q Okay. Now, your field trip portion of the mission was completed in mid January?

A Yes.

Q And then you all remained available and still assisted by phone?

A By phone and by email, yes.

Q Right. Because you all, the CDC was still doing the -- all of the geno -- all that testing that took place --

A Correct.

Q -- and offering to do any additional testing?

A Correct.

Q Okay. And so that continued to take place, and then ultimately conclusions were reached, and that's the last page of the May 15 trip report, correct?

A [No audible response.]

Q And then I think thereafter --

A Lawsuits. Well, sure, yes.

Q Is that right?

A Well, the last page is our quasi species analysis. But I get your intent, which is we had the discussion section here on page 8 and 9, where we're --

Q Oh. My last page of the --

A So this didn't have like our conclusions and summary on it; isn't that what you're saying?

Q I thought this was done after --

A After we -- right. Right. I think it was in progress while we were there, completed after we left, yes.

Q Okay. Now, your -- you were not conducting a criminal investigation?

A No.

Q You had no idea that what you were doing would result in criminal charges, correct?

A No.

Q Yes?

A Oh, I'm sorry. I didn't. I had no idea.

Q Correct, yes?

A Correct, yes. I had no idea.

Q I just want to be sure. It's a double negative.

A I apologize.

Q We go by the record.

A Yes, sir. I had no idea.

Q And you had -- your goals in reaching likely cause of transmission, and I'm speaking you as meaning CDC and your job there --

I love the way you cough. That's a CDC cough, correct, a proper covering?

A Right. Sorry.

Q Now, I read I'm supposed to do that, and you follow the best practices?

A I try to practice what we preach, yeah.

Q The -- your mission is to identify the likely cause of transmission, and then -- and as quickly as possible?

A That's one component of our mission, yes.

Q Right. I mean, as thorough -- quick but thorough, and because you want it to stop --

A Correct.

Q -- the practice?

A Yes.

Q And you're going to additionally use it to educate?

A Sure.

Q Okay. Okay. And does that cover the mission?

A Well, I mean, our -- another, you know, main part of our mission is to get people to identify all the

infections because, you know, the majority of hepatitis C infections are not symptomatic and people may not know they're infected.

So a component of this experience was, through Southern Nevada Health District, notifying patients and getting them tested. And if people were found to be infected with any blood-borne pathogen, getting them referred for appropriate evaluation is also a component.

But yes, you're right. There's that, and then we want to try to figure out how it might have happened so that we can stop it from continuing to happen. And we do have a role of educating other providers in the public, you know, how things can be transmitted and what lapses -- what practices should be followed and how safe care can be given.

Q Okay. And in your -- in the trip report, the -- before I get there, I'm going to have to back up. I saw something else.

The -- on your most likely cause of transmission, multi-use propofol vial and reusing syringe could contaminate the vial.

A Correct.

Q Okay. There's been evidence about a spike being used on the 50 size propofol vial. And the evidence has been what we've called a spike was a device that you've put in top and then you like drew 5, 10 cc syringes of propofol without

using a needle. You simply hooked it onto the spigot, drew 5 of them, then you put on the needles afterwards.

A Okay.

Q Were you aware of that?

A I don't recall that, no.

Q Okay. Does that -- when you were testifying about back flush and pressure and things, because you -- I think you were talking about that someone may believe they are safely reusing a needle and syringe going into a propofol vial by keeping negative pressure to prevent any contamination; is that correct?

A By keeping pressure on the plunger to prevent backflow. Okay.

Q Okay. I mean, that is a common belief out there, correct?

A That is a misperception out there, yes.

Q Right. A widespread misperception?

A I can't -- I can't say with certainty. I hope not.

Q Okay. Well, it's -- remarkably, it's keep --

A It's something that we comment on so that it won't perpetuate.

Q Well, remarkably, it keeps coming up, correct?

A Coming up where?

Q In your -- in the articles I read and some of

the articles that you're an author on, the percentage of people that still persist believing this myth.

MR. STAUDAHER: Objection. Which myth are we specifically talking about?

THE COURT: You're talking about the negative --

MR. WRIGHT: I'm talking about the negative pressure --

THE COURT: -- pressure plunger idea?

MR. WRIGHT: But believing it's safe to re-enter, reuse needle and syringe. I can safely re-enter a vial by what I've called negative pressure, whatever it is.

THE WITNESS: Well, that is one of the misperceptions that we address on the CDC website and would bring up in publication so that it doesn't perpetuate. There are others we can go through, but you're not asking about those, so.

BY MR. WRIGHT:

Q The -- how does that fit in? Because I don't understand negative pressure, you know, and the pressure in the vial versus the syringe and plunger or something. But what if I'm using a spike on the propofol vial?

A I can't -- I can't answer that. You know, I don't know what the spike is or what the manufacturer's, you know, claims about it are. I would not consider a spike being a protective mechanism to prevent contamination of a vial if you're reusing a syringe.

Q Okay. But you don't even know how it works.

A But I can -- no, I am familiar with the concept that you're talking about. I would not consider that a protective mechanism, but, you know, I don't know what the manufacturer claims are and if FDA approved or any of that, so I can't -- I'm answering that in a bit of a vacuum. I can't --

Q Okay. You didn't factor -- I mean, you weren't even aware of the spike use?

A I don't recall the spike use coming up.

Q Okay. Your presumption was all, all propofol -- all filling of syringes with propofol was done by needle and syringe going through, wiping the little top with alcohol, air dry, and then putting the needle in to draw?

A Correct.

Q Okay. Now, you ended up, your report, or the CDC trip report came up with best practices, right? I'm on page 9.

A So is this under our actions and recommendations, or where are you looking at?

Q Yes. Right at the bottom.

A The bottom of page 9, going on to page 10.

Q Yeah. As we observed -- I'm at the very bottom of page 9. "As we observed and interviewed individual staff members, we pointed out our best practices in infection

control." Okay. And is that -- and I thought that's what you all called your recommendations at the CDC, best practices. I saw that on a website.

A Right.

Q Okay. So the -- I have a hard time in reading and understanding the terminology of the various agencies when I read about standards, recommendations, best practices, rules, regulations. What are your -- what's your understanding of the CDC's best practices? What does that mean?

A So CDC is not a regulatory agency, so we don't -- we can't -- we don't have an enforcement authority. If you do something wrong, we can't do anything to you. But we come out with, and this is through my division, what we consider evidence based recommendations and what I consider standards of care. But whether that's enforced by the people who do have authority to enforce or not, that's under their jurisdiction. I think that people should be doing these things.

I mean, our recommendations are don't reuse a needle and syringe from patient to patient. I mean, it's basic and falls under what we call standard precautions, which is what we consider the basic expectation to prevent -- protect patients and healthcare workers. But we don't have the regulatory badge to come and do anything to you if you don't

do that.

Q So I can freely ignore your best practice?

A I think that would be a really stupid thing to do.

Q Or I might be sitting here.

A And I wouldn't want to be your patient if you did that, so.

Q But I cough like this too [indicating].

A And if you do, I can't say that the people who do have a badge and authority like the Centers for Medicare and Medicaid Services or BLC wouldn't, wouldn't do something --

Q I'm not suggesting --

A -- or you wouldn't have something like this happen.

Q I'm not ridiculing or suggesting they shouldn't be followed. But these are -- I mean, because I have seen it written in on different articles, recommendations, standards, regulations. I mean, there is someone, I guess, who -- out there who can order these type of things.

A Right. So again, people like the Centers for Medicare and Medicaid Services, or a joint commission works with them, you know, have some regulatory authority to enforce if you are not doing things correctly. But I think it -- well, I'll stop there.

Q Okay. And sometimes like the -- what you just said, was that -- what did you just say, what center?

A Centers for Medicare and Medicaid Services, so Medicare.

Q Okay. What's their initials?

A CMS.

Q CMS. Okay. CMS can like order things because they're the federal government, and the way the federal government always does anything, if you want to deal with Medicaid, Medicare, then here's the rules.

A Right. If you want to get paid --

Q Right.

A -- here's the rules.

Q If you don't want to get paid, then don't follow them.

A Right.

Q Okay. So they have the ability. And sometimes those regulatory rules don't mirror CDC's best practices?

A I'm not aware of examples. We actually work pretty closely with CMS, and have worked on checklists and training of their surveyors to make sure that they are enforcing the best practices and the safe practices for patients and healthcare workers, but --

Q Okay. Let's go through the best practices that you pointed out to the clinic.

A Okay.

Q And these, you already said as these came up, the moment a worst practice was observed, you pointed out best practices --

A We --

Q -- during the visit?

A Yeah. Sometimes not --

Q Like don't do this --

A -- right at that second. For the egregious things, yes. But some of the other stuff, you know, I'm not going to stop the procedure and say, you know, if it's something that's more minor. But we pointed them out as we were going along, yes.

Q Okay. So this was like a recap?

A Yes.

Q Okay. Number 1, I'm on page 10 now --

A Yes, sir.

Q -- of Exhibit 92. "Injection safety. We reviewed with the Clinic A staff the following: Never reuse needles or syringes when drawing medication," correct?

A Correct.

Q "Never pool medications from individual vial." And that's the using the leftovers, pooling into one, correct?

A Correct.

Q "Never use single use vials for multiple

patients."

A Correct.

Q "Never recap needles," right?

A Yes.

Q "And immediately dispose of sharps in appropriate containers."

A Yes.

Q And the -- then hand hygiene, you explained they weren't doing as well as they should, so you told them how to do it properly?

A Correct.

Q And then patient care equipment, that was the enzymatic detergent issue?

A Yes, sir.

Q Okay. Now, on injection safety, never use single use vials for multiple patients.

A Yes.

Q Right. The -- you're aware, I presume, that if I have a 50 propofol vial, okay?

A Okay.

Q If I use safe practices, using a new needle and syringe every single time I go into it and wipe it. Well, I either have a spike or I wipe the top. I do everything best practices, I can use it on multiple patients safely, correct?

A We don't recommend that at CDC.

Q I understand your best practices, and we'll get to whether they're followed or not.

A And I think by doing that you're taking a risk with patients, to reuse a single dose vial.

Q Right. You work for the CDC and you're going to stick with your best practices.

A I am.

Q I understand. My question is, is it -- if I take that 50 -- I mean, we had a witness testify here in this courtroom who's a CRNA who presently works at two big clinics in California, and they to this day multi use single use vials of propofol because they use a new needle and syringe every single time they enter it. Are you surprised at that?

A I'm disappointed.

Q Okay. But you're not surprised, are you?

A I'm not surprised, but I'm disappointed.

Q Because you know the statistics out there in the real world, correct?

A Yes.

Q And what is it, like 28 percent --

A So --

Q -- are still multi-dosing safely despite best practices recommendations?

A So again, I don't know that it's safely. I don't -- it's labeled for single patient use for a reason, for

patient safety. And so when you don't do that, I don't think you're doing the safest thing for patients. That's why we don't recommend doing it. That's why it's not labeled for multi-patient use. That's why FDA didn't approve it for multi-patient use.

Q I thought it was labeled single patient use -- I mean, like this fellow, his name is Mr. Sagendorf. I don't want to tattle him out. But now that I know that you don't have regulatory authority, I'll disclose it.

A I have friends who do though.

Q I'll bet.

THE COURT: Well, we won't tell you where he works.

BY MR. WRIGHT:

Q They believe that they are acting safely and economically in their practice. I mean, let me put it that way. I mean, because the CDC way would be if I have a 50 and use 10, I'm tossing out four-fifths of the product which is still good if I'm using it within an hour or two.

A So to respond to that, it's not just the CDC recommendation. The American Society for Anesthesiology has the same recommendation. The Association for Professionals in Infection Control have the same recommendation. So it's not just the CDC recommendation.

And I guess to the point that you're saying is, you know, why -- why not buy the right size vial for the patient

so that you don't have to do that and you can do things more safely for them.

Q I don't know, because I don't think --

A Why buy a 50 cc if you --

Q -- every patient is exactly a 10. I don't think they're a 15. I don't think they're a 23. They aren't. I mean, the evidence we've heard in this courtroom is it's for an upper it may take 100 whatevers, 10, and for the colonoscopy it's between 100 and 220 milliliters or whatever. And so there isn't an array of propofol vials. Let's see, I'm going to do an 18 on this patient, it just doesn't work.

A But if you're --

MR. STAUDAHER: Objection, Your Honor. That mischaracterizes prior testimony, as well as the state of the vials that are out there and available for use.

MR. WRIGHT: I didn't --

MR. STAUDAHER: We have ranges of 10, 20, 50, 100.

THE COURT: Okay.

MR. WRIGHT: Okay. I said an 18 or a 23.

THE COURT: And again, ladies and gentlemen, it's your recollection of what people have testified to --

MR. WRIGHT: Okay. What size --

THE COURT: -- what the past testimony has been.

Go ahead.

BY MR. WRIGHT:

Q What size do you think propofol comes in?

A I'd have to look on their website to see what the array is. But if I know that my facility typically gives between 100 and 200 milligrams, then why do I need to buy a 50 cc vial if I can get the smaller and do more safe care for my patient?

Q I don't know. But I think there's -- all I know is from your studies, one-fourth of the population still multi-doses safely, in their view, propofol.

A What study are you referring to? Can we hone in on which study it is?

Q You tell me if I'm wrong.

A So the only --

Q No, I mean, I -- no, I don't have all of them at my fingertips. That is --

MR. STAUDAHER: Well, then I'm going to object to assuming facts not in evidence, Your Honor.

MR. WRIGHT: You tell --

THE COURT: Okay.

BY MR. WRIGHT:

Q You tell me the current, the most recent number of -- well, let's just start right in Nevada. Didn't CDC come out here after this event and check our all 53 ambulatory surgical centers in Nevada?

A So CDC didn't check all 53. CDC came out to do some training and work with the inspectors so that they could inspect all 53.

Q Okay. And what were the results of that?

A I don't recall.

Q Other clinics were doing the same thing, correct?

A I -- I don't recall the specifics of Nevada, of what was found in those clinics.

Q Other -- you --

A I'm willing --

Q You tell me the results of the other studies. My understanding from reading the journals I've never read before in my life and will never read again, those journals I was reading, that there was ongoing people like Vincent Sagendorf and the two clinics he worked at that continues to multi use, to use propofol vials for --

A So I'm willing to agree with you that there are providers that are using single use vials for multiple patients contrary to recommendations, but I can't give you a number nationally of how many people are doing that.

Q Okay. It's a -- it's a large -- I mean, it's not 1 percent, right?

MR. STAUDAHER: Objection. Assumes facts not in evidence.

THE COURT: Well --

MR. WRIGHT: I'm asking.

THE COURT: -- she can -- he asked it as a question, it's not 1 percent, right. And of course, the jury is reminded that the questions are not evidence. The evidence comes from the witness stand.

MR. WRIGHT: You can answer.

THE WITNESS: Oh. So I can't give you a national number. I don't know what the percent is.

BY MR. WRIGHT:

Q Can you give me an educated guess?

A I mean, I can --

MR. STAUDAHER: Objection. Speculation.

THE COURT: Well, overruled. If she -- you know, if she doesn't feel that she can answer the question, she can certainly respond that way.

THE WITNESS: So I don't have a national estimate for you. The only study I can think of is the one that we did looking at a small sample of ambulatory surgery centers in other states back --

MR. WRIGHT: 2000 --

THE WITNESS: '10 maybe.

MR. WRIGHT: '10.

THE WITNESS: And found, I think, in that one that 28 percent of the facilities were using single dose vials for

multiple patients.

MR. WRIGHT: That was the one you were --

THE WITNESS: But that's not --

MR. WRIGHT: You were the author.

THE WITNESS: Well, you said multiple articles. I didn't know which one you were talking about. That's what I'm asking.

MR. WRIGHT: You knew.

MR. STAUDAHER: Objection. Argumentative.

THE COURT: How many states -- okay. How many states -- I think he was --

MR. WRIGHT: I knew I got that number somewhere.

THE COURT: How many states did you look at in order to prepare that study or to author that article?

THE WITNESS: So that was a study that we did with the CMS and surveyors. It was a pilot of a tool that we developed with them in three states.

(Pause in proceeding.)

THE WITNESS: That's it.

MR. WRIGHT: That's it.

BY MR. WRIGHT:

Q Who's the lead author?

A I am.

Q And did -- this study, I may be wrong because all I've done is read them, but it almost looks like it was

somewhat prompted by what happened here.

A True.

Q Okay. And after what happened here, meaning with this Clinic A, you're aware that there was a look at all of the ambulatory surgical centers in Nevada?

A Yes.

Q Okay. And concerns were raised?

A Yes.

Q And concerns arose because it seemed that ambulatory surgical centers kind of went under the radar while hospitals were being more observed and surveilled; is that fair?

A That's fair.

Q Okay. And it seemed like a lot of medical treatment had moved out of hospitals for little surgeries, little procedures into ambulatory surgical centers.

A Yes.

Q And the surveillance and education and monitoring and like having an on site health control officer didn't keep up in ASCs the same way it did in hospitals.

A That is -- that was a concern, yes.

Q Okay. And did those things prompt this study?

A It prompted our work with CMS on helping surveyors be more systematic about the infection control practices that they're observing. And so this study was us

piloting a tool that we developed for surveyors to use to see how that worked in the survey process and to determine, you know, what was what's going to be found with practices.

Q Okay. And you all -- and when I say you all, I'm talking about that study. With this study, it was put out to all the states calling for volunteers to go through this testing?

A So CMS reached out to their state survey agencies to ask if any -- who wanted to participate in the pilot, yes.

Q Okay. And the four states agreed?

A It was three states in this.

Q Three?

A Yes, sir.

Q You -- and generally what did they -- how did this work? We have the three states, we agree, and you had set up -- you, CDC, you assisted in setting up like a surveillance form, a method of going in and checking best practices?

A Right. So we developed essentially an infection control worksheet is what we called it, that would allow the surveyors, regardless of the states or the facility, to be looking at the same things ideally in the same way so that we could capture information systematically.

Q Okay. And they went out and did that, correct?

A We went with them in the beginning, representation from CDC. But yes, they continued doing it independently as well.

Q I had asked you about the bad -- the BLC going out and looking at all the ASCs in Nevada took place before this.

A Yes. That's correct.

Q Look at page -- I'll call it page 2 of --

A Okay.

MR. STAUDAHER: What are we referring to, Mr. --

MR. WRIGHT: I'm just trying to refresh her recollection.

MR. STAUDAHER: On what? What are you showing her?

BY MR. WRIGHT:

Q Did that refresh your recollection about the results of the Nevada survey?

A Yes. So this would be information from CMS, not that -- right. So do you want me to go through this, or --

Q Well, I don't want -- want you to read it. Just I'm asking does that refresh your recollection?

A Yeah.

Q Okay. And the -- of the 51 ASCs surveyed in Nevada, 28 had infection control issues?

A Right. So this isn't limited to the use of single dose vials. This is some type of infection control

lapse was noted.

Q Okay. And do we know what -- do you happen to recall -- I mean, this is simply mentioned in here. This isn't the Nevada study.

A Right. So this is information that came from the Centers for Medicare and Medicaid Services, so I don't have -- I don't know the breakdown of single dose vial use. And to be clear, when we're talking about single dose vial reuse here, we're not talking about reuse of syringes to go into those vials. We're just talking about straight use, right, that's how you're--

Q But you all were looking for both, correct?

A Correct. Yep.

Q And like in your survey, you found both?

A In this pilot?

Q No, no. I'm talking about the -- your -- the one you participated in.

A The one here at the clinic in Las Vegas? What --

Q No.

A I don't understand.

THE COURT: Isn't that the article she wrote with the three other --

MR. WRIGHT: It's the article you wrote.

THE COURT: -- states that were studied?

THE WITNESS: Right. So did I observe reuse of syringes, or did we observe reuse of syringes to go into medication vials, no, or for more than one patient, no. If you go to Table 2. Table 2 under injection safety and medication.

MR. WRIGHT: What I read on page 1, 2, 3, 4 --

THE WITNESS: So 2276? Okay.

MR. WRIGHT: Yes. I'm looking at the very top paragraph. I can't figure out the [inaudible].

THE WITNESS: Okay. Right. So we didn't have any instances of syringe or needle reuse.

MR. WRIGHT: Okay. That -- I'm going to go through them.

THE WITNESS: Okay. Sorry.

BY MR. WRIGHT:

Q First, that's 28 percent of all the -- 28 percent of the four pilot states were reusing -- were using single dose vials as multi-dose vials, correct?

A So I'm looking at the table which has the percentages, and 28.1 percent of the facilities including the pilot were reusing single dose vials for more than one patient, correct.

Q Okay. So more than one out of four were reusing --

A Correct.

Q -- multi-dose vials the same way Clinic A here was?

A Multiple reusing single dose vials the same -- and not the same way Clinic A was, because there wasn't reuse of needles and syringes in this instance.

Q Okay. I'm talking multi-dose vials. I'll get to the other components. Okay. They were still, even after Las Vegas happened, all the news, everything else, 28 percent of the clinics persisted violating your best practices, correct?

A Correct.

THE COURT: Mr. Wright, I think we're going to take our morning recess now.

MR. WRIGHT: Okay.

THE COURT: Ladies and gentlemen, we're just going to take a quick recess. Before I excuse you, I must remind you that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person or subject matter relating to the case, and please don't form or express an opinion on the trial.

Notepads in your chairs, and please exit through the rear doors.

And ma'am, of course, don't discuss your testimony.

THE WITNESS: Thank you.

(Jurors recessed at 11:04 a.m.)

THE COURT: Yeah, you go this way.

We can take our break too. There are five juror questions up here. The pile of three, I think, are appropriate juror questions. The two I don't think are appropriate questions, but I'll ask them if there's no objections or you want me to ask them. So here's the three and here's the two.

(Court recessed at 11:05 a.m. until 11:18 a.m.)

(Outside the presence of the jury.)

THE COURT: Bring them in.

MR. SANTACROCE: As to the questions, I'm going to object to the two questions. The other three from the jury I have no objection to.

THE COURT: Okay. So the two I didn't like you don't like either?

MR. SANTACROCE: No.

THE COURT: Okay. That's -- all right.

MR. STAUDAHER: I like them. [Inaudible] and I think they actually go to what the last question is.

THE COURT: Well, I think one's argument. One to me is argument like, well, just because everybody's doing it does that mean it's okay. And the other one is to me calls for a legal civil conclusion whether or not there would be liability.

So to me this is -- the first one I didn't like is more of a legal conclusion, and the second one is really, you know, does it make it any more safe. Of course it doesn't. That's more argumentative. I mean, if you want to spin from those questions in some way, you're fine to do that. But, you know, the one calls for a legal conclusion and to me is more like a civil liability issue. But if everybody agreed to them, I'll ask them.

MR. WRIGHT: No. We don't even agree to Your Honor's three. They've been -- the Linda Hubbard one has been asked and answered [inaudible] on cross. And then they bellyache that we keep going over the same stuff.

THE COURT: We can't all agree on what the testimony was. We're supposed to expect that they remember every single thing and wrote it down? I mean, sometimes they might realize, oh, I didn't catch that, I want to ask it. That's acceptable.

MR. WRIGHT: Okay. Whining that we keep repeating the same stuff, that's what I -- we ought to answer. [Inaudible.]

THE COURT: Well, we don't get to object to asked and answered to the juror questions, because that means that they didn't catch it and we're not catching everything. So, you know, I'm amazed that they're still awake frankly. Seriously, I mean, these guys are troopers, and they bring in snacks for

the staff every day.

MS. WECKERLY: That's nice.

MR. SANTACROCE: Not for the lawyers.

THE COURT: I don't think we're supposed to share them with you guys.

MR. STAUDAHER: That's fine.

MS. WECKERLY: That's nice though, that they do that.

THE COURT: Well, you know, we obviously -- the county doesn't pay for anything other than when they're deliberating, so sometimes, you know, Shari will make something and give it to them. I mean, if the county would pay for it, we'd give them breakfast every day, but they won't.

In fact, the county has said that even when they're deliberating we're not allowed to buy them breakfast. We can only buy them lunch and then if it goes past a certain time dinner. But we're not a dinner department. We're not. I don't want to stay.

(Pause in proceeding.)

(Jurors reconvene at 11:21 a.m.)

THE COURT: Court is now back in session. And Mr. Wright, you may resume your cross-examination.

CROSS-EXAMINATION (continued)

BY MR. WRIGHT:

Q The infection control assessment of ambulatory

surgical centers --

A Yes.

Q -- the nationwide one as opposed to Nevada --

A It's not nationwide. It's just three states.

Q It's pilot -- I mean, they extrapolated from the three states, correct?

A So it's not a nationally -- it's just a small sample in three states. So it's not nationwide.

Q Oh, correct. It was a taking a sample --

A Right.

Q -- and they conclude that it's probably worse than the sample?

A Where --

Q I'll find it.

A Okay. Thank you.

Q Let's go through and ask you just some questions out of the national study. We already covered the 28 percent. These were unannounced surveys, correct?

A Yes. Correct.

Q Just walk in and we're here to survey --

A Yes.

Q -- and then they do their survey?

A Yes.

Q Okay. So 19 percent had hand hygiene problems, we'll skip over that. 28 percent multi-dosing single dose

vials.

A Yes.

Q Then 39 of 68 pilot ASCs were ultimately cited for deficiencies in infection control, and 20 of 68, 29.4 percent were cited for deficiencies related to medication administration, including use of single dose medications for multiple patients.

A Correct.

Q Okay. I was looking at 22, 78, where it said the number of infection control lapses identified is potentially an underestimate.

A Yes.

Q Okay. And why is that?

A It's -- we say before it's not known that if what -- if the observations that were made at the time reflected the routine practices in the facility, so therefore they could -- the observed lapses could be an underestimate.

Q Okay. Nineteen of 67 facilities had deficiencies related to injection practices or medication handling primarily through use of single dose vials for more than one patient, right?

MR. STAUDAHER: Your Honor, I'm going to move to admit this if he's going to go ahead and read from it. I have no problem with that. Let's go ahead and do it.

THE COURT: All right. Do you have any objection to

admitting the --

MR. WRIGHT: Yes.

THE COURT: Okay. Obviously, Mr. Staudaher, you can also cover what you want out of the study during your redirect examination.

MR. WRIGHT: I gave him a copy. The --

THE COURT: I'm sorry. Was there a question?

MR. WRIGHT: No. I'm looking for something.

BY MR. WRIGHT:

Q Tell me about the evolution of the changing of best practices and standards. What were they in 2000, do you know?

A I need you to be more specific. What best practices are --

Q Well, it seems to me that what was good in like the 1990s by 2005 is no longer good. We've become more safe, more conscious. We're aware of more issues. Am I wrong?

A I don't know how to answer that question without knowing what standards you're referring to before versus now.

Q Okay. Well, do you think the standards today, your best practices have been always the same?

A No. I think -- I think that as you said, you know, we see outbreaks, we learn, and so we make recommendations and as I'm sure that those changed over time. I just can't think of specifics for you.

was involved not just on those two days, the entire year. And so that's her explanation that she gave me.

So now I'm just supposed to accept it and not say that's preposterous, the CRNA worked all year. What is the real reason you're linking them; that's what I asked her. And so now I'm being told I can't go there because I'm waiving an interest.

THE COURT: That's a different question than what --

MR. WRIGHT: That's what I asked.

THE COURT: Well, you started with the CRNA worked all -- worked other days. Well, yes, but the other days there may or may not have been infection.

So the inference was, well, he worked all these other days and there wasn't infection on those days. And what I'm saying is there may or may not have been infection on those days. We don't know and we don't know what her answer is going to be. And I'm not going to tell her, you know, she -- she's okay, you know.

MR. WRIGHT: Okay. I won't pursue it.

THE COURT: No, pursue it.

MR. WRIGHT: On the Court's instructions --

THE COURT: Pursue --

MR. WRIGHT: -- I won't pursue this --

THE COURT: No, no. Wait a minute.

MR. WRIGHT: -- further.

THE COURT: Wait a minute. I never told you, you can't pursue it. So don't stand there and say, oh, I'm not going to pursue it on the Court's instruction and that -- try to make that the record.

MR. WRIGHT: I'm not -- okay. What can I ask?

THE COURT: Pursue it if you will. Here's the deal. The question you just said is fine. But she's --

MR. WRIGHT: That's what I asked already.

THE COURT: -- going to answer -- she's going to answer the questions truthfully and I'm not going to, you know, limit that. And she can explain why she linked Mr. Lakeman on those days.

MR. WRIGHT: Okay.

THE COURT: And if your point is to point out, well, there's other people that were working that same day, the nurse --

MR. WRIGHT: That wasn't my point.

THE COURT: Okay. I don't know what your point is then.

MR. WRIGHT: My point was she gave a ridiculous answer. I said, What is it about July 25 and September 21, why you even make this a big cluster as opposed it was two separate incidents. Maybe one was propofol, maybe one was reuse of scopes improperly washed.

I mean, I have no idea why they linked the two, so I

asked her, Why do you think because it happened on this day and this day, why do you conclude it's likely the same cause? And her answer to me -- I didn't know what she was going to say to this. Her answer to me was, Because the same CRNA worked on both days.

I said, Well, that would be a good answer if that was the only two days the CRNA worked, but he also happened to have worked all the other days in between and before and since, so that isn't a distinguishing characteristic causing those two to be lumped. But if I pursue it and accept that nonsense, I'm opening the door --

THE COURT: State.

MR. WRIGHT: -- to hearsay.

MS. WECKERLY: The -- I don't -- I mean, her answer to me was -- my understanding of her answer was the CRNA who admitted to unsafe practices was the one who was working on both days. Now, their -- part of the reason why they -- part of the reason why it's an injection and the -- and the injection practices and the notification was as long as it was, or as widespread as it was is because those practices existed for that amount of time. That's why they made that distinction.

If they thought it was a nurse, they would have done it from the employment date of that nurse forward. And so, I mean, their answers are -- they're intertwined with what they

know from their investigation, and I don't -- I just -- I just can't wrap my mind around why it would be okay to suggest that she can't fully answer based on her range of knowledge.

THE COURT: I think she can answer truthfully. Basically, I'm not going to tell you what to ask her. Ask her whatever you want. And I'm not going to limit her ability to answer truthfully and I'm not, you know, if she needs to provide a complete answer to answer truthfully, then she can. I don't know what her answer would be.

I mean, as you stand here and you say, well, that's just preposterous that they would link it to Mr. Lakeman, I don't think it's preposterous. I mean, he's told her that he's engaged in unsafe practices and he's the common denominator on the two days. To me it's more likely that you have a single same cause on two different days than that one day it's a dirty scope and then the other day it's --

MR. WRIGHT: Why is that?

THE COURT: Because it's just more likely that it's -- to me that makes -- to me that makes intuitive sense. Intuitively that makes sense to me. So when you say, oh, it's ridiculous, it's preposterous, I don't hear the evidence that way frankly. Now, you may hear it as preposterous.

But, you know, to me, I don't see what's so preposterous about her saying that, well, it's the same guy on two days that we got these who's admitted to unsafe and --

because is it more likely a single cause, or is it more likely that, okay, you've got unsafe injection practices and you've got dirty scopes.

And for various reasons, I mean, it's probably less like -- as we know, it's not likely to be transmitted through the scope, because let's face it, you're eating tons of dirty stuff all the time and not, you know, necessarily getting infected. So I mean, she's analyzing it according to what's going directly into your bloodstream and other things, what's likely to be a direct blood exposure.

So there's other factors that she's, you know, she's looking in. Is it a dirty sheet? No, because how is that going to touch your blood and spread a blood-borne infection. So she's not just looking at that. She's looking at, okay, we know that the infection is going to be entering the bloodstream directly, which would make sense then why people are getting infected, as opposed to some of these other things, like a dirty bite block, which necessarily isn't going to be entering the bloodstream.

So we know if you're injecting something it's entering the bloodstream. So to me, I don't find her reasoning, her rationale at all preposterous and I think she's entitled to explain that. And I want the record to be clear, I'm not limiting your questions and I think she needs to be --

MR. WRIGHT: You're telling me that she's going to be

allowed --

THE COURT: I don't know what she's going to say.

MR. WRIGHT: You're telling me that she is going to be allowed to answer by using evidence I do not have access to.

THE COURT: Mr. Wright, I am --

MR. WRIGHT: And that violates the confrontation clause and I want it -- I don't care about sheets and bite blocks. Obviously I'm not making myself clear. A witness has information, who's on the stand, that she is going to utilize to form her opinions and give answers that I am denied access to. I don't have the 106. I don't have their medical records. I dispute it and the witness cannot rely upon that.

She should be instructed you cannot rely upon evidence that is not made available. It wasn't in the discovery. I don't care if we call her a summary witness or an expert witness. Either way, under 1000 -- 1008, whatever the equivalent Nevada rule is, I have the right to it. And it's Davis vs. Alaska or whatever --

THE COURT: No, I --

MR. WRIGHT: -- in the confrontation clause case where a statute tried to limit my access to it and it was unconstitutional, and that's exactly what's happening here.

THE COURT: State.

MS. WECKERLY: Your Honor, well, I mean, I'm sure the

Court wants to review the cases we found, but I mean, some of the cases we found were on like toxic shock, where there was a bunch of victims and that type of thing and it was this exact issue. And the courts reasoned that people have every reason to candidly report.

And so to a certain extent that type of information being reported to an agency or to scientists who then use that information in formulating their conclusions, there isn't going to be a confrontation clause violation. Now, we'd like the Court to review it --

THE COURT: I would just note, you know, intuitively again, people who suffered from toxic shock, I'm assuming that was like a tampon-based thing that came out in the mid '80s. The big thing there, that isn't socially taboo.

MR. WRIGHT: It's a civil case.

THE COURT: Well, not only that, but --

MR. WRIGHT: There's no confrontation clause.

THE COURT: -- the other thing is with hepatitis C involving say IV drug use and other things, there are social and legal taboos to some of the conduct. So I think people are more motivated to not accurately report than they would in the toxic shock cases, as I understood that outbreak and how that was investigated.

Because I -- I mean, I was in college when that whole big thing happened, and it was huge news and it was, you know,

the New York Times had a magazine article and, you know, so I just kind of remember it just from the media and how that went.

But all I'm saying is I'm happy to look at the cases. Obviously a civil case is very different from a criminal prosecution --

MS. WECKERLY: Sure.

THE COURT: -- and I think some of the reasoning, as I said, as to motivation of the victims and the infected people, is going to be a little bit different in the toxic shock cases.

MS. WECKERLY: I agree with that, but I mean, we have experts that have cumulative knowledge of different studies and different reports. And all -- and the doctors who have testified -- or the doctor who testified yesterday was aware of other outbreaks and other instances and what happened with, you know, nurses that she's never had contact with not even involved in those outbreak investigations. But because she's an expert, she has this range of knowledge and --

Well, I mean, I understand -- I understand that the admissibility of the other people may be a decision the Court's yet to make, but I just go back to you still cannot have -- instruct a witness that they can't testify to what they know.

THE COURT: That they can't testify truthfully.

Here's the thing, Mr. Wright. I'm just going to sum it up this way. You can ask whatever questions you want. And maybe I'm not understanding you correctly, but it sounds to me like what you want to question is her methods or her reasoning or something like that.

And if you attack the witness's reasoning, then I think she's entitled to speak truthfully as to why she performed the linkage that she did. Because I don't think it's fair for you to attack her reasoning like, oh, why did she isolate these two days or something like that, without allowing her to sort of, if you will, defend herself and speak truthfully about what her reasoning was.

Now, I don't know what she's going to say. It's possible all she will say is because Mr. Lakeman was the common denominator, it's a blood-borne illness, it's direct transfusion into the bloodstream and why look anywhere else when it appeared obvious. That may be all she will say.

Obviously I don't know what she's going to say, but all I'm saying is if that's where you're going with this and that's what I'm hearing from you, that it was preposterous that she would just isolate and link these two days like that and you're going to somehow challenge her reasoning, then I think she's entitled to explain her reasoning, whatever that may be, and I don't know what the answer is.

MR. WRIGHT: Okay.

THE COURT: And I'm certainly not going to limit her and tell her no, you can't explain your reasoning as a CDC official and as a medical expert.

MR. WRIGHT: Okay. I just want to comment on what the State said and the Court's ruling. The -- first of all, I'm familiar with the civil cases in which there isn't a confrontation clause issue.

THE COURT: I agree.

MR. WRIGHT: It has nothing to do with this case. And secondly, experts do talk about the New York outbreak, this outbreak, that outbreak. But I have the right to ask them and challenge them on every one of them. I can say give me the article, give me -- because there is nothing with an expert that is off limits and it's all producible.

I have no problem with them talking about the New York one or the New Mexico one, and them using their historical knowledge as to what's probable and likely. Fully understood. But that isn't this situation. She's -- your -- the ruling is I can go ahead and she is allowed to explain her answer truthfully, which includes utilizing information I do not have that the State has -- the State of Nevada has precluded me from receiving.

THE COURT: First of all --

MR. WRIGHT: So if I cross --

THE COURT: -- that's not true. It's not -- well --

MR. WRIGHT: It's the state statute.

THE COURT: Okay. It is a --

MR. WRIGHT: It's the State of Nevada --

THE COURT: It's a state statute and it's --

MR. WRIGHT: -- created a privilege --

THE COURT: -- the Clark County Health District that was ruled on by a state court judge.

MR. WRIGHT: Right. Correct. So the State has said I don't get it. So your ruling, you won't restrict her, you won't instruct her that if I ask her questions she's at liberty to use the privileged secret information I can't have despite my confrontation rights. So with that ruling, I won't ask her.

THE COURT: Well, all I'm saying is if you're challenging her reasoning, then to me, I don't think she can be limited in trying to explain her reasoning in linking it. I mean, that's what I understand that you're saying. You want to challenge her reasoning, but she can't say what her reasoning was. So --

MR. WRIGHT: Correct. If it -- if she's -- absolutely, if she's relying --

THE COURT: Well, then to me, Mr. Wright --

MR. WRIGHT: -- on information I can't have because the State of Nevada chose to do that. They have remedies for these. It isn't unusual. It happens in informant cases and

everything else.

If they want to put up a shield that interferes with my confrontation rights, there are remedies to how to deal with it other than telling me I have to dance around it and give up my confrontation rights. That's what's happening here. But with that ruling that she's allowed to bring in that evidence because it's part of her logic, I'm not going to cross-examine her on it.

THE COURT: I don't know what the -- well, then let's bring her in here and see what her answer to the question was. Because now you've tried to create the record that, oh, well, she would have said this and I can't answer the question. I don't know what she would say or not say. I don't know what her answer is.

All I'm saying is I'm not going to instruct a witness that they have to lie or mislead the jury about what their reasoning was. They're allowed to testify truthfully as a scientist. She's allowed to say, no, that wasn't my reasoning, that's not why I did it. To me, I mean, if you want to make argument and say this doesn't make any sense with the evidence that we've heard, then that's argument and that's fine.

But I don't think it's right to tell a witness that if they ask for your reasoning you can't give it, or if someone says, well, you didn't follow scientific models, which

essentially sounds to me like, you know, you're making arbitrary -- arbitrary calls here, that she can't defend herself and explain her reasoning, if that's how I understand you want to proceed.

MR. WRIGHT: It is.

THE COURT: Ms. Weckerly, what do you recommend at this point?

MR. WRIGHT: That's the law. I mean, it's the same problem when the witness gets on that has informant information that's not admissible because the State won't disclose it. The remedy is the witness can't testify. It isn't a question of the witness has to lie or anything else. The State made their bed and they have to live in it. It's not at the expense of my confrontation rights.

I didn't create this mess that they did. It's their obligation to play by the rules and do it right. Labus and the two CDC witnesses know things that they used to reach their conclusions that are being concealed from me by statute. And so I'm supposed to just accept what they say, but if I challenge them on it, then I'm waiving confrontation rights and it comes in. That isn't the remedy in a situation like this.

The remedy is they either turn it over because of my rights trump their secrecy or the witnesses don't testify. That's the way it's addressed. I've disqualified expert in an

IRS case because I couldn't cross-examine him, because his conclusions were polluted by inadmissible evidence. So how do I cross-examine him and say, what do you mean you reached this? His true answer would be because I know your client said, nyeh, nyeh, nyeh, nyeh.

THE COURT: Well, Mr. --

MR. WRIGHT: In that situation they couldn't put him on. It's not --

THE COURT: I want to make it -- I think an important distinction --

MR. WRIGHT: -- mine -- my rights are waived.

THE COURT: -- has to be drawn here between inadmissible evidence or evidence that has been ordered stricken by the court or suppressed because of a constitutional violation, which is what you're talking about, and evidence that would be admissible but wasn't disclosed because of important state interests, which in my mind are different but equal to the interests of a different agency of the state or the county, the Clark County District Attorney's Office.

MR. WRIGHT: It's like Guantanamo, the state secrets.

THE COURT: Well, no.

MR. WRIGHT: In the state secret cases the government makes an option, are we going to turn over to this supposed terrorist this information he has a right to, or are we going

to forego prosecution. And they make those decisions. We're not treading new grounds on this.

It isn't they say, okay, Mr. Terrorist, we're putting you on trial but we're not going to show you the stuff, and don't you go near challenging anything or you're going to open the door to things.

THE COURT: Does anyone from the State want to respond to this? I feel like it's a dialogue between me and Mr. Wright.

MS. WECKERLY: I mean, I don't know -- I just view them as different -- as different issues conceptually, but --

THE COURT: Well, we're talking only about cross-examination and this --

MS. WECKERLY: Okay. But if it's cross-examination, I mean, to me that happens all the time in trial. You'll have a detective go, well, you know, I've seen this in a hundred other cases and this is why I drew this conclusion.

I mean, she's allowed to draw from her range of knowledge in the case or her range of knowledge scientifically. I mean, he can attack like why that may or may not be valid, or the strength of the information or what weight to give it, or why she gave it the weight she did. But she still knows why she relied on certain things.

And I really don't know what her answer's going to be, because the CDC left the investigation pretty early on.

So I mean, I don't -- I -- and we haven't talked to her obviously, so --

THE COURT: Right.

MS. WECKERLY: -- I have no idea what she's going to say.

THE COURT: I mean, all I'm saying, Mr. Wright, is if you ask the question about her reasoning or her rationale, you know, she can testify truthfully to that as a scientist what she relied on. So, you know, I don't know what the answer is going to be either.

MR. WRIGHT: I'm just telling you if -- I mean, on the example of a detective on the witness stand and if there's a statement my client gave him and it is not admissible, and there isn't a distinction between was it suppressed or is it a privilege, I mean, there isn't -- either way it's not admissible. The detective doesn't get to say, yeah, I know, Mr. Wright, because your client confessed when I talked to him. I don't care how I examine him, that doesn't come out.

And I can leave -- I had this issue in front of Judge Wendell. I sat there and examined -- polygraph couldn't come in, and so the guy's talk -- the polygraph examiner is -- the fact that it was a polygraph --

THE COURT: Right. Of course.

MR. WRIGHT: -- you know, isn't admissible or anything.

Yet he interviewed my client, and so I was allowed to sit there and make the polygraph operator look like a goofball because I said, Wait, you're telling me you interviewed my client, yeah; you didn't record it, yeah; who else was there, just me and him. Now, every other interview we've heard about in this whole case, there were others there and they recorded it. You're telling me you just had this conversation, you and him, nobody else present sitting in a room, yes.

And what was the explanation for it? Because there was a polygraph going on and that's the way we do it. They weren't allowed to bring that out. And was I drawing a false inference? You're damn right, because those are the rules of what's admissible and what isn't.

THE COURT: Well, to me, I mean, I think you've made your record. I don't know what she's going to say, but if you ask her, you know, what -- you may -- you know, you're obviously a very experienced excellent lawyer. You can probably come up with a way to ask her questions that she's not going to say, you know, my reasoning was based on these other things. All I'm -- I don't know what her answer is.

All I'm telling you is if you challenge her reasoning, I think, as, you know, a scientist, she's going to be able to testify or I'm going to allow her to testify as to what her reasoning was. I don't know what her reasoning is, but, you know, to me she's relying on various things.

And, you know, I do draw a distinction between conduct of law enforcement or the prosecutors that was -- resulted in suppression and, you know, something here where you have two competing and significant State interests; again, the control of the spread of disease and the prosecution of criminals. And they're both being, you know, the one is protected and --

MR. WRIGHT: And my rights take the back seat and I'm just saying you've got it backwards. Davis vs. Alaska, I think, is the case that the State's super privilege folds under confrontation clause. I understand.

THE COURT: I mean, all I'm saying is, you know, ask your questions. But if she tries to answer, you know, truthfully as to, you know, her reasoning -- if you open the door to her reasoning, which it sounds like it's what you're trying to do, then I think she can tell you what her reasoning was.

Now, there are other ways for you to get that information, or rely on argument and things like that, inferences and evidence that didn't come in if it doesn't come in. But when you start attacking, you know, a scientific official's reasoning, I think they're allowed to say what their reasoning was if that's the line you're going to go down. And so because, you know, again, I think that that would call for a complete -- a complete answer if that's where

you're going.

Now, I don't know what her reasoning -- to me it's again, just to reiterate, it's not preposterous to draw the conclusion she did just based on the data we have in front of us right now. Two days, Ron Lakeman admitting to dangerous injection practices, and the spread of hepatitis on those days through transmission that would occur directly into the bloodstream, I don't think that that sounds preposterous to me.

I don't think we need to go and think about dirty scopes and other things on those particular days. And obviously saline would also go directly into the bloodstream.

MR. WRIGHT: Why for three weeks have we listened to all this other crap? I mean, you're voicing my objections from the beginning of the case.

I agree with you completely that we've sat here for a month almost hearing about Chux cut in half, bite blocks, all this other stuff which has nothing to do with the case other than to dirty it up, and make the doctor a despicable person worthy of conviction whether or not the transmission was what they alleged. And so we just keep hearing it over and over and over, and now the Court's agreeing with me it has nothing to do with the case.

THE COURT: Well, it does -- I mean, as to Mr. Lakeman, no. But as to your client, you know, I don't

believe the State has -- maybe they do have direct evidence of Dr. Desai telling, hey, reuse the syringes, reuse -- well, they do have direct evidence reuse the propofol. I don't know about the syringes but, you know, maybe there was something and I missed it. Maybe that's coming down the road.

But, you know, to the -- they're trying to show the culture of the center. I think, yes, has it been redundant, have we needed to hear from every nurse that ever worked there and every GI tech saying exactly the same thing? I agree it's been redundant.

But, you know, where are they going with this? I get the relevancy. They're trying to show it's a culture of cutting costs and micromanagement, and that he was in charge of everything down to, you know, how much -- how big the Chux is you're using. And that's, you know, that's their theory here. And so are they allowed to present their theory? Yes.

Is it -- somewhat has it been redundant? Yes. Do I think we needed to hear from all the GI techs coming in? No. I think, you know, that I don't personally find that that added anything, or all the, you know, various nurses that who all said essentially the same thing, you know, I think we could have, you know, done with fewer of them.

But it's their case and how they choose to put it on and, you know, again, they're trying to show the culture that pervaded the center and that your client micromanaged

everything and they need to show that, that it wasn't just Mr. Lakeman or the nurse anesthetists acting on sort of their own to say these things. So yeah, I get the relevance whether it's redundant or not.

Let's take two minutes and then bring --

MR. WRIGHT: Could I add -- not -- this is just an old thing. I want to offer today's Review-Journal story. I will bring it as a bystanders bill in evidence for the record.

THE COURT: Okay. What was in today's Review-Journal?

MR. WRIGHT: Mr. German reported what he understood the witness testimony to be yesterday.

THE COURT: Oh, that it was a culture -- or that --

MR. WRIGHT: No. What --

THE COURT: -- the owner didn't want waste; is that the quote, your interest?

MR. WRIGHT: Correct. But he tied it -- he said that when asked, he tied it exactly to reuse of syringes. And exactly the inference I complained about and moved for a mistrial is exactly the way it's written in the newspaper.

THE COURT: Well, and as I remember the article, it also noted that you'd moved for a mistrial and that the Court denied the request and gave the instruction to the jury.

MR. WRIGHT: Well, I'm just offering it --

THE COURT: I don't have a problem, Mr. Wright,

making it a court's exhibit. I would just note -- you know, make whatever you want a court's exhibit.

I would just note that how a Review-Journal reporter chooses to spin the testimony really isn't that relevant, because the transcript's going to stand alone. And if it ever comes to a review in court, I think they're going to rely on the transcript and their own interpretation of it. But I'm happy to make it an exhibit.

MR. WRIGHT: Okay.

THE COURT: You know, there's been a lot of other interesting things in the media. I don't know if anybody read the letters to the editor yesterday. Did you read that about the lady who --

MR. WRIGHT: Yeah. Was that a witness?

THE COURT: -- didn't get anesthesia and struggled and...

MR. STAUDAHER: I haven't read any of [inaudible].

THE COURT: I was expecting you to add her as a last minute witness.

MS. WECKERLY: We can endorse her today.

MR. WRIGHT: I didn't know if that was -- if she was already a witness. I can't keep them straight now.

MR. STAUDAHER: We'll have to look.

THE COURT: If anyone needs to use the restroom, do it now, please, so that we can go through and not --

Kenny, let the jury know.

(Court recessed at 9:46 a.m. until 9:50 a.m.)

(Outside the presence of the jury.)

THE COURT: Are we doing -- Ms. Weckerly, are we doing the next CDC person today?

MS. WECKERLY: I hope so.

THE COURT: There was talk about Mr. Chaffee, but that's --

MS. WECKERLY: He's tomorrow.

THE COURT: Okay.

MS. WECKERLY: We have another witness ready if we get past the two CDC doctors, or not.

MS. STANISH: Who?

MS. WECKERLY: Nancy.

MS. STANISH: Oh, okay. Yeah, you mentioned that would just be direct, right? Or given where we are, probably not even that.

MS. WECKERLY: I'll be happy if we get through this witness.

MS. STANISH: Yeah, yeah. I hear you.

THE COURT: Today's the last day that we have to end right at 5:00. So other days we can finish with whoever.

Yeah, but she's a Safe Key kid, so maybe they have Safe Key still today, and then she's made other arrangements for the rest of the summer. I don't -- maybe the kid's in

camp or -- I don't know.

(Pause in proceeding.)

(Jurors reconvene at 9:53 a.m.)

THE COURT: Court is now back in session, and you can get the last witness, Dr. Schaefer.

MELISSA SCHAEFER, STATE'S WITNESS, SWORN

THE COURT: Mr. Wright, you may continue your cross-examination.

MR. WRIGHT: Thank you.

CROSS-EXAMINATION (Continued)

BY MR. WRIGHT:

Q Good morning.

A Good morning.

Q Let me give you your -- do you have your three reports?

A Yes, sir. I do.

Q Or your three documents?

A Yes, sir.

Q Okay. The trip report, the Exhibit 92 report, we were talking about the trip report when we ended yesterday and were somewhat going through it.

A Okay.

Q Now, the trip report, this is the -- May 15 is the final trip report.

A That's the last version of the trip report, or

the -- yes.

Q Okay. And was the -- you talked about an interim trip report when you -- you all left Las Vegas.

A Yes.

Q Okay. And the -- any major changes?

A Not that I recall. I don't have a copy of that. But as I mentioned yesterday, you know, with this report we have the testing that was completed at CDC, so that would have been an addition.

Q Okay. You were showing the last page.

A Yes, sir.

Q The tree or clusters that we've seen before in the court.

A Yes, sir. So without having the two side by side, I can't --

Q Okay. But your conclusions of what the likely cause was, everything remained the same?

A Correct.

Q Okay. And then at the -- the trip report is normally an internal document of CDC?

A No. It is -- it's a document generated by CDC that we provide to the health department who invited us to come. And then it's essentially theirs to do with what they would like, if they want to disseminate it or not. I believe the health department actually posted it on their website.

And people can get it from us through the Freedom of Information Act. If they send a request to CDC, it would be released under those parameters.

Q Okay. But you all don't release it other than to the agency?

A To the health department.

Q Right. And so --

A That's the typical.

Q -- it's not like posted and available --

A It's not.

Q -- through CDC?

A We don't post it on the web. It's available through CDC if we get a request, as I said, through like a Freedom --

Q Okay.

A -- of Information Act.

Q Because you like at the same time, May 16, 2008, you have the MMWR --

A Yes, sir.

Q -- report. I mean, that's what I call it.

A Yes. That's correct.

Q And if -- this is the publication?

A Is one of the publications.

Q One of the publications.

A Correct.

we're talking about in this case, the CDC report -- the trip report came out in May of 2008, and December of 2009 is the report that we wanted to get in which -- I know we still have yet to litigate that, but we are -- that is coming out -- that's the Brian Labus report.

The one that is the culmination of everything, the published paper, came out in March, I think, electronically, and then in August in print the same year, in 2010, by this witness who is currently on the stand right now as being one of the authors.

I mean, that information is available to those individuals and that went into the determination -- also the determination as to whether they believe the transmission mode was the correct one in the first place.

So it's not -- it's not proper for him to be able to give a false impression to this jury and have the State not be able to at least rebut that or bring in evidence then that shows something different.

MR. WRIGHT: Well, I don't -- I don't mind opening the door to rebuttal. I'm just saying we have to apply the rules of evidence. Rebuttal just doesn't mean, oh, okay, there you go, now no more confrontation and I can use hearsay. I -- it isn't -- it -- if they can't rebut it properly by the rules of evidence they can't. They're the ones that chose to not investigate further and put the case together this way.

There's nothing prevented -- I mean, I can't figure this case out at all -- there's nothing prevented the 126 patients from being subpoenaed to the grand jury. There's nothing prevented getting a subpoena duces tecum for their blood draw. There's nothing that's prevented the 107 -- there isn't. It's evidence.

I can acquire it. I could get it.

THE COURT: Well, you'd have to --

MR. WRIGHT: I don't have to.

THE COURT: -- get a Court order and there might be a problem there for people who aren't even named as victims in the case. Getting --

MR. WRIGHT: Hell, you can get a DNA swab for being falsely arrested, I just read this morning. I don't have --

THE COURT: Well --

MR. WRIGHT: -- but they -- they're the ones that did it this way. If they want to bring in the 107 witnesses, and I've taken -- this isn't some new position I've taken. That's why I wouldn't stipulate at the inception to the -- the reports I've stipulated in CDC, trip report, and most probably now, even the journal. It just caught me by surprise. But the way I read it, it doesn't bring in the other 107. But --

MR. STAUDAHER: It does not mention those directly, no.

MR. WRIGHT: Okay. Well, see, I didn't know because

I didn't know they were going to offer it. But that's what I have been resisting was that evidence improperly coming in. I have no problem if they bring it in the right way. I don't care that it's inconvenient.

THE COURT: Does anyone from the State want to respond?

MR. STAUDAHER: Well, I mean, part of what these people based their opinions on, their conclusions on, relates to exactly what we're talking about. It's not isolated to two incident days at -- along. They -- it's the reason why they went back and said you've got to notify people back to 2004, and why it went to 63,000 people in the Valley who got notified and had to come in for testing.

If they only thought that there was these two incident days and they had no evidence of anything else, that's as far as it would have gotten; but because the practices were prevalent, they talked to the individuals there to talk -- to find out how long they had been going on, they witnessed the practices themselves, they were a known method of transmission, they looked at the other things, and in fact, they had other -- the people on other days that showed up as being positive, they investigated those individuals --

THE COURT: Okay. Let me stop you because it's not clear on the record. I'm still talking to you. All right. These other 109 people, how were they able to identify them as

having been infected? Were they part of the 60,000 people who were notified and then went in and got tested, or had they previously been diagnosed with hepatitis and then were somehow linked to the clinic, or how were these 109 people --

MR. STAUDAHER: No, these --

THE COURT: -- identified? Are they part of the 60,000 --

MR. STAUDAHER: They're part of the --

THE COURT: -- that went in for testing?

MR. STAUDAHER: Yeah, they're part of the notification; however, when the testing went forward, if they came in voluntarily, if they got samples of these people who were -- already had been already, you know, at a blood draw someplace --

THE COURT: Quest or whatever.

MR. STAUDAHER: -- however it went, it was part of the notification. Those came from that -- that portion.

THE COURT: Okay.

MR. STAUDAHER: So --

THE COURT: So let's just say some of them went into the Health Department and some of them may have given their blood at Quest on a prior occasion, whatever. They are all tested --

MR. STAUDAHER: Yes, and it's actually a much larger number, but after they culled out the ones that they believed

they could not link to the clinic, we were left with the subset --

THE COURT: Right.

MR. STAUDAHER: -- of the 109 or 6 or 7 or whatever.

THE COURT: Okay. And so these people test positive for hepatitis and then through the investigation they say, oh, yeah, I got, you know, and I had a colonoscopy in 2005 or whatever, and then do they try to genetically link their infection or do they just say -- Yuri or Igor or whatever say, oh, no, you know, it's been too long. There's no way. It would have mutated because the infection is at this point over X number of years, so we're not even going to bother to try to genetically link i,t, or what happens at that point?

MR. STAUDAHER: I think it's a combination of those. It's too remote in time once you get past a certain point --

THE COURT: Okay.

MR. STAUDAHER: -- and I think that by -- because they had gone through and seen what they saw, did the genetic testing, and they had the mechanism that they believed was accurate which was confirmed by the testing results that they got later on, that I'm not sure that they would have gone back and tested these people had they been -- had they been able to do so.

So I don't know the exact answer to that question from Brian Labus; we'd have to ask him that.

THE COURT: And then someone from the Health District would have interviewed these people, and with the exception of a few who weren't tested or didn't get interviewed, they would have said, you know, no, I didn't have risky sex and no I wasn't an IV drug user and no, I didn't snort cocaine or whatever the questions may be, and then based on those answers they said, okay, well, these people were likely infected through the clinic?

MR. STAUDAHER: Essentially, yes. That --

THE COURT: Okay.

MR. STAUDAHER: -- was their one --

THE COURT: And my understanding --

MR. STAUDAHER: -- common risk factor.

THE COURT: -- is you have the names of most or all of these people?

MR. STAUDAHER: No, we do not. We asked -- that's part of what we --

THE COURT: Right.

MR. STAUDAHER: -- asked for.

THE COURT: Well, there was a lot of discussion that you already had the names or you didn't already have the names or the names where you were missing were the names of the people who had never been tested for whatever reason, either because they had moved or they died or --

MR. STAUDAHER: No. Your Honor, those were -- names

we actually had were on just the two incident days. The 126-odd -- or 109 people are from the investigation from the notification. We don't have any of those names.

THE COURT: You have -- as you stand here today as an officer of the court, you say you have none of the names? You don't know any of these 109 people?

MR. STAUDAHER: Well, with the exception of, I think, Chanin [phonetic] who was a civil plaintiff that I think was -- was an award. I think everybody is aware of that person's name. Michael Washington, who was also a plaintiff, he's one of our --

THE COURT: Right.

MR. STAUDAHER: -- unnamed victims.

THE COURT: He went to trial, so that was --

MR. STAUDAHER: Right. But --

THE COURT: -- everybody knew him.

MR. STAUDAHER: -- but no, we do not have a list of all of those names from the Health District because that was one of the things that we were litigating --

THE COURT: Okay. Now --

MR. STAUDAHER: -- and they prevent -- we were prevented --

THE COURT: -- one of --

MR. STAUDAHER: -- from getting them.

THE COURT: -- one of the ways to have gotten the

names would have been to just check and see who the plaintiffs were in the infected cases -- the -- in the infected, what we call the infected civil cases, correct?

MR. STAUDAHER: You mean as far as filed cases --

THE COURT: Yeah, filed --

MR. STAUDAHER: -- to maybe go back?

THE COURT: -- cases and what -- what we call the infected group. Did you do that at all?

MR. STAUDAHER: Did we go back and look at the names of those people. No, we did not.

THE COURT: Okay. So that was one source. I'm not sure if all 109 filed suits, worse --

MR. WRIGHT: Class action. That's the biggest motivator for them to say they got it there.

THE COURT: Yeah, but we don't know --

MR. WRIGHT: They were jumping on the money --

THE COURT: -- not all of them --

MR. WRIGHT: -- wagon.

THE COURT: -- well -- I know, but I don't know offhand how many infected plaintiffs there are, and so there could have --

MR. STAUDAHER: There's over 150 cases. That's to my --

THE COURT: Some are uninfected. There's both. So I don't know if they all filed cases or didn't. So there would

have been a source to at least get some of the names; possibly not, you know, all of the names, but some of the names, and that was not done.

So, Mr. Staudaher, do you want to address, or, Ms. Weckerly, do you want to address Mr. Wright's arguments on the confrontation clause and why this evidence should come in?

MR. STAUDAHER: Well, I think that's part of the -- and as far as the Health District report is concerned, which is the basis by which some of the conclusions were made, we have not yet litigated that and I'm not sure that we're prepared to do that at this moment regarding the Health District report which is -- which relies on the studies that were done, the patient notification in its conclusions.

It's didn't -- it didn't come to its conclusions in isolation. It used the entirety of their investigation, which included things that went beyond what was done by the CDC when they came out here. And that included the patient notification, the subsequent testing, and the results of those tests and how those were incorporated into that report, which the State still believes, even though it's a hearsay document technically, comes in under some exceptions.

THE COURT: Yeah, I mean, if they -- here's the deal, Mr. Staudaher. If they have a constitutional confrontation clause right, whether you call it a public record or a business record, you know, I don't think that's going to

obviate, you know, get around that right.

I mean, here's the thing, Mr. Wright. As you know, you know, there are factors that epidemiologists look at to trace the spread of disease, and we've already talked about this, you know. Even taking into account inaccurate reporting and things like that, and I'll give you -- so let's be generous, let's say 50 percent of the people who reported reported inaccurately, meaning, they didn't disclose IV drug use or promiscuous risky sex or whatever the case may be. I think that's high, but I'll give you 50 percent; you still have 50 infected people.

And so, you know, I think that there is a safe number that we can be sure of that were infected on different days through the Health Clinic because I don't think it's believable or realistic to say that all 109 people or 29 or whatever the number is, were all inaccurately reporting, and therefore, there's only those two days.

So I think we know with some certainty that there are other people who would have been infected on other days. And, you know, you say, well, you can create a false impression all the time, well, that's also done within rules. For example, drugs are suppressed.

You stand up there and say the State's given you no evidence of these drugs, we haven't seen this. You don't -- you know, people don't get up on the stand and outright lie

and say, oh, you know, this didn't happen, if we all know it did happen.

So there are rules as to what you can do as a defense attorney when evidence is suppressed or what have you. You know ways you can argue it to the jury that are still ethical and, you know, don't -- don't clearly misstate the situation and, you know, obviously one of the examples I've given.

So, you know, I think that --

MR. WRIGHT: Let me respond to a couple points. You keep presuming that some portion of those 107 actually got hepatitis C at the clinic.

THE COURT: Well, accurately --

MR. WRIGHT: And I don't know --

THE COURT: -- reported no risk factors. That's the issue. The issue is accurately reporting the risk factors. That's what you want to confront them about because anything else --

MR. WRIGHT: Right. And I --

THE COURT: -- is coming --

MR. WRIGHT: -- yeah.

THE COURT: -- from the medical records. So the only thing you could be confronting these people about was, did they accurately recall their risk factors, their drug use, their IV use, their transfusions, their sexual riskiness, all

that stuff that they're asked about. That's the only thing you're really confronting them about because other records show that they were patients and they got a colonoscopy and stuff like that.

So what is it that you want to confront them about?

MR. WRIGHT: I want them --

THE COURT: That's it exactly.

MR. WRIGHT: -- and I want their medical records because I think they got it elsewhere beforehand and they're jumping on the money wagon, and I don't believe any of the 107 got it at the clinic by the practices. And the Court and the State keeps presuming well, some part of them got them because of this, and you're basing it purely on hearsay and no confrontation.

Now I'm hearing for the first time, which is news to me, that if Labus gets on and his report comes in, he gets to hide the identity of the 107 and I can't even use compulsory process to get them here.

THE COURT: Where did you -- I -- no one said that.

MR. WRIGHT: Well, we don't know who they are, and he's not going to reveal it, right?

THE COURT: Well, that was what was litigated with the Health District that they don't have to reveal it, and there's a statute right on point.

MR. WRIGHT: So they're -- you're going to put a

witness on the stand as an --

THE COURT: I'm not putting --

MR. WRIGHT: -- expert --

THE COURT: -- anybody on the stand.

MR. WRIGHT: Okay. I'm just -- I'm not saying you, I'm just speaking generically. The State's going to put a witness on the stand who is an expert who has looked at things that only he can see and I can't. This is preposterous. There's no such thing. There's rules to deal with this. When the State wants to invoke a privilege and doesn't want to disclose something through an informant or something, the remedy is you dismiss the thing. You don't play hide the ball.

THE COURT: Yeah, but see there's two different actors here when you -- the informant is law enforcement and the State's prosecutor's office. Here you have the Health District, and they're charged with a completely different function that's unrelated to law enforcement or criminal -- you know, criminal proceedings. That's not their concern.

Their concern is the spread of disease. And, you know, other -- well, essentially the spread of disease, whether that's through a lack of cleanliness or smoking or infection or whatever. That's what they're charged with doing. So I don't think that's, you know, necessarily the analogy.

MR. WRIGHT: I'm not --

THE COURT: Because you have -- even though it's all the government, their functions are completely different than a police agency whose function is apprehending criminals and getting cases ready for prosecution. I mean, to me the prosecutor's office and the police or the FBI and the US Attorney, they're working together with a shared goal, whereas the Health District does not have a shared goal with law enforcement and the District Attorney's Office. It's completely different functions.

MR. WRIGHT: They should have thought of that before they decided to hook their wagon to the Southern Nevada Health District report and method because it is their case, it is the report they want in. They chose to adopt it and turn it into a criminal case. And you find for me -- let the State find, I don't care if it's a Guantanamo case -- find it with national secrets, find something where a witness can get on the stand and he has knowledge about something which only he can see and I can't and I'm cross-examining him.

There is no such case. The remedy is those cases are dismissed if that's the option of the State to proceed with it. They -- they're the ones that have created this mess. They -- and why didn't -- on the prior question on the 107, was any follow-up done? Were they interviewed? Were they tested? Was genetic testing done? The answer to that,

oh, all will be from Brian Labus, no, because we didn't care anymore because we're not criminal investigators.

Once we saw the unsafe injection practices and saw propofol use, even if there had been no hepatitis C, we were doing the notification because it put people at risk. And so further investigation or verification didn't even matter. That's -- that's why they did nothing. And so there was no further investigation. And that's exactly what he said in his deposition.

And so the State just adopted it and said, oh, okay, we're done too. So I -- my -- I still say if they -- if they can't put it on, I have the right to ask my questions and draw inferences, and I open the door to them using proper rebuttal, lawful with confrontation.

I presumed -- I didn't -- there's so much involved in this. I've -- when I was standing up there saying, you know 107, you know, why didn't you bring them into the grand jury or something, I presumed they knew the 107 people we're talking about that are in -- that are identified in Southern Nevada Health District report.

And so this is the first I'm hearing that they don't even have access to it.

THE COURT: Well, you knew that they didn't have access because that was litigated in here when they subpoenaed the Health --

MR. WRIGHT: That 107?

THE COURT: -- the Health District --

MR. WRIGHT: I thought we were talking about the two dates.

MR. STAUDAHER: It doesn't -- and as the Court will recall, Counsel for both defendants stood mute about the whole issue. We had litigated it trying to get that information out thinking that it would be important, and they never said, We need it as defense attorneys for our case, not --

MR. WRIGHT: I'm supposed to help --

MR. STAUDAHER: -- a single one --

MR. WRIGHT: -- the State?

MR. STAUDAHER: No, it's for your own defense. That's what you're trying to do now, and that's the issue that they stood mute on, didn't litigate back then when this was brought up. They knew it was going to be an issue. They didn't indicate at all, not one time, that they required or requested or wanted it for confrontation clause purposes for their investigation, for anything. They didn't say anything. They just stood back.

The Court ruled and we abided by that that we could not get that information. If they weren't going to give it to -- give us the information on who was tested and not tested when -- or were lost to follow up on patients that we actually knew the names of on the very days in question, they certainly

were not going to give it to us in any other stance. They've always fought us in finding out identifications of people. Personal identifiers --

MR. WRIGHT: I didn't --

MR. STAUDAHER: -- that's what they use as their basis all the time is they cannot, will not, under statute be able to provide personal identifiers for any patient. I mean, that's their position.

MR. WRIGHT: How I can be accused of sandbagging the State by saying the State has the burden of proof and has to gather and put on all the evidence is beyond me. I was supposed to join in the government's request to gather evidence to prosecute my client? Am I hearing right?

MR. STAUDAHER: No, that's not what was said and what was meant at all. It's that this issue was litigated with them present. There was not a mention that they required the --

MR. WRIGHT: I don't remember --

MR. STAUDAHER: -- information for their own purposes.

MR. WRIGHT: -- filing anything.

MR. STAUDAHER: Now, here we are in the middle of trial and they're claiming they want access to that information. I mean, it's --

THE COURT: Well, no, they -- they're saying that if

you're going to put on the evidence you need to put on the evidence, meaning, the evidence of who had it.

MR. STAUDAHER: But the Court could order Mr. Labus to provide that information.

THE COURT: Well, we litigated that already, Mr. Staudaher, and there's a -- in my view there's a statute right on point that protects the Health District. And frankly, the legitimate concerns of the Health District in preventing the spread of disease and having an open exchange with the Health District are just as significant as the legitimate goals of the Clark County District Attorney's Office in prosecuting offenders.

So I can't say that your goals are superior to the goals of the Health District, which have been recognized and protected by the Nevada legislature. So, you know, I'm not going to reverse my order and order Mr. Labus to do something that he didn't. And as was argued and pointed out by Terry Coffing, the attorney for the Health District, there were other ways for the State to get that information.

And in fact, I could sit here right now and I could pull up Odyssey and I could read to you the names of infected plaintiffs if we were going to go that route, but I'm not going to do that. But if I could sit here and do it, certainly the District Attorney's Office could have investigated the civil lawsuits that were filed.

Look, you had good cooperation, as I understand it, with Ms. Killebrew and Bob Eglet's office, Mr. Ham who has been here and Edward Bernstein's office. And these were the big plaintiff's firms that handled the litigation, and there were some others as well, but there were a lot of plaintiffs' firms involved in most of these cases.

You know, you may have been even able to get them to share, you know, copies of the complaints that were filed in connection with the infected lawsuits. So, you know, to stand there and say, oh, this was our only source of this information, when I could sit here right now and find the information for you, although that's not the Court's role and I'm not going to do it, I'm not, you know, to me that's not very credible. Because like I said, I don't know, did you ask Ms. Killebrew? Did you ask Mr. Ham? Did you ask Ms. Weiss? The lawyers that we've seen here in this courtroom in connection with the plaintiffs in this case, did you ask any of them? Hey, who are your other infected clients? Hey, can you give me copies of the complaints you filed in these cases? Was that done?

MR. STAUDAHER: Ask for complaints for noninfected patients, no, we didn't ask that.

THE COURT: Or in -- other infected patients?

MR. STAUDAHER: Or other infected patients beyond those listed in our case?

THE COURT: Yes.

MR. STAUDAHER: No, we did not.

THE COURT: Well, how hard would that have been? How hard would that have been to say, hey, Ms. Killebrew, you mind helping the State out here? Who else -- you know, who else do you know who is infected?

MR. STAUDAHER: One of the issues --

THE COURT: All I'm saying is for you to stand there and tell this Court, oh, the only way we could get it was from the Southern Nevada Health District, it's not believable to me. Just off the top of my head I came up with two ways for you to get the information. Now, if you said, yes, I asked Ms. Killebrew and she felt it was inappropriate to divulge that, okay, then that's fine. I would respect that representation. But you can't make that representation to me because you didn't even do it.

MR. STAUDAHER: Well, the representation I can make regarding that issue is that we did have conversations with both Ms. Weiss and Ms. Killebrew and the like about divulging information about their clients, the ones who are named in our case. None of that happened or would happen until we agreed that we were on the confidentiality agreement and that that covered them for those cases.

Now, I don't know that the confidentiality agreement that we signed onto in general covered us for every single

case, but we had to be assured by them -- or we had to assure them that it was related to our prosecution, to the individuals that we were naming as victims in this case, and that only then did they provide that information to us.

So it wasn't as though we were -- we even asked for a blanket because they were giving us, essentially, we need confirmation, we need you to show us that you're covered under the confidentiality agreement related to these patients and -- and Your Honor was even part of that, the signing on of us being part of that agreement.

THE COURT: Right. I'm talking about the fact that a complaint -- a civil complaint was filed. That's public record. That's not confidential. That is a matter --

MR. STAUDAHER: But it's medical records.

THE COURT: -- of public record. And it's not the defense's job to go and find those. All I'm saying is don't, you know -- you know, don't stand up there and make arguments that aren't credible because for you to say that the only way to get this information was from the Health District without trying other things is just not believable, okay?

Now, you may disagree with my order that the Health District didn't need to turn it over, but you didn't try. From what I'm hearing here is you didn't try to find it another way. Now, that's not the confrontation clause issue, which no one on your side has bothered to address, in my view.

So, you know, I -- Ms. Weckerly, do you want to take over?

MS. WECKERLY: Well, I mean, I would like to address the confrontation clause issue. I think there is a statute, and I think it's 50.085 that allows an expert to testify regarding matters that would be otherwise inadmissible. I will tell the Court I haven't, like, looked up all the cases associated with that statute, but all the time, I mean, we asked this very expert, hey, wasn't there a case back in whatever San Pedro where, hey, it turned out it was the saline practice; that she's relaying all kinds of hearsay, saying, yes, that was the practice, this, that, and the other.

That happens all the time. Experts testify and rely on hearsay all the time in that type of setting. So I don't -- I guess I'm failing to see what the difference is when -- when Labus does it for our case. I mean, I -- I think that he can talk about studies he knows about that he didn't have anything to do with. Experts have a wide range of what they can testify to.

Now, in terms of the confrontation clause, I think that's what's specifically addressed in the wording of the statute, that it's information that would otherwise be inadmissible. The defense can certainly ask him, well, you don't know, you know, if this person falsely reported, if they're a drug user, or whatever.

So certainly the jury can weigh the weight of what

he's saying, but I -- I guess I'm missing how that statute doesn't directly address this issue. But admittedly, I haven't done all the research on it, but, I mean, in my head this happens all the time.

THE COURT: Yeah. I mean, that's basically what I was saying, Mr. Wright, when epidemiologists -- they rely on this kind of information all the time. That's what they do. That's what they -- that's what they do to determine how has a disease been spread. They have to rely on people's reporting. Oh, wait, you know, I mean let's look at the recent outbreak of Salmonella. I ate at this restaurant. I had the -- you know, I had this, I had that; that's what they study. I mean, that's how they do it.

MR. WRIGHT: I couldn't disagree more. I -- there -- I don't know of the exception to the confrontation clause. They aren't using this as an expert to bolster his opinion. They are wanting Labus to say 107 other people were infected, clinic associated. That isn't an expert opinion or anything else. And experts cannot testify -- if an expert gets on the stand, I've had experts disqualified in IRS cases because the information they looked at was confidential informant information which I -- or was suppressed information.

And so if I cross-examine them to fully get out the basis of their opinion, they'd get to slide in that which is otherwise inadmissible. And when you present that with an

expert witness, then they have to find a different expert --

THE COURT: Yeah, but you're talking about --

MR. WRIGHT: -- because expert witnesses are fungible because you can replace -- if Labus is nothing but an expert coming here to tell us things, get a different one.

THE COURT: Well, first of all, I think there's a difference between evidence that they're not presenting and evidence which has been affirmatively suppressed by the Court or they've said, hey, State, disclose your confidential informant, and the State or the government says, no, we're not going to do it. That's -- or, you know, they didn't use -- have a search warrant. And we -- the Court says you needed a search warrant; this evidence is suppressed.

To me that's different. If they then try to get around a Court order through an expert or something like that, that's a different situation, completely different, and in my view would be completely inappropriate because at that point you're circumventing a Court order through trying to, you know, bootstrap it in through an expert or something like that.

And let's not forget the purpose of the suppression rule. It's to detour unlawful police and State conduct. So that's really offensive if that's what they would do in that situation. This is a different situation.

Look, here's what I'm sort of -- I'll think about it

further. Here's what I'm leaning towards, is allowing whichever expert to say that basically. We were able to identify, you know, 100-plus, or whatever the number is, cases of hepatitis that we could not attribute to another source, but we couldn't link it definitively to the clinic either. Because as I understand it, that's the truth.

Ms. Weckerly, is that the truth according to how you understand the evidence?

MS. WECKERLY: Yeah, I mean, I -- my recollection is he -- not alone, but he put people in different categories, and if they had any of a -- if they reported any of the risk factors, they didn't go into their calculation because they couldn't eliminate that as a possibility.

THE COURT: Right.

MS. WECKERLY: And so of that, you know, I mean, I'm sure they've got hundreds and hundreds of people, but of that where they --

THE COURT: Right. So then you're left with 107 --

MS. WECKERLY: Right.

THE COURT: -- that you couldn't attribute to another -- another cause, but you couldn't decisively attribute it to the clinic either. By "decisively", it's not linked genetically --

MR. STAUDAHER: Right.

THE COURT: -- you can't attribute it to a source

patient, so you've got this number out there that scientifically hasn't been linked to the clinic but they can attribute it to an outside source. I mean, I -- is that accurate? That sounds --

MR. STAUDAHER: Well, I -- the only problem I have is when you say "scientifically" because they did run through their -- whatever their statistical analyses and whatever based on the results of what they got in their investigation, which did not include, obviously, the genetic link because it wasn't there, or the fact that there was, you know, an observed transmission, you know, an unsafe injection practice on the particular day, that kind of thing.

But with regard to what they did have, they did use some sort of analysis and it was -- it was my understanding they used both a statistical as well as some other computer-based analyses to do some of this work.

THE COURT: Well, maybe I'm going to hear from Mr. Labus, then, out of the presence of the jury, so he can explain to me the statistical analysis and show me he has a basis -- I mean, I'm assuming, based on what he does, he would have the sufficient knowledge to testify regarding statistics and how it works and, you know, et cetera.

But otherwise it's going to be the way I just said it, that they couldn't determine an alternate cause and they couldn't link it absolutely to the clinic. So there is this

number out there that we just don't know for sure. It could be the clinic, and I think that that then -- I think that -- that that's the truth. And I think if it's, you know, if it's not said it's absolutely the clinic, but we can't attribute it to another cause, then that's -- we can't attribute it to another cause because they didn't give us another reason.

MR. STAUDAHER: He will not come in and say that.

THE COURT: Now, were they being inaccurate? Were they forgetting? Were they lying? Okay. Maybe. But you still can attribute it to another cause given all these things.

MR. WRIGHT: But what I --

THE COURT: That's the truth.

MR. WRIGHT: -- but what I am losing there --

THE COURT: It's fine.

MR. WRIGHT: -- is my right to test the evidence when he says that because what I'm understanding is, I just have to accept it as given, and I can't say tell me who they are and show me their medical records --

THE COURT: Yeah, but you can --

MR. WRIGHT: -- because I don't believe any of them got it. That's my position.

THE COURT: Well, you can --

MR. WRIGHT: So how do I challenge it?

THE COURT: Yeah, by cross-examining him. That --

MR. WRIGHT: And he says, I can't tell you.

THE COURT: -- that his statistical model is flawed.

MR. WRIGHT: I'm not talking model, I'm talking about he has a -- he contends there are identified, known people -- I don't even know if he's looked at their medical records. I don't know if he's verified they didn't have it already.

THE COURT: Well, then that's part of your confrontation and your cross-examination of him.

MR. WRIGHT: Okay. As long as he --

THE COURT: You know, look at their medical records.

MR. WRIGHT: -- reveals it.

THE COURT: You don't know if they had surgery. You don't know if they did this, that, or the other thing. You don't know if they ever had drug rehab. You didn't look at that, you didn't look at this, whatever you want to ask him. I mean, that's -- that's right there, that's your cross if you want to go that way.

MR. WRIGHT: I want to cross them.

THE COURT: Well --

MR. WRIGHT: And he's not going to tell me. He's going to say, Mr. Wright, I got 107 and I won't tell you who they are and I won't show you anything about them. I'm just telling you take my word for it because we talked to them and they don't have any other risk factors. That -- I'm -- where is this whole right of confrontation to the information?

That's hearsay what they've told Brian Labus or his employees.

THE COURT: Well, to me you can point it out in your cross-examination that his information is only as good as the information he received, which they could have been underreporting, misreporting, falsifying that some of this behavior is not -- is taboo, is illegal behavior. There's a million reasons why people aren't going to accurately report.

MR. STAUDAHER: And I believe he will acknowledge that. I don't think that there's any surprise there. He's going to get -- if he gets on the stand and is asked those questions, I think he'll say exactly what the Court just said, that they have to rely on --

THE COURT: All right. Going forward --

MR. STAUDAHER: -- those people.

THE COURT: -- Mr. Wright, going forward with this current witness, what is it that -- because we were stopped at your line of questioning. So, you know, when we come back tomorrow where is it that you're going -- going to go?

MR. WRIGHT: Well, I'll tell you where I want to go, but at the same time I'm not sure if the Court is going to tell me if I pursue it, I'm opening the door --

THE COURT: That's why I'm asking --

MR. WRIGHT: -- for hearsay.

THE COURT: -- you -- that's why I'm asking you.

MR. WRIGHT: Oh, okay. What I intend to do, I mean,

I had asked her why she chose the CDC is lumping July and September as a common cause. And I said, Why are you presuming that the method of transmission for these two discrete dates were the same? September date, I can fully understand. The July one I don't. And her --

THE COURT: That's a fine question. That doesn't open the door.

MR. WRIGHT: No, her answer to me then was, Well, because the same CRNA who did the work in September using improper practices was the same CRNA in July. Okay? That was her answer. And then I think I responded that's the same CRNA who was working every other day of the year also. So I don't see the commonality because the commonality would be the same for the whole year.

And I was -- that was perceived that I was leaving the inference that there weren't any others out there. Probably was. But that's how we got to where we were because I don't know why she -- I mean, I started off saying, Look, you had -- both of them had biopsies, and that's a method of transmission, meaning Washington and the source. They both had a biopsy and all it took was for a transmission of hepatitis C where someone reused the biopsy which there has been evidence that that happens here.

And so why did you just blindly presume it's the same as on the 21st of September other than this? And her

answer was because it's the same CRNA was working on that day. And then I said, well, same CRNA worked 300 other days that year too.

THE COURT: Let me ask this: Of the 106 other people did anybody at the Health District try to do -- chart those people out as to who worked on those people? Because they know who they are.

MS. WECKERLY: I mean, I know from reading a deposition that I think Mr. Lakeman is named in other, you know -- just from, like, the text of it that it has to be, but I don't -- I don't think the Health District classified anything by -- I mean, I'm not sure, I could ask them -- by CRNA.

THE COURT: You know what I'm saying? Like, or did they say, okay, we have 109 people who may have been infected or it looks like they were infected at the clinic? Five were infected on the same day, you know, five had their colonoscopies on the same day, or is it 109 different days? I mean, what are we looking at? Didn't they do anything like that? Do you see what I'm saying?

MS. WECKERLY: Yeah.

THE COURT: Because they know who their names are, they have -- they could have had the records, so did they even bother to go through and say there were other cluster days, or is it 109 different days? Is it 50 days? I mean, I don't

know. I'd kind of like to know that.

MS. WECKERLY: We can ask them that. I don't know if they classified it that way, but we can ask.

THE COURT: Wouldn't anybody else be curious about this? Were there cluster days --

MR. WRIGHT: I'm curious.

MR. SANTACROCE: I'm curious.

THE COURT: -- or not cluster days or --

MR. STAUDAHER: Well, the civil --

THE COURT: -- is it --

MR. STAUDAHER: -- on the civil side we've heard that there are identified other cluster days. I'm not sure if the Health District looked at that or if they agreed with it or they tried to do that. That's --

THE COURT: Because that to me would be fairly easy to do. I mean, of all the 109 patients, you know, you basically have two procedures going on, colonoscopies and endoscopies, and it's pretty easy to, you know, say, well, my endoscopy was this day and my colonoscopy was that day, you know, and the other people, what did they have? What days were those? And are there clusters or not clusters?

MS. WECKERLY: We can ask them.

THE COURT: I mean --

MR. SANTACROCE: But from my perspective for my client, the fact that she has linked him to these two days

because he was the same CRNA who had these supposedly unsafe practices puts me in a bind because now they want to bring up 107 other people to infer that somehow my client was involved in their treatment without allowing me to find out if he was doing the treatment.

THE COURT: Well, I --

MS. STANISH: Well, we're going to do it now in the middle of the trial. Good time to investigate the case. Good time.

MR. SANTACROCE: So I have a dilemma there, and just for the record, I'm joining in Mr. Wright's objection. And that's the dilemma. I have to infer now 107 other people have it when she's let the cat out of the bag saying, well, we hooked -- we linked these two dates because Mr. Lakeman was the CRNA, well -- well, what about the other --

THE COURT: Well, it could either be really good for you, Mr. Santacroce --

MR. SANTACROCE: Could be good or it could be bad.

THE COURT: -- or really bad for you.

MR. SANTACROCE: Yeah, it could be very good or bad, you're right. But I don't want to take that chance.

THE COURT: Well, I know you don't want to take that chance, but I don't know, to me what -- I mean, I'm sitting here wondering, it may neither be here nor there, you know, wasn't this all linked? They do this big thing linking these

days, and what about all these other days? What -- who did what when and -- I don't know.

MS. STANISH: Yeah, maybe someone should have investigated that a long time ago if we're going to present it in a criminal trial. You know, we basically have criminalized a malpractice case, criminalized a epidemiology investigation, and as Mr. Wright pointed out, hooked the wagon to that, and it's -- plenty of ways to, as the Court has pointed out, to do this investigation.

They made their bed; they have to lay in it. They shouldn't put -- we shouldn't have to sacrifice our constitutional rights because they elected to proceed this way.

THE COURT: All right. Well, I'm going to think about it. I would suggest at this point, because I'm not sure how we're going to handle this, that the State needs to talk to Mr. Labus or whomever and find out -- there may be exculpatory evidence here is the other problem for Mr. Lakeman. What if --

MS. STANISH: Exactly. And you're --

THE COURT: -- what if they linked all these other days and it's other nurse anesthetists --

MS. STANISH: Right.

THE COURT: -- because now you have this --

MS. STANISH: Right.

THE COURT: -- this person saying to -- when I say exculpatory, it doesn't necessarily exculpate him on those days; but if she's saying, well, it's him and the other days, you know, it's different CRNA's or it's the same, I don't know, there could be something there.

So what I'd like the State to do is to try to find out what they did on -- about these other 109 people. Did they link them on days? Did they -- what investigation? What do we know there? Because there could be something here -- like I said, it could be good information for Mr. Lakeman. I just don't know. But I think at this point --

MS. STANISH: Your Honor, this is --

THE COURT: -- before, you know, we consider introducing it, I think we need to know more. I mean, I know it's in the report and I will say this, you know, Ms. Stanish, you say, Oh, wow, they didn't do their investigation. We've had -- you've had this report, so, I mean, these are questions that would be -- come up.

MS. WECKERLY: I mean, the other thing I would say is, if they thought there was exculpatory information in there, they're all aware of it. I mean, they're aware of the existence.

THE COURT: That's what I just said --

MS. WECKERLY: Like, they could go get it.

THE COURT: -- they're aware of the report. The

report has been -- been here.

MS. STANISH: My -- you know, my issue, you know, Your Honor, if you're saying let's get more information about this, let's bring in additional evidence pertaining to 109 potential other cases, you know, what about our right to discovery of that information? I mean --

THE COURT: Oh, I'm not saying, Ms. Stanish --

MS. STANISH: -- how --

THE COURT: -- you're going to introduce it. I just think at this point in evaluating -- I -- I mean, I just would like to know what did they do, you know? What are the days? Are there clusters or not clusters? You know, I'm assuming it would be in the report if they -- if they had done additional work, but I don't know and I don't want to rely on assumptions.

So I'd at least like to know -- I'm not saying you can present it to the jury --

MS. STANISH: I understand.

THE COURT: -- but at least the other information will be out there. I'll understand and hopefully you can make a better determination on what's going to come in, and it will also be in the record for any potential appellate purpose, you know. Again, as to -- because I'm sitting here left with these questions. You know, I don't think the 109 people are necessarily put in a context unless we know, is it 109

different days? Is it 10 days? What is it?

I think that that -- I think that that could be very important. And, you know, as Mr. Lakeman, if it's Mr. Lakeman on the other, you know, 10 days or whatever, I'm not going to let you introduce that because that wasn't disclosed ahead of time, but Mr. Santacroce certainly would like to know that --

MR. SANTACROCE: Yeah.

THE COURT: -- before he goes, you know, going forward on cross.

MR. SANTACROCE: Exactly.

THE COURT: So okay. That's where we are, and I'll think about it and the more information we have, I think the better.

(Court recessed for the evening at 5:14 p.m.)

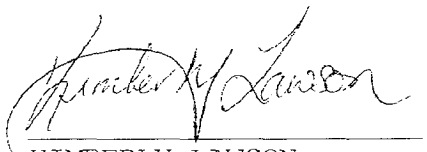
CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT FROM THE AUDIO-VISUAL RECORDING OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

AFFIRMATION

I AFFIRM THAT THIS TRANSCRIPT DOES NOT CONTAIN THE SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER OF ANY PERSON OR ENTITY.

KARR REPORTING, INC.
Aurora, Colorado



KIMBERLY LAWSON

COPY

Electronically Filed
03/11/2014 12:58:23 PM

CLERK OF THE COURT

TRAN

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

THE STATE OF NEVADA, Plaintiff, vs. DIPAK KANTILAL DESAI, RONALD E. LAKEMAN, Defendants.	)	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT NO. XXI **TRANSCRIPT OF PROCEEDING**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 29

WEDNESDAY, JUNE 5, 2013

APPEARANCES:

FOR THE STATE:	MICHAEL V. STAUDAHER, ESQ. PAMELA WECKERLY, ESQ. Chief Deputy District Attorneys
FOR DEFENDANT DESAI:	RICHARD A. WRIGHT, ESQ. MARGARET M. STANISH, ESQ.
FOR DEFENDANT LAKEMAN:	FREDERICK A. SANTACROCE, ESQ.

RECORDED BY JANIE OLSEN COURT RECORDER
TRANSCRIBED BY: KARR Reporting, Inc.

INDEX

WITNESSES FOR THE STATE:

EXHIBITS

LAS VEGAS, NEVADA, TUESDAY, JUNE 5, 2013, 9:05 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: Since we're waiting on the jury, let's begin where we left off last night. Does the State have anything new to report?

MS. WECKERLY: With regard to what issue?

THE COURT: The issue of the 109 people -- 107 people who were infected.

MS. WECKERLY: They didn't -- they -- my understanding, although I haven't completely verified it, is that they didn't look for a cluster because they couldn't do genetic testing on it, so they -- that's what they define as a cluster --

THE COURT: Right. So they didn't do --

MS. WECKERLY: -- and it was too remote in time.

THE COURT: So they didn't do a day analysis or a provider analysis or anything like that?

MS. WECKERLY: No. They may know that there's more than one on that day, but they wouldn't call that a cluster because they couldn't do the source, you know. But they didn't divide -- and I know they didn't divide by CRNA.

THE COURT: Okay. Do you have the information, like how many were on a particular day? Do they do that, or do they just kind of say, well, we think, you know, that some

were on the same day but we don't really remember, or what? What's the gist of the information?

MS. WECKERLY: We're trying to get that. I don't have that information right now.

THE COURT: Okay. Because they didn't compile it in any kind of a format where it could be transmitted to you; is that essentially the situation?

MS. WECKERLY: I think so.

THE COURT: Okay. All right. Anything else -- basically, here's pretty much where we left off Friday. I mean, I think the State can say there were 109 other people who were infected that they -- through their own reporting or interviews with them, they couldn't attribute to another source, but they couldn't scientifically or definitively link it to the center. That's pretty much it.

So they can't say where it -- you know, they -- it's not linked to another source and it's not definitively linked to the center, but there's other people out there.

MR. WRIGHT: I object to it on hearsay and confrontation. I mean, there was no evidence I have available to me to establish the 109. I don't have their medical records. I don't have their interviews. I don't have them saying they weren't -- they're risk free. I'm supposed to take the State's word for it. What do you mean, they just get to say we say 109 people have hep C?

THE COURT: Well, I think if the door is opened, then --

MR. WRIGHT: The door's open to hearsay?

THE COURT: Then their testing is we tested --

MR. WRIGHT: Why not say 10,000?

THE COURT: Well, because that's not what the evidence is. The evidence --

MR. WRIGHT: What evidence?

THE COURT: -- is 109 people. I mean, they can say we tested -- we sent out 60,000 letters, you know, 45 people -- 45,000 people came in for testing, of those 45,000 people 1,000 people tested positive for hep C or whatever, or AIDS.

Of those 1,000, through self-reporting, 500 were attributed to other sources, 109 we couldn't attribute to other sources, but we didn't scientifically link to the center. And the nine or whatever we have here we were able to link scientifically to the cluster days through the work of the CDC.

MR. WRIGHT: I want the discovery, that summary evidence you're doing. And for summary evidence, I have to have the right to everything that supports it. I don't have the 109 phantom infected people. It's not delivered to me. I don't have their records. I don't have to take their word for it. This is a criminal trial. I have confrontation

rights.

THE COURT: State.

MS. WECKERLY: Well, we've done -- Mr. Staudaher, we've done some research on that, on introducing that type of recording. We can present those cases to the Court. I'm sure you want to review them before you make a decision.

But I just draw a little bit of a distinction here. When we have a case where someone does a bad search and they find a gun, there's no mention of the gun in the trial. And I get that that's a constitutional remedy. But it's a curative. It's a shield. It's not something that then you can get up and say there was no weapon ever found in this case.

THE COURT: I agree. That's why I said to Mr. Wright --

MR. WRIGHT: Can so. I can too.

THE COURT: -- now you can say there was no evidence, the State did not prove their case because they didn't present any evidence of a gun.

MS. WECKERLY: Right.

MR. WRIGHT: I can say that.

MS. WECKERLY: And so I actually look at this sort of different --

MR. WRIGHT: Are you telling me I can't?

THE COURT: You can say just what I said.

MR. WRIGHT: Right.

THE COURT: But you can't put your client up on the stand to say, oh, they didn't find a gun, because then they're going to bring in the fact --

MS. WECKERLY: Well, I think it goes farther. I don't think you can ask a witness -- I mean, these two women know there were other cases, these two doctors, and certainly Labus knows that. You can't not let them answer that.

THE COURT: You can't ask a witness to lie essentially. You can't tell a witness that they can't testify truthfully because they're under oath; is that what you're saying, Ms. Weckerly?

MS. WECKERLY: Well, I see it as twofold. I don't think you can use it as a sword or use it affirmatively. I think, you know, the Court can make whatever ruling the Court wants to on the actual CDC report. But I think it's a different question if they're allowed to create a false impression with witnesses.

And I think when you ask questions like, well, there was no infection in the other 300 days when they believe there was from their testing, that that's -- that's now you've crossed into a different line and opened the door regardless of the ruling.

THE COURT: And you've opened the door.

MR. WRIGHT: Through hearsay. I've opened the door to legally admissible evidence. I haven't opened the door to

say, okay, now we get to throw the rules of evidence out.

THE COURT: No, because --

MR. WRIGHT: This is summary evidence.

THE COURT: -- when you ask a question, the witness is entitled to provide an honest answer as best as they can. And these are scientific people, so when you ask them who rely on hearsay all the time in their studies of the spread of disease --

MR. WRIGHT: Which I am entitled to.

THE COURT: -- that's what -- that's what they do. That's how they study disease.

MR. WRIGHT: Everything --

THE COURT: They have to rely on reporting and things --

MR. WRIGHT: Everything an expert says I have the right to. He can rely on hearsay and he has to deliver to me the articles that he's read. In this case, and it isn't I'm playing unfair, I'm hiding. They have to present the evidence. I'm contesting every fact in the case. I entered a plea of not guilty, and so that's what we're doing.

And just because they presented this case the way they chose to present it and just stayed with CDC and Brian Labus and did nothing else when they had the ability to, that doesn't come back to roost on me to where I'm hearing you opened the door and now hearsay's allowed and you don't have

the right to have the evidence that they are going -- that the witnesses are going to be relying upon.

How do I examine them, cross-examine them on the 106?

THE COURT: Well, if you ask her though, there were only these two days identified and she --

MR. WRIGHT: I didn't ask her that.

THE COURT: -- wants to answer truthfully, then she's going to answer, well, we actually identified other days, or -- because that would be in her -- in the -- as I understand it, in the witness's view, a truthful and complete answer.

Is that essentially what you're saying, Ms. Weckerly?

MS. WECKERLY: Yes. I mean, they couldn't do the testing on that. So from their perspective, if they can't do genetic testing, I mean, you know, it's different to them. And there were two -- I mean, I think a lot of this is, you know, there were 250 or so plaintiff cases, and we don't know necessarily which one of those the health department categorized which way, because some of those people might have had risk factors and wouldn't end up in the 109.

But I mean, I guess we are just asking on cross-examination there shouldn't be a false impression created. We'd like the Court to review the caselaw we found on admitting the report in its entirety. I look at those as two different issues.

THE COURT: Right. I agree they're two different issues.

MS. WECKERLY: So I mean, that, where we're at now is we don't think that's a proper question on cross or the witness gets to answer. And then in terms of the report, we'd like to submit the cases for the Court's review.

THE COURT: I'll look at the cases on the report. I mean, to me looking at the report, it's a 300-page report. It's more of an investigative type report. The report is one thing. The issue is does the information come in about the 109 other people; does it come in because they open the door to it, does it come in because it's in the report? I mean, just because it's in the report, if it's not admissible, then I don't think you can sort of bootstrap it into the report.

So, you know, the issue right now is whether or not it's going to come in through Mr. Wright opening the door to it. I agree with you there. I'm happy to look at the question -- at the caselaw that you found. Again, you know, this is not a simple, you know, you say, well, it's part of the ordinary course of their business. Well, that's somewhat true. They investigate outbreak of disease.

But this is a very comprehensive report. This was an unusual outbreak. It's one of the biggest hepatitis outbreaks in the country ever. It's not?

MS. STANISH: No, ma'am. It's the largest

notification that's --

THE COURT: Oh, I'm sorry. I confused that.

MS. STANISH: -- been sent out. But there are plenty of others that have had more people infected.

THE COURT: In any event, my point was it was an unusual situation. And so, you know, to say, well, this is ordinary, in the ordinary course of their business while they're charged with doing investigations, you know, this report, I'm inclined to say no. But I'm happy, I'm glad you found some caselaw. I'm happy to look at it. Certainly the defense should be provided with whatever it is you found. And if they find other things, I'm happy to read those as well.

So Mr. Wright, you know, here we are going forward now. What is it that you want to ask the witness?

MR. WRIGHT: Well, first I want to object to me being told that I can't fully cross-examine a witness who's testifying because if I do, I'm opening the door to hearsay and evidence that will not be presented to me. This is just like a witness who has state secrets or some privilege, and so I'm supposed to dance around them because the State put us in this box, and tread carefully and not fully cross-examine.

So when this witness says, when I say why do you call July a cluster when it's two and why do you even link it to September, well, because the same CRNA was involved in both days. And so to me that's preposterous, because the same CRNA

was involved not just on those two days, the entire year. And so that's her explanation that she gave me.

So now I'm just supposed to accept it and not say that's preposterous, the CRNA worked all year. What is the real reason you're linking them; that's what I asked her. And so now I'm being told I can't go there because I'm waiving an interest.

THE COURT: That's a different question than what --

MR. WRIGHT: That's what I asked.

THE COURT: Well, you started with the CRNA worked all -- worked other days. Well, yes, but the other days there may or may not have been infection.

So the inference was, well, he worked all these other days and there wasn't infection on those days. And what I'm saying is there may or may not have been infection on those days. We don't know and we don't know what her answer is going to be. And I'm not going to tell her, you know, she -- she's okay, you know.

MR. WRIGHT: Okay. I won't pursue it.

THE COURT: No, pursue it.

MR. WRIGHT: On the Court's instructions --

THE COURT: Pursue --

MR. WRIGHT: -- I won't pursue this --

THE COURT: No, no. Wait a minute.

MR. WRIGHT: -- further.

sending updates and what we're seeing and finding.

Q Okay.

A And so Joe Perrs was my supervisor in my division, and that's who responded.

Q Okay. Now, when you and -- you and Gayle come out. And you're the field team?

A Correct.

Q And you are the only two members of CDC here?

A Correct.

Q Okay. And you came out on January 9?

A Correct.

Q Report had been received to CDC on January 2?

A That is my understanding, but I didn't receive that --

Q Right.

A -- report.

Q But it was, like, two cases and then jumped to three --

A Yes.

Q -- and the commonality for that was all three of them are -- had a procedure done at the same clinic and two of them on actually the same date --

A Correct.

Q -- correct? And that raises a great big red flag to begin with that -- it would be might coincidental that

three acute hep C cases, all one clinic, two on one day?

A Correct.

Q And so that bears further investigation, right?

A Correct.

Q And the CDC is at the beck and call of the states to come to help?

A They contacted us for assistance, and so we were happy to provide assistance.

Q Okay. But you -- you all don't have jurisdiction. Even though you're the feds, you can't just jump in without an invitation?

A Correct.

Q Okay. And so you were invited by the appropriate authorities --

A Yes.

Q -- to come and participate?

A Yes.

Q And as you understand it when you -- and did -- was Gayle or yourself higher in -- who was the boss between the team?

A Well, so it's very collaborative but Gayle was a second-year officer, I was a first-year officer, and so the Division of Viral Hepatitis was taking the lead in the investigation. So, you know, I think it was -- we worked great together, it was a joint investigation, but I would

consider her the lead author; she's the senior author on our publications --

Q Okay.

A -- et cetera.

Q And she had one more year than -- than you?

A Correct, at CDC and that training program, yes.

Q Okay. And each of you were beyond the fellowship training and are now called what?

A What is my position now?

Q Yeah.

A I'm a medical officer.

Q Okay. And Gayle also?

A Yes.

Q Okay. Now -- as you understood it when you arrived, you already had been doing background investigation and research in preparation?

A I mean, we had been meeting with our supervisors to get ready to travel and that also involved, you know, generating early drafts of abstraction forms that we would use to review medical records and questionnaires that we can modify in the field so that we would have stuff ready to go to hit the ground running.

Q Okay. And you -- you understood that no contact had been made by local -- what I'll call the local health authorities with the clinic?

A That is my understanding.

Q And you arrived and so that the first notice to the clinic of the investigation and the fact of hepatitis C transmission there would have been when you all walked in the door on January 9?

A Right. So at that time it was potential transmission, right --

Q Right.

A -- we hadn't confirmed anything, and the phone call from the health department when we arrived before we got to the clinic, I think was the first notice that the clinic had that we were there doing an investigation.

Q Okay. And the phone call was -- were -- as you understand it, was we're coming over?

A Yes. I don't know what additional information was --

Q Okay.

A -- provided, but yes.

Q And so then the we're coming over, it was you and Gayle, Brian Labus, you recall --

A Yes.

Q -- Southern Nevada Health District --

A Yes.

Q -- and a representative or more from BLC, a state licensing agency?

A I -- I'm certain about Gayle and myself and Brian and I'm fairly certain, but couldn't tell you the name of the BLC person.

Q Okay. And you weren't -- you were doing a, what I'd call a public health investigation?

A Yes, sir.

Q And so you -- you were not keeping reports of who's present at a meeting, who said what, like a law-enforcement investigator might do?

A Correct.

Q Okay. So, like, when -- when you say that first meeting probably late afternoon on Wednesday, that was the 9th --

A Is that the 9th?

Q -- was a Wednesday.

A Okay.

Q You don't have any report you can go to on that to determine who all was present and who said what?

A So I have the notes that I took, which you all have which I think, you know, I wrote, Tonya and, you know, had some question marks of other names; but I didn't write date, time, you know, documenting name and title of everyone present, no.

Q Okay. And is -- and is that -- on those 32 pages of notes is that first 7 pages just typed, right?

A Yes. So -- so page 1 of that --

Q Yes?

A -- is where, I think that reflects on the people that were initially there at that meeting when we walked in. And so, you know, I -- you have my handwritten notes, and then these were notes that I had typed up to help Dr. Fischer and others as she's writing reports, you know, so she can review.

Q Okay.

A So there's overlap and repetition here, but that -- where it says, Roster --

Q Yes?

A -- is the folks who would have been at that first meeting.

Q Okay.

A And where we went over -- well, sorry, I'll let you ask.

Q But the -- and so the -- the first seven pages, the typed --

A Yeah.

Q -- was a later compilation recollection putting into written form using all your notes?

A Yeah. So this typed document is not from that first-day entrance conference, it's, you know, taking stuff that you have that's scribbled and handwritten here, and trying to clean it up a little bit and -- and, you know, to

help us when we're drafting -- we were writing the trip report while we were in the field, so help with that.

Q Okay. And so the -- you all arrive, you're -- you end up in the upstairs office of Tonya Rushing?

A Yes.

Q You knew her to be, like, a chief executive officer?

A I think she was their chief financial officer, I think.

Q Okay.

A Yeah, she was a -- yes, some --

Q Okay. And Dr. Clifford Carrol was there?

A Yes.

Q And we -- Jeff K. -- Krueger -- and Katie, question mark. From being here in the court, we know that's Katie Maley --

A Okay.

Q -- I mean, the charge nurse.

A Okay.

Q And when you all walk in, who mainly does the talking?

A I think Brian did a lot of the talking. I think Gayle also chimed in. I think those were the two folks who were -- who were primarily leading the --

Q Okay. And the -- I presume -- you said -- you

told them why we're here and what we're going to do?

A Correct.

Q And that was a generic description of it. So I'm presuming you told them that there is a -- been a hepatitis C cluster. Is that the word that's used, or?

A I don't know if that word was used then, but that we had these three reports of acute infection --

Q Okay.

A -- in patients who had had procedures within the incubation period at their clinic and that we were concerned about possible transmission in the facility and wanted to do an investigation.

Q Okay. And the -- you tell them it's three patients and it's patients from their clinic and two on the same date?

A I believe so. I don't --

Q Okay.

A -- recall specifically, but yes.

Q Okay. But it was -- I mean, I'm guessing the meeting took hour or something?

A I -- honestly I can't recall the duration of the meeting.

Q Okay. But you need to explain why you all were there, and the fact that this was going forward and to seek their assistance and cooperation?

A Yes.

Q Okay. And what -- what was the reaction of Tonya, the charge nurse -- the two nurses and Dr. Carrol?

A So I can't speak about individual reactions, but my, you know, best recollection is there was surprise and concern on their part.

Q Okay. And did -- did they pledge cooperation? Not in those words --

A Yes --

Q -- but --

A -- they agreed to cooperate with the investigation, yes.

Q Okay. And any -- any questioning that comes to mind about, Are you sure? How could this happen? I mean --

A I think Dr. Carrol had some questions about how we made the diagnosis of acute hepatitis C in these folks. I don't recall other specifics because we hadn't launched the investigation yet, and we didn't go in saying, we're certain transmission happened here, this way, done. You know, it was a, we're looking into this. These are these reports.

Q Okay. And at this stage in the investigation do -- do you have -- and assuming, I mean, part of your investigation is going to be to determine that these three people -- and the number grew --

A Right.

Q -- but those three got their hepatitis C at the clinic, correct?

A Sorry, I missed the beginning part of the question, so --

Q Okay. Part of the investigation is, did they get the hep C --

A Yes.

Q -- at the --

A Yes.

Q -- clinic; and then if they did, how did they get it?

A How did they get it, and how can we keep it from continuing?

Q Right.

A Yes.

Q Okay. So as you went in at the inception, the three patients had already been screened in the sense they didn't have it before and they didn't have any known risk factors?

A So I believe the Health Department had done interviews with each of those three, which is a standardized questionnaire about -- because these folks had acute disease -- so risk factors during that six-month window that we usually consider as the incubation period from exposure to, you know, symptom onset. That's the time period back that we

go. So any risk factors during that time period, any prior positives, yes.

Q Okay. And so the acute -- just because we -- we're not as knowledgeable about this as you are -- and so the -- on the -- the three having acute, I mean, that in layman's terms mean they just got it within six months?

A Well, so acute --

Q Normally?

A -- acute means they are symptomatic --

Q Okay.

A -- so they're showing they have symptoms. And so there is a time period that we usually look at from when we do these investigations where, you know, on this date you have symptom onset, what we consider the likely exposure period of when you are exposed to the virus to become infected. And so the upper range of that is six months.

Q Okay.

A The very upper range.

Q And so -- and just so I'm making sure I understand, I -- just suppose I have hep C and don't know it; you know, I've had it for six years, just one day it doesn't turn acute?

A Right. I mean, these people had a discrete onset of symptoms suggesting acute inflammation for them.

Q Okay. And suggesting that it was newly acquired

because --

A Yes.

Q -- it's acute?

A Yes.

Q Okay. So we -- going in you know they've got hep C recently, they have no risk factors that are known by questioning them within that time frame, so it's a -- you go in already with a pretty good inclination that it may be clinic-related?

A Right. So that's part of the interview that the Health District did, and as part of that interview they asked about, you know, healthcare exposure during that time period. I don't have the questionnaire in front of me --

Q Okay.

A -- but the endoscopy procedure was during that window, and then, you know, they are the people getting these reports and so the same person was, like, wow, I just did an interview with this patient -- oh, this person said the clinic too --

Q Okay.

A -- so that --

Q Okay. Was -- and did you go in with any preconceived inkling, notion, as to method of transmission?

A Well, I mean, so before we went out and obviously our supervisors, you know, in both divisions have,

you know, quite a bit of experience with these types of investigations and the literature are talking about, you know, how transmission has previously been documented in these outbreaks, and so we were going to make sure to look at those things when we went there.

Q Okay. And you know, as you've said, I mean, it's blood-to-blood transmission --

A Right.

Q -- for hepatitis C, and so those are the areas you're going to be focusing on and paying attention to what we've historically learned have been the likely causes in the past?

A Yes.

Q Okay. And so you prepare your abstract, your chart, and you're going to go in, get the patient charts for both days?

A Right.

Q Okay. And the -- I think there were, like, 126 is what I recall from your trip report, or 120, I don't know.

A I can check the report but that sounds -- that sounds about right --

Q Okay.

A -- for those two dates.

Q And so you -- you-all, first day tell them here's what we're going to need, and that, I'm presuming it

was the first day because, as I understand it, you all were back there the next day reviewing all the charts --

A Right. So --

Q -- patient charts?

A -- right. So we, you know, we're telling them this is the investigation we're going to be doing, you know, we're going to need a space to work, we're going to need medical records brought to us, we're going to need access to review procedures and talk to your staff.

Q Okay. And it's going to be -- make staff available to -- for interviews, as needed?

A Right.

Q Make -- make the place available for observations of everything from start to finish?

A Right. We try to be as unobtrusive as possible, but, you know, and watch while they're doing their patient care so that we're not forcing them to stop seeing patients, but yes, that's correct.

Q Okay. And you -- your understanding is that the clinic -- oh, wait, you were there Wednesday the 9th, chart reviews -- all of the charts were presented, meaning all the patient charts for all the patients on the 25th of July and the 21st of September, correct?

A Yeah, so we asked for their medical chart, which is at one side of the clinic, and then the procedure char,t,

which is the other side of the clinic. I don't know if they were all provided that first day, or if they were getting them, but they eventually provided them.

Q Okay. There were no records not made available to your knowledge?

A Not that I recall.

Q Okay. And so when all this is provided you and Gayle and/or others are pouring over them --

A Correct.

Q -- and you do not copy them?

A I don't recall copying or taking any of them with us. No, we -- I think we were, you know, transcribing onto the abstraction form.

Q Okay.

A I don't recall.

Q Because on your abstraction you are going to gather out of the patient charts everything that you believed was significant for those patients?

A For what was documented in the medical records, yes.

Q Right. And so the -- having those -- what you've -- and I don't want to lock you in on time frames or anything, but your first task was to look at all of the charts, abstract them, looking for what we've called commonalities. Gee, was it one -- one doctor on each of these

or was it one this or that?

A Well, so part of what we're doing is not just looking for commonalities, but we're also looking for any other cases. You know, are there any other acute infections that weren't reported to the Health Department that, you know, so getting names to cross-match with their surveillance data and see if anybody pops up. We're looking for potential source patients, people who are known to be hepatitis C positive before they come in for their procedure.

And, you know, I don't think that we abstracted the totality of all those patients before we started doing observations. I think we started with the people that we knew were our case; you know, people who had acute disease, looking at that, and I -- again, I can't --

Q Okay.

A -- tell you when we finished versus that, but I don't think that we finished everybody before we started observing.

Q Okay. And did the -- at some point, and I can't remember the evolution of the other cases coming up --

A Right.

Q -- but as you were there, patients on the 21st of November -- additional patients with hepatitis C were identified, correct?

A So September 21st?

Q Yes --

A Not November? And yes, so eventually we did find other cases --

Q Okay.

A -- on September 21st.

Q Okay. And while you were there the number grew from three to four to five to six?

A Yes, the number grew. Yes.

Q Okay. And the -- and so knowing -- you were knowing all of that, and so then observations start -- or --

A Yeah, I don't know --

Q -- so --

A -- if we knew about these others before we started observing. I can't tell you in proximity, but observations started in the midst of this, yes.

Q Okay. And are -- how -- are patients -- patients are told. I mean, do they get consents? How does this work?

A Yeah, I don't -- so we typically rely on the clinic to get consent and to tell the patient, you know -- because I want to give them the opportunity to explain who we are and what we're doing there and in whatever terms they want to; and so I don't remember how that happened, but I do know that patients were told that we were there and gave permission, but I don't know how that was recorded or

documented.

Q Okay.

A And we certainly weren't hiding. We were standing in the room as they were wheeled in while they're awake.

Q And the -- do you all -- do you wear uniforms or anything?

A No.

Q Okay.

A I have my, you know, badge around my neck which I think I wore during the time, but I'm in clothes like I am here today.

Q Okay. And you were -- you made various observations over a nine-or ten-day period --

A Yes --

Q -- correct?

A -- we did.

Q Okay. And you, I think from reading everything, each of you, you and Gayle, like, totally observed at least one of everything?

A Yes.

Q Okay. And so you observed in the preop area? You observed procedures in the procedure room, whether it's uppers or colonoscopies?

A Yes.

Q Okay. And you have testified already to observing what we've been calling multi-patient use of propofol vials?

A Yes.

Q Okay. And that was an early-on observation of yourself of Linda Hubbard?

A Yes.

Q Okay. And you observed Linda Hubbard -- and do you recall what size of propofol vials were being used?

A I don't. I -- off the top of my head, I don't know if I've written it down. I -- I don't want to say the wrong thing so I think they were the 20cc, I'm pretty --

Q Okay.

A -- sure about that. But I'd have to --

Q Okay.

A -- dig through notes.

Q But you were aware, I mean, that the clinic was using what we call 20s and 50s?

A Yes.

Q Okay. And Linda Hubbard -- you're observing multiple procedures --

A Yes.

Q -- correct?

A Yes.

Q Do you know who the doctor was during those

procedures?

A I don't recall, no.

Q Okay. And she -- she was taking new propofol vials, drawing up, injecting patient, setting it aside -- it has partial propofol still in it --

A The vial not the --

Q -- yes --

A -- syringe --

Q -- the vial?

A -- yes.

Q Syringe she would use and appropriately discard?

A Yes.

Q Other than maybe -- wasn't there a needle issue or something?

A Yes, so she was observed, you know, walking through the room with an uncapped needle at one point, and I also observed her recapping a needle at one point, which is not safe for her.

Q Okay. If the -- just on the needle thing, recapping a needle?

A Yes.

Q Is that good or bad?

A It's --

Q I mean, I -- I hear you say it was dangerous to walk around the room with a needle and it's also dangerous to

recap the needle?

A So the right thing to do is when you're done, drop it in the Sharps container and not wander through the room with it. So you shouldn't have to recap it, and you shouldn't have to walk through the room with it.

Q Okay. And the recapping it just means she is at risk of sticking herself --

A Correct.

Q -- while trying to put the cap on?

A Correct.

Q So use, drop --

A Yes.

Q -- in Sharps container?

A Yes.

Q Okay. And she was dropping -- she was using clean syringes, what we call clean -- clean needle and syringe every time?

A So she was using a clean needle and syringe each time she went into a vial of propofol. I did not see her reusing needles and syringes to enter propofol or from patient to patient.

Q Okay. So she wasn't what we'd call double dipping?

A No, not that --

Q Okay.

A -- I -- not that I saw.

Q Okay. And you were watching multiple procedures and while others had other tasks to do, your task was to watch and see what she was doing?

A Yes.

Q Okay. And the -- so then after a few patients she has a few -- and it was three or four, whatever you've explained -- you have partially filled propofol vials still remaining?

A Yes.

Q And so then she took new needle, syringe, pooled -- meaning she filled up, like, the 10cc syringe by using the remnants of three or four propofol vials?

A By using remnants of more than one. I don't know how --

Q Okay.

A -- I can't recall if it was two, three, four, yes.

Q Okay. So -- and then -- I mean, and what her -- she was obviously doing was then using all of the propofol, was going to throw them away and use the leftovers in one final syringe?

A Right. So using up all the propofol so that the vials would be empty.

Q Okay.

A Yes.

Q And so her transgression was -- and what she was doing, aside from ignoring the label on the propofol vial, what she was doing was safe?

A Well, I don't consider that practice safe, but as you said, the main transgression there is using these vials for more than one patient. I also have concerns when you start pooling from -- again, from -- it's kind of doing -- saying the same thing. One, you know, you're using these vials for multiple patients, which shouldn't have happened; and then, two, the pooling -- again, it's still using the vial for more than one patient, but if something happens in one vial, you know, you've -- to get the sufficient dose you're, you know, pooling it or potentially -- you know, if this vial is contaminated and I drop some and then I need just a couple more cc from this vial and I go in, I've contaminated that vial and anything left -- potentially contaminated that vial and anything left if I haven't drawn up the whole thing.

Q All right. But, I mean, that would require a mistake on her part? I mean, if she is -- if she is sitting there using new needle, new syringe every single time she entered the vial --

A So focusing just on viral hepatitis transmission, yes, I would not -- I would not -- without syringe reuse or without having those vials in a really bloody

environment where blood is, you know, getting on the top and introduced that way, I'm more concerned with bacteria with --

Q Okay.

A -- with the multi --

Q And on the bacteria, I mean, you've explained these -- these propofol vials are labeled single --

A Patient use.

Q -- patient use?

A Yes.

Q Okay. And you're familiar from your training in the emergency room, propofol use?

A Right. The -- right, it's for a single patient. Each vial is --

Q Okay.

A -- for a single patient.

Q And the -- and for single patient that doesn't mean single use, meaning you can only enter it and use it once?

A Well --

Q It means single-patient use even if I use it four times within the time frame on the same patient, correct?

A Right. So CDC's recommendation about that is that, you know, the best practice is to draw up the entire contents in your syringe from the vial and administer to the patient. And we have some caveat that if you feel like you

have to go -- that that's not safe, that you can't safely titrate the dose, that if you have to reenter a vial it's within -- for that patient, that procedure, with a new needle, with a new syringe, and you -- you recognize the risk/benefit that you're taking with multiple entries into a vial.

Q Okay. But the -- I mean, the actual labeling, see, I just look at these things simplistically --

A Sure.

Q -- and if I see single use, that means I can go in, use it one time, and then throw it away? That to me would mean single use. I can only use it once. But if it's single-patient use --

A So I'd have to look at the label of propofol if it says single patient use, single use, or single dose. I think we at CDC consider those the same, but healthcare personnel may have other interpretations of that. But we consider single patient use, single dose, single use as for that individual patient, for that procedure, draw it up and administer it is the best practice.

Q I'm not sure I'm clear on that. I mean, do you understand what I -- do you see the difference that I do between single use of an item?

A So all I can tell you is we equate those terms as the same thing, single dose, single use, single patient use, to us at CDC means, and to me means the same thing. It's

for that patient and their -- that distinct procedure. And I -- and the best practice is you draw it all up and you give it to the patient in one syringe --

Q Okay.

A -- and that you don't --

Q Well, I've got to --

A -- do reentry.

Q -- I've got a 10cc syringe --

A Right.

Q -- and I've got a 20cc vial, okay? And I -- I've been understanding through five -- four weeks of this trial that I can -- I can draw out two syringes, I can take two separate, clean syringes and draw it out and then use it on a patient, and I'm in heaven with CDC, BLC, every other agency I can think of. Now, you're telling me --

A Well, I'm telling --

Q -- from CDC's perspective --

A -- no, I --

Q -- I can't do that.

A -- sorry. No, I guess I'm -- I'm not saying that. I'm saying that we want you to use the right vial size for your patient and your procedure. So if you typically administer 100 milligrams, I'd want you to get 100-milligram vial and draw it up so that you don't have to take multiple syringes out. But what you're describing would not be a

concern for me for viral hepatitis transmission.

Q Okay. And if -- and what Linda Hubbard was doing, setting aside the bacterial issue on shelf life, my term, for once it's opened she was not administering propofol in any method that would have led to transmission of hepatitis C?

A She was not reusing syringes or needles, which is what would be my predominant concern, and I didn't see blood contamination.

Q Okay. So if -- if all we had was Linda Hubbard's method and that's what she did all of the time, you know, if she -- if her conduct you observed is what her conduct had been the two and a half years over there, she didn't -- any of her patients wouldn't have gotten hepatitis C because --

A Unless a vial she used had been contaminated by someone else, no.

Q Okay.

A Not that I can -- can see.

Q Now, on the contamination -- the bacterial issue of propofol, it's single use -- I'll call it single patient use --

A Okay.

Q -- single patient use vial because it does not have any preservatives, layman's term?

A More or less, yes.

Q Okay. Meaning once I start using it, it has nothing in it by which is going to inhibit bacterial growth or something?

A Correct.

Q So I'm presuming saline and lidocaine multiuse bottles have a preservative that they can -- no bacteria grow.

A If they are truly labeled multidose and not single dose or single use, then they should have some type of bacteriostatic preservative. It has nothing to do with viruses but would prevent or is supposed to prevent the multiplication of bacteria in them.

Q Okay. And so would -- would -- the propofol we've heard here in the courtroom has a use time of a maximum of six hours. Other more safe CRNAs viewed it as one or two hours.

A That's my understanding from the label, yes.

Q Okay. So that means that what Linda Hubbard was doing, all within an hour or so?

A Yeah, I think the procedures were pretty quick --

Q Okay.

A -- for that time period, so...

Q It was a pretty busy place?

A Yeah. So --

Q Okay.

A -- I think that that sounds like it would -- probably within an hour, I think so.

Q Okay. So as far as -- there wasn't a bacterial growth issue or anything? I mean, because it was rampant pooling?

A Well, I mean, every time you reenter a vial you're potentially introducing bacteria and contamination, but no, that wasn't a high concern for me for those particular patients.

Q Okay. And so her -- I mean, just to repeat, her transgression was using a single-use labeled vial as a multiuse vial?

A Yes.

Q Okay. And you observed other CRNAs?

A So I think I observed one procedure with Mr. Mathahs, but it was the last case of the day, so he'd kind of drawn up the meds already, and then I don't recall specifically if I observed others. I don't recall.

Q Okay. The -- in your either -- what we call your Metropolitan Police interview or your grand jury interview, you said you observed other CRNAs and you just can't recall, other than Mathahs, who else it would have been.

A Well, I know there was a CRNA that's first name was Vinny.

Q Vinny?

A I think there were -- I think there were two Vinny's, and --

Q Okay. Vinny Sagendorf?

A I don't recall the last name that -- I will, if that's who was there. So I know there were two Vinny's and I, you know, today I can't recall; I might have observed him, but I don't recall specifics.

Q Okay. And in observing did you -- did you ever see any reuse of syringes?

A I didn't -- as far as from patient to patient or reentering vials, I did not, no.

Q Okay. And first of all, patient to patient, just so we can make sure we're on the same terminology, that would mean somebody used a syringe and vial on the patient that's in there and then in rolls a new patient, you take and use the same one on the next patient?

A Did not observe that --

Q Okay.

A -- at all.

Q And the -- and that happens out there in your CDC world, correct?

A Yeah.

Q I mean, those instances?

A Yes.

Q Okay. And on the other type of reuse we're talking about double dipping, would be reusing the same needle and syringe to go back into the vial a second time.

A After it's been used on the patient, yes.

Q Okay. And to draw up again?

A Yes.

Q And so you saw none of that?

A I saw none of that.

Q Okay. But you -- but you did see -- I mean, you were aware, other than Linda Hubbard, using the propofol vials as multidose?

A Yes.

Q Okay. And you understood that that was the standard practice, the norm, as to what the CRNAs were doing?

A Yes.

Q Okay. And although you didn't see any reuse of syringes you're aware Gayle did?

A Yes.

Q Okay. Because you all would talk about what each other saw?

A Yes.

Q Okay. And the -- you -- and it's in your reports, but I mean, she -- you were in observing in one room and she was in a different room, and was she observing Mr. Mathahs?

A Yes.

Q Okay. So it was Mr. Mathahs she saw double dipping?

A Yes.

Q Okay. And not the other -- the other type of reuse patient to patient?

A Correct. She did not report --

Q Okay.

A -- seeing that.

Q And this was early on in the ten-day investigation?

A Yes.

Q And that -- that dual observation, I'll call it, I mean, it -- this all happened -- this observation Mathahs reusing by Gayle and of course, Gayle also saw or was aware of propofol vial multi-patient use, right?

A She was aware of propofol being used for multiple patients.

Q Okay. And you were. And so with these two, this was immediately addressed with the clinic?

A Yes.

Q Okay. And that -- was that by yourself?

A No.

Q Okay. By Gayle?

A By Gayle and I believe Brian Labus.

Q Okay. And it was, as you understand it, it was reporting to the clinic these are single-use propofol vials and there is to be no multiuse whatsoever and there shall be no reuse of syringes?

A That's my understanding, but I was not at that meeting.

Q Okay. And the -- but the -- it was being reported back to your superiors what had been found and what actions you were taking?

A Yes.

Q Okay. And the -- I mean, your goal in the -- in being there is figure out anything unsafe happening, and if it is stop it, right?

A Yes.

Q And prevent it so that if that is causation, it stops?

A Correct.

Q And the -- it -- and thereafter it did stop?

A Yes.

Q Okay. Because you all continued to observe?

A Correct.

Q Okay. And from then on there was no multiuse of propofol vials?

A Correct.

Q And you saw no reuse of syringes in your

observations?

A Correct.

Q Okay. Now, at that time -- now, I want to take it at the time where we are, and you just told them correct this --

A Yes.

Q -- meaning, multidosing propofol and syringe reuse, did you all reach a determination, ah-ha, we've solved it?

A Well, we stayed there for several more days to continue investigating, so I think, you know, we certainly were, like, this could -- this could be it. I mean, this is enough to, you know, test and -- this has been transitioned before, the source of transmission before, so this could be it.

But it required still some chart review to look and see can we find a source on those days, was there, you know, reuse on those days, you know, redosing, and then also continuing to look at these other things just to make sure they weren't also part of the problem.

Q Okay. And -- I mean, is it fair to say you continued to further look at all of the options?

A Yeah, I mean --

Q Okay.

A -- right. Yes.

Q The likely causes, let me put it that way, of the transmission?

A Yeah. I mean, we continued -- we still looked at the endoscope reprocessing -- we were still looking -- I don't remember at what point we looked at the saline flush, whether it was before this or after. But yeah, I mean, I can't -- I don't recall the order in which we identified syringe reuse and propofol reuse versus if we'd already looked at the scopes and the saline. I don't recall the order of that.

Q Okay.

A But we still were reviewing records and, you know --

Q Okay.

A -- additional observations.

Q At the time when you all are still there before you leave and it's grown, I think to, like, six identified hepatitis C cases, you all still don't have the rooms being able to be segregated --

A Correct.

Q -- by patient?

A Correct.

Q And you aren't having to address the -- how the hepatitis C went from room to room and skipped over people?

A So we haven't at this point tested all of the

patients seen on that day, so we don't know how many cases we're going to find. You know, we've abstracted medical records to plug that in later, but, you know, I don't have at this point an order of people; we don't have a room assignment; you know, we're trying to put people in order with times, which is challenging, so yes, we --

Q Right.

A -- we're still missing some of those --

Q So yeah, I mean --

A -- components.

Q -- like, without a doubt -- I mean, it remained one on July 25th?

A Correct.

Q And then, like, five or six on September 21st?

A So I think ultimately we ended up with, I think, seven on September 21st --

Q Okay.

A -- and one on July 21st --

Q Right.

A -- I think is --

Q Okay.

A -- what we --

Q And -- but as of that time -- and I'm still here before your trip report is written or anything, meaning in Las --

A Yes --

Q -- Vegas.

A -- okay. I'm sorry.

Q It has grown, so I mean, now it's way more than coincidental --

A Yes.

Q -- when you have half a dozen acute hepatitis C patients all out of a clinic on the same day?

A Yes.

Q Then you're wanting to know, did they all get it there, you know, is like the first big question. And of course, that ended up -- that's when we got into -- what was your fellow's name that was here, Yuri?

A Yes.

Q Okay. The -- all of that stuff that essentially shows that the cluster -- and I'll talk about September 21st -- the cluster on September 21st of those patients that got hepatitis C, it was determined that their hepatitis C came from source patients' hepatitis C?

A Correct.

Q Okay.

A From a source patient, yes.

Q Correct. And so -- but you didn't know all of that when you were here?

A Right. We didn't have the results of that

quasi-species analysis, I don't believe, at that time because we still had to test patients on that day.

Q Okay. And you all are looking to determine, before you leave, the likely cause of transmission?

A Right. I mean, ultimately before I leave I want to make sure that there's not any unsafe practices that are putting people at risk. Ideally, yes, we, you know, are looking to confirm the outbreak, to try to find all the cases so people can get referred for care appropriately and to identify how it might have occurred so we can stop it from continuing.

Q Okay. And all of this speed is somewhat of the essence because of the nature of the disease? I mean, on getting people help, correct?

A Right. So, you know, we want to identify people who have disease so that they can get referred for care and their clinician can decide what, if any, treatment course they may or may not need. But keeping in mind that we're now in January and we're looking at dates from September and July. So we're already several months past when they were exposed and infected.

Q Okay. And the -- let's see, Gayle's the hepatitis C specialist --

A She was from that division --

Q -- okay.

A -- yes.

Q All right. And the -- okay. Now, on your trip report --

A Yes, sir.

Q -- I call it "your" but who wrote it?

A So we're talking about this, right?

Q Yes.

A Okay. So Gayle is again the lead author, but I contributed to the content with her, and then it goes to our supervisors to review it and edit and help fix or give suggestions, and then it actually goes through a clearance process at CDC where it goes through other people, and then we send it to the Health Department.

Q Okay.

A Is when it's finalized.

Q And the -- on page 2 of objectives, now, this report -- I may be repeating, but this is the report -- at the end of your trip this is what's delivered back to the State -- the authorities that invited you --

A Yes --

Q -- correct?

A -- ultimately we generate a report summarizing what we did while we were there, what still needs to be done, what our recommendations are, and provide that to the Health Department to do with what they'd like.

Q Okay. And on -- this is dated May 15, so you all had left by approximately January 19, if it was a ten -- or January 18 or 19, who has input into this? Does the local Health District of the State or just CDC?

A So this -- I think -- and again, Gayle would potentially recall better than I do, we left -- we drafted an early draft of this that we left behind, I think even before we left in January, and then continued to refine as we had additional information here for this report because at this point, you know, we have some quasi species --

Q Okay.

A -- that we didn't -- so this is the May 18, and so again, this is, you know, Gayle putting the draft together, I'm providing some input, as I said, it goes to our supervisors, it goes through CDC clearance. I don't recall if we sent -- obviously the Health Department had a -- the earlier version we left behind of this. I don't recall if they provided any edits or additional input into this before we sent --

Q Okay.

A -- it back to them.

Q Do you have the initial draft that was left behind?

A I don't. No.

Q On the objectives, I'm looking at page 2.

Interview and collect specimens from identified hepatitis C patients for phylogenetic analysis at CDC.

A Mm-hmm.

Q Okay. Now, part of you all coming out here was to get those specimens for testing?

A Correct.

Q Okay. And then investigating infection-control procedures at clinic A, that's the clinic here, especially use with multidose vials, reuse of single-use vials, and reprocessing of endoscopes?

A Right.

Q Okay. And was -- was that -- was this, like, written out before you came out? I mean, this is from your historical looking back, knowing what type of clinic it is. This is what you're going to be looking for?

A So there's something called an Epi-1, which is what -- when we're going to do an Epi-Aid or a field investigation gets drafted to get approval at CDC for an Epi-Aid to proceed. And so that gives a brief blurb about, you know, this is the situation, these are the objectives of the investigation, here's the team that's going.

And so typically when we do the trip reports, we move objectives from the Epi-1 to here. I don't have a copy of the Epi-1, and I don't recall what those objectives were in it.

Q Okay. Clinic A generally appeared clean and well organized.

A What page are you --

Q I'm on page 4.

A -- okay.

Q I'm just jumping around to highlight some things.

A Yes.

Q And is that -- that's your opinion --

A Yes.

Q -- also?

A Yes.

Q Okay. There were issues with adequate hand hygiene -- an inadequate hand hygiene, correct?

A Yes.

Q Well, page 5 you already talked about endoscope reprocessing. Where it says, The biopsy equipment was disposable and thrown out at the end of the procedure --

A Yes.

Q -- correct? The --

A That's what we observed, yes.

Q -- those were your observations?

A Yes.

Q And the -- a biopsy equipment is something that, if reused patient to patient could cause blood-borne

transmission? These are my words.

A Right. So theoretically if you're doing a biopsy and get blood from the device and then go and use it on another patient with a blood-generating procedure, I suppose theoretically it could. Not all of our cases had biopsies, so --

Q Right.

A -- and we observed them discarding them.

Q Okay. Yeah, but I was looking at the chart when you were looking at September 25.

A Yes, go ahead. September 21?

Q I'm sorry, these dates kill me.

A But yeah, no, I'm with you.

Q July 25 --

A Yes.

Q -- Mr. Washington --

A Yes.

Q -- with -- and the source patient?

A Yes.

Q Mr. Santacroce took you through hep saline --

A Yes.

Q -- and both patients had biopsies?

A Correct.

Q Okay. And the source patient first had a biopsy and then Mr. Washington had a biopsy on the chart which you

have displayed?

A Yes, correct.

Q Okay.

A At some point after that, yes.

Q All right. You pointed out you -- on the source patient had an upper endoscope. Mr. Washington had a colonoscopy?

A I can -- so Mr. Washington was the case patient, right, who became infected?

Q Yeah.

A Okay. So he had a colonoscopy and then our potential source that day had an upper, yes.

Q Okay. And they both had biopsies?

A Yes.

Q Okay. And there's -- are the biopsies -- biopsy equipment for an upper the same as a lower?

A I believe so, but I --

Q Okay.

A -- am not -- I believe they use the same, but I couldn't say that with 100 percent certainty.

Q Okay. And so if I understand, you-all, meaning the CDC and the Southern Nevada Health District, seem to have married September 21st to July 25th as being some common cause, correct?

A Yes. I mean, we saw a systematic poor practice

that was -- that we were told was routinely done and has been tied to transmission previously. So yes, I think that what caused transmission on the 21st was likely also what caused transmission on the 25th.

Q Okay. But if you take that approach, you're kind of -- you're lumping them together --

A True.

Q -- and ignoring the fact that there may have been a hepatitis transmission in July from the source patient to Mr. Washington that was unrelated to the propofol and the method of injection, correct?

A True, but I'm also looking at the person -- the nurse anesthetist who administered propofol on the 25th who reported routinely reusing syringes to double dip. So that again seems like the most likely source, but yes.

Q Okay. But this is the same -- the same nurse anesthetist who has been working there -- you can find him there every other 300 other days that year too, correct?

MR. STAUDAHER: Your Honor, may we approach?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we had a request from one of the jurors for a little bit early today, so we're going to go ahead and take our evening recess at this point. We'll reconvene tomorrow morning at 9 a.m.

During the evening recess, you are reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium, and please don't form or express an opinion on the trial.

If you'd all place your notepads in your chairs and follow the bailiff through the rear door, we'll see you back tomorrow morning at 9.

(Jury recessed for the evening at 4:15 p.m.)

And, ma'am --

THE WITNESS: Yes, ma'am.

THE COURT: -- during the evening recess, please don't discuss your testimony with anyone else.

THE WITNESS: Okay.

THE COURT: And then if you could be here a little bit before 9 so we can start right at 9.

THE WITNESS: Yes, ma'am. And can -- should I leave --

THE COURT: Yeah, just -- anything that's --

THE WITNESS: These are what I brought with me.

THE COURT: Oh, you keep those.

THE WITNESS: Okay.

THE COURT: Yeah, just bring them back with you tomorrow.

THE WITNESS: Okay.

THE COURT: Yeah, I mean, if you get here, like, at 8:50 or 8:55 that's fine.

THE WITNESS: Okay.

THE COURT: And, State, may the witness be excused for the day? All right.

All right. Why don't we all take a brief, you know, few -- couple-minute break and then we'll come back and address this issue on the record.

(Court recessed at 4:15 p.m. until 4:22 p.m.)

(Outside the presence of the jury.)

THE COURT: All right. We're on the record out of the presence of the jury. The State had approached during Mr. Wright's questioning with essentially the objection that the question created the false impression that the only days that there was hepatitis transmission appeared to be on the two days that are at issue in this case, as opposed to other days when other people were infected, but that those people have never been linked genetically.

Is that essentially your objection, Mr. Staudaher?

MR. STAUDAHER: Yes, Your Honor.

THE COURT: All right. Mr. Wright?

MR. WRIGHT: Yes. I do -- I am hamstrung by the

State not investigating the case properly for a criminal presentation and just adopting the Southern Nevada Health District's report blindly, and the CDC report and not following through like a normal criminal investigation would do.

And I'm hamstrung by that because on the one hand the inference I want to bring out the State's correct about. I want to bring out that if the investigative transmission was what -- like this witness thinks, and it's because, well, it makes sense, we saw it, and on the 25th and on the 21st it's the same CRNA and so therefore that must be the way it was transmitted.

If in fact, the same CRNA is doing the same thing every single day and there isn't any other transmission on those other days, it makes it less probable that they've identified the right method of transmission. And what the State's saying is if I do that, they're going to want to bring in the balance of the CD -- of the Southern Nevada Health District report, which -- which says 107 other people may have got it at the clinic in four years, but the only way we lumped them in as saying they may have is because they were interviewed and in being interviewed they deny the risk factors. I mean, that's how they are clinic-associated.

And of course, if the State hadn't just stopped with adopting -- by adopting the Southern Nevada Health District

report and just went ahead and investigated it, they would have interviewed all of those people themselves. They would call them as witnesses. They would allow me to confront them, before they start putting in the hearsay-based confrontationless-based, or lacking confrontation, conclusion that they make.

And so because they didn't do that, I -- I'm -- the way I'm hearing it, I'm at peril if I use logic in my cross-examination of their witness -- witnesses; I somehow waive my hearsay objection and my right of confrontation to have those 107 people present. And that's -- I don't think that's a proper dilemma for me.

I don't mind creating what you call a false inference. I create false inferences in courts every day, and they're created because we have rules of evidence. Certain things are admissible and some aren't. And I can sit and tell a jury my client didn't possess a goddamn thing when I know he did and it was suppressed. And I don't care if it's a false inference. We play by the rules and the Constitution and that's how evidence gets in. And that's all we're doing here and I'm trying to do.

THE COURT: State?

MR. STAUDAHER: I mean, it opens the door to rebuttal argument or rebuttal evidence when he prevent -- produces evidence that he knows, in this particular case, there's been

no suppression. I mean, he knows it's a false impression, he knows it's false in the fact that the jury isn't getting the information that it could have, if, just even the Health District report was in, let alone the fact that we know that there were many other cases that were supposedly litigated and all those cases are under some sort of confidentiality agreement.

We were party to that to the degree that we could to get at least some information from the civil defense attorneys so that we could provide that to the Defense and did so. The issue here is that it's not -- it's not just fundamental fairness, it's what's proper. You cannot get up there and argue or present evidence that he knows is false and leave the jury with a false impression when, in fact, he's arguing on the other side that that information shouldn't be coming in at all in the case.

If he can go ahead and ask those questions, the State's position is that if he does so, he does -- he essentially opens the door to that information coming in in rebuttal from the State, either through the documentary evidence that we have, or, you know, through the witnesses that are going to be coming in and testifying, like Brian Labus and others who were actually present for the investigation.

I will note for the record that the reports that

IN THE SUPREME COURT OF THE STATE OF NEVADA

DIPAK KANTILAL DESAI, Appellant, vs. THE STATE OF NEVADA, Respondent.	)	CASE NO. 64591

APPELLANT'S APPENDIX VOLUME 24

FRANNY A. FORSMAN, ESQ.
Nevada Bar No. 000014
P.O. Box 43401
Las Vegas, Nevada 89116
(702) 501-8728

RICHARD A. WRIGHT, ESQ.
Nevada Bar No. 000886
WRIGHT, STANISH & WINCKLER
300 S. Fourth Street, Suite 701
Las Vegas, Nevada 89101

Attorneys for Appellant

STEVEN S. OWENS
Chief Deputy District Attorney
Nevada Bar No. 004352
200 Lewis Avenue
Las Vegas, Nevada 89155
(702) 671-2750
Attorney for Respondent

INDEX TO APPENDIX VOLUMES 1 through 41

Q -- all right?

A Yes.

Q And before I ask you the conclusions, a peer-reviewed journal means what? When something goes out for peer review when it's published for the scientific population to look at or anybody else, what do you have to do?

A So that's what I was talking about. You submit it to the editor, and then they send it out blinded to reviewers so they don't know who wrote the article, and they read the article and determine, you know, was it a well-done study, is it valid, is there -- do they have questions that aren't answered and, you know, need followup.

And so -- and is it appropriate for the journal that you're submitting it to. Is it appropriate for that audience. And then based on the responses from reviewers, it goes back to the editor and they decide, yep, we're going to publish it, yes, we'll publish it but we need you to make some revisions, or you know what, no, we're not publishing it. Sorry.

And so that's kind of how they use the peer review process to inform if it's a well-designed study if it -- an answer is any, you know, appropriate for the journal and the audience is of interest at the time.

THE COURT: Let me ask you this: Was this the only journal you sent this to for peer review -- for publication, or do you send it like to, you know, Journal of the American

Medical Association and other journals; if you know?

THE WITNESS: I don't recall. Since I'm not -- typically, whoever is the first author takes responsibility for submitting and dealing with any editorial comments or responses and revisions. So I honestly don't recall.

THE COURT: Okay. And that was kind of up to that person to determine what journals to send it to and if they --

THE WITNESS: Yeah, I mean, I -- I'm sure our supervisors, you know, had some input because people sometimes want to go to one journal versus the other, but I don't remember.

THE COURT: Okay. Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q So what were the conclusions?

A So the conclusion was that we had essentially documented two separate dates where transmission of hepatitis C virus occurred at this facility, and we believe that transmission resulted from reuse of syringes to access vials that were then used for multiple patients.

Q So the two different clusters that you looked at on those two different days, did they relate to each other?

A No.

Q Was that another reason why you believe that the practices that you observed, are in the report, were based on unsafe injection practices?

A Right.

Q And that that's what caused the infection?

A Right. Yes.

MR. STAUDAHER: Pass the witness, Your Honor.

THE COURT: All right. Who would like to begin with cross? I guess, Mr. Santacroce, can you begin?

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good morning, Ms. Schaefer. I represent Mr. Lakeman. I want to talk to you about the methodology you -- when I say "you," I mean the CDC -- employed in reaching your conclusion that you just testified to.

I believe you testified that you did a period of record review --

A Correct.

Q -- correct?

A Yes.

Q And then observation?

A Yes.

Q And then interviews?

A Yes.

Q And anything else that the CDC did in its methodology to reach its conclusion?

A Well, there was testing of patients and specialized testing done at CDC. There was also testing of --

blood testing of the healthcare workers and interviews of patients and providers. I assume when you say "interviews" that's what you mean, but --

Q Correct.

A -- that's -- that's the gist of things, yes.

Q And bottom line you mention the word "commonalities" a couple of times in your testimony.

A Correct.

Q Commonalities are important to you in determining how an infection is transmitted; isn't that correct?

A They are a factor that we look at for -- yes, they're a factor that we look at as part of our investigation.

Q When you talk about commonalities, what are you talking about?

A Like I mentioned, looking to see did the source patient in cases all get the same scope used on them, or did they all have biopsies. Did they all get the same type of medication. Things like that.

Q Okay. I want to take you through some of the areas that you looked at in reaching your conclusion. You talked about reviewing the charts, so let's talk about that for a minute. What particular information did you glean from the chart that led you -- or contributed to your conclusion?

A So can I pull up one of the reports to

reference?

Q You can refresh your recollection.

A Okay. So I'm going back to our trip report, that same page 13 --

Q Okay.

A -- we've put up previously.

Q All right. Well, why don't I put that up here. Has that been displayed already?

A Yes, sir.

THE COURT: Yeah, and that's admitted.

MR. SANTACROCE: Okay.

THE COURT: Okay. Was that 164, Mr. Staudaher?

MR. STAUDAHER: No, I believe that 79 is down there.

THE COURT: It's 92 according to the court clerk.

BY MR. SANTACROCE:

Q And what page are you looking at?

A Page 13, sir. So again, the top table here is looking at -- the bottom table is looking at those that were the sources or the people who were known previously infected when they came in and we believe were the source of the virus that was transmitted to patients.

Q And now which date is this, then, both dates?

A Both dates are on here.

Q Okay.

A Was there one date you'd like to focus on?

Q Well, let's start with the 25th of July.

A So for the 25th of July we documented a single instance of transmission from source patient to one case, so you see case one here and you see potential source one here.

Q Okay.

A And so again, same date of procedure. We look at the start time and we see that the source patient preceded the case patient, which you would expect. They had different types of procedures so one had a colonoscopy, one had an upper endoscopy. So that wasn't the same procedure type. They had different scopes used on them, so there wasn't a shared scope in common. They both did have biopsies. They both had the same nurse anesthetist. And you'll note that the potential source patient had multiple doses of propofol administered. And so as I mentioned, that's important because that would have been reuse of syringes on that patient to contaminate the vial and then that vial being used for the next patient to transmit the infection.

Q Okay.

A So that's what I'm getting at.

Q Well, let's talk about each of these, then.

A Sure. Do you need me to clear it?

Q No. No.

A Okay.

Q Yeah, if you would, please.

A Okay.

Q The endoscope number 155 and 301.

A Correct.

Q Now, how did you arrive at those endoscope numbers?

A So that was -- is what was documented in the record and also through interviews with the facility. And again, I'd have to find it in the report -- I think it's in the trip report. They told us how many scopes, how many colonoscopes they had and how many endoscopes they had, you know, at the facility, and then they had numbers that were recorded, and so that was what was documented in the medical record.

Q And I recall in your grand jury testimony that you said you had some problems documenting the number of the scopes, correct?

A No. The scope was documented consistently. I think we had a couple instances where it looked like the same scope was documented back to back for --

Q In other words, used on two people, one after another?

A Right. Right. And so it looked like there wouldn't have been sufficient time to disinfect, so we asked the facility about that. They went back and looked and said that they had some electronic way to show that it was just

misrecorded.

Q Did you see that electronic way?

A I don't recall. I don't recall if they brought it in or not. I don't remember.

Q So you accepted their explanation. Now, in these commonalities, if there's one predicate that's false, it could change the entire conclusion; isn't that correct?

A Well, can you expand on what you mean?

Q Yeah. In other words -- let's just take the scopes, for example. Let's say that -- you didn't verify that this electronic recording process actually verified that they were different scopes you used on back-to-back patients, correct?

A Well, my understanding is, you know, one of them had a colonoscopy, so it goes up your bottom, and one had the upper endoscopy that goes down your throat, and that they used different types of scopes for those procedures is -- was my understanding.

Q But I'm asking you, did you see documentation to that effect?

A I saw documentation of the scope that was recorded for the -- in the record.

Q And you saw those recordings that showed that a same scope was used back to back, correct?

A I think -- I don't know how many occasions. I

think it was one and it was not this instance.

Q Okay. But my -- my question to you was if there's a break in the link of the chain, the commonalities, it could throw off a conclusion, your conclusion?

A I don't think even if the same scope was used it would change my conclusions. Again, it goes back to, you know, looking at the reprocessing procedures there and then looking at the unsafe injection practices which were observed and reported to us and looking at the literature of where we have seen transmission previously. So --

Q Well, you've seen transmission through endoscopes before, haven't you?

A I haven't linked to the specific scope. I haven't seen it definitively documented, no.

Q At the time that you did this investigation, how long had you been an investigator?

A I had worked at CDC for about six months.

Q Okay. And was this your first investigation?

A This was my second Epi-Aid. This was probably, I think, my first outbreak field investigation.

Q So when you say you haven't seen it, you are aware of literature that indicates that transmission can come from that, correct?

A Well, I'm not so comfortable with that literature, to be honest. I think -- I don't know. I don't

want to expand on it.

Q Did you see literature or not? Whether you're comfortable or not is not my question. Did you see literature that indicated that the transmission of hepatitis C could come from endoscopes?

A I have seen literature suggesting that, yes.

Q Okay. And the particular -- and it was the area that you looked at specifically and you dismissed --

A Correct. We looked at it and did not think that it was the source of transmission here, correct.

Q Now, another area that you looked at was the preop area, correct?

A Correct.

Q And the commonality would be who started the IV heplocks, correct?

A Well, so we look at the use of saline flush there and the practices of saline flush. And so there was no repeat flushing that was observed or reported. So --

Q On what day?

A While we were doing observations. So whatever day we were there.

Q In January of 2008?

A Correct.

Q You had no way to verify or observe what happened on January -- or September 21, 2007, or July 25th of

2007, in regard to how the heplocks were started and flushed?

A I was not there on those dates, but that's part of why when we do the investigation. We ask, Have practices changed since those times? Are you doing anything differently? And got no indication that that was the case.

Q So if nurses came here and testified that changes were made at that time, that would be contrary to what --

MR. STAUDAHER: Objection, Your Honor. Mischaracterizes the testimony.

THE COURT: Yeah, that's -- that's sustained.

BY MR. SANTACROCE:

Q So on this January date when you observed the installation of the heplocks and the saline flushes, there was no particular concern to you?

A No.

Q Were they using multidose saline bottles?

A Yes, they were.

Q Okay. And that didn't present a concern to you?

A Well, the vials were labeled as multidose, so technically they can be used for multiple patients. And we did not observe any reuse of syringes or needles into those vials, which would be how I would believe that transmission of hepatitis virus would occur, or direct reuse of needles and syringes. I didn't observe that. So I was not concerned.

Q On that particular day you didn't observe that?

A Correct.

Q Okay. Now, you're aware of literature that suggests that there has been hepatitis C infection outbreaks due to reuse of multidose saline bottles, correct?

A Correct. Through reuse of syringes and needles to go into those vials.

Q And the CDC has documented those outbreaks, correct?

A Well, with our Health Department colleagues, yes, we have investigated.

Q Well, in this particular chart it was of concern to you to note who started the IV start; isn't that correct?

A Correct.

Q And on case 1, which you talked about on July 25, CRNA 4, who you've identified as Ron Lakeman, started both on case 1 and the potential source patient, correct?

A That's what we documented, but I think, Mr. Staudaher -- the record he showed contradicted that, if I'm recalling.

Q Showed you an error in that documentation, didn't he?

A Correct.

Q I'll represent to you this is Exhibit -- State's Exhibit 2. This is Michael Washington's patient file. And

I'm going to show you Bates Stamp No. --

MR. SANTACROCE: 2350 for Counsel.

THE WITNESS: And, sir, can you refresh my memory. Is Mr. Washington who we defined as Case 1, or was he the potential source? I don't recall.

MR. SANTACROCE: Okay. I'll be happy to do that right now.

THE WITNESS: Thank you.

BY MR. SANTACROCE:

Q As soon as I find this Bates stamp.

A Sure.

Q Well, let's talk about who Mr. Washington was.

A Thank you.

Q I'll show you State's Exhibit No. 157. Okay. Do you see that?

A Yes, sir.

Q I'm going to step over here so I can see it, but you can look on your monitor.

A Yep.

Q The blue strip there is both the -- well, it was the source patient for Michael Washington. Do you see that?

A Okay. So Mr. Washington was an -- became infected?

Q Became infected by the source patient; we've marked it in blue.

A Okay. And --

Q Go ahead.

A -- is there any possibility to see what -- or you can walk me through what the headers for these different columns are so I know --

Q Oh, sure.

A -- who is --

Q I'll have to move that down --

A -- what -- I'm sorry. Thank you.

Q I can't fit it all on one screen, so we'll have to look at the headers.

A Okay.

Q And tell me when you've -- would you just like to look at the chart instead of being on the screen? Would that help you?

A Well, whatever you all need for them to see --

Q Well, you look at it and then I'll put it back up on the screen, okay?

A Okay. Thank you. I appreciate it. So is it correct to say, then, that this does not list who was the IV start in the headers? It's just who was in the procedure area?

Q That's correct.

A Okay.

Q It does not list who the IV start was.

A Okay.

Q But we'll get to that.

A Okay.

Q Okay?

A Okay.

Q So are you familiar with this chart now, do you think?

A I think so.

Q Okay.

A Let's see.

Q Because I'm going to show you now Mr. Washington's patient chart, which I believe you reviewed in order to get certain information on your Chart 13, okay?

A Somebody from our team would have.

Q Okay.

A I don't know if it was me specifically, but...

Q Okay. But it was information that you relied on in reaching a conclusion, correct?

A It was information we used in our conclusions, correct.

Q So now I'm going to show you Bates Stamp 2350. This tells us -- this is the patient chart for Michael Washington. This tells us who started the IV; do you see that?

A I do.

Q And it wasn't Mr. Lakeman, correct?

A Correct.

Q It was someone by the initials of LC; do you see that?

A I do.

Q Okay. So when we go back to your chart, you have some erroneous information here on which you base some conclusions.

A Well, so I don't -- so you're correct. We have documented incorrectly that Mr. Lakeman started the IV on Mr. Washington, but I don't think that that impacts the conclusions that we make, because assuming that you don't have any information suggesting that we had a documentation error for the potential source patient -- for there to be transmission through a saline vial -- there would have had to have been saline used on the source patient and syringe reuse to get that source patient's blood into the saline to then be used on Mr. Washington.

So if indeed Mr. Lakeman started the source patient's IV and our understanding is that the CRNAs don't use saline, that couldn't have been a source for Mr. Washington because the source patient didn't get saline. Does that make sense?

Q It doesn't to me, but maybe to the jury. So in any event, the fact that I'm bringing this out is that you

have erroneous information on this chart, which you testified to; you relied on this information to reach your conclusion?

A I'm -- I still disagree that -- I will stipulate or I agree that you have demonstrated that we had erroneous information on the IV start for Mr. Washington, our case patient 1, but even with that it doesn't impact my conclusions because our source patient 1, unless you have other information, still had an IV start from CRNA 4.

And our understanding, as I said, is that the nurse anesthetist when they placed the IV didn't use saline flush because they went ahead and gave this sedative. So in order for saline flush to have even been a factor, which I don't think it was regardless because we didn't observe or have reports, the potential source didn't have saline used on them.

So that common source of saline couldn't have become contaminated if -- when the saline was used on Mr. Washington it wouldn't have had this person's blood in it.

So it doesn't change my conclusions even -- even with this information.

Q Okay. I'm going to ask you to take a look at State's Exhibit 156. This is a similar chart from September 21, 2007.

A Thank you. Okay. So same format, just different --

Q Yeah. I just want you to look at it and make

sure that you understand the columns and things of that nature, okay?

A I think so, yep.

Q Okay. Let's talk about this for a minute. Let's start at the top here.

A So can I just orient for a quick second?

Q Absolutely.

A So the top -- well, you orient me. I'm sorry. I'll --

Q Okay. The orange strips are -- is the source patient. Yellow strip is a patient that cannot be genetically linked to the cluster. The green strips are the people that are alleged to have been infected at the clinic, okay?

A Yes.

Q Got it?

A So the yellow is someone who has hepatitis, but genetic testing could not have been performed on them.

Q Couldn't be linked to the clusters.

A Okay.

Q Okay? So now, on this top section you have a source patient who is Kenneth Rubino.

A Yes, sir.

Q And then you have another patient, then you have an infected patient, Rudolfo Meano -- Meana, then you have one, two, three, four, five people who haven't reported it,

having hepatitis.

A Okay.

Q Then you have another infected patient, then you have another patient who hasn't reported, and then you have another infected patient, and --

A So can -- can I ask --

Q -- three clusters of that, okay?

A So can I ask one question, or --

Q No --

A -- okay.

Q -- you can't.

A Okay. I just wanted to clarify --

Q Okay.

A -- something you said.

Q I ask the questions, you answer them, and then we'll get along great, okay?

A I just don't understand when -- when you're talking about the five who are not recorded as being infected, does that mean they were negative or you don't have results on them?

Q You're asking me questions.

THE COURT: Yeah.

THE WITNESS: I'm sorry.

THE COURT: Basically --

THE WITNESS: I'm sorry. I just didn't understand

what he meant.

THE COURT: -- a lot of witnesses like to do that, but the lawyers ask the questions --

THE WITNESS: Okay. I just didn't understand. I'm sorry.

THE COURT: Here's the thing though. If Mr. Santacroce asks you a question and you don't understand the question or you can't answer the question with the information you have or Mr. Santacroce's question, you know, he says something in his question that's wrong or you don't agree with, then of course, you can say I can't answer the question or I don't understand the question or what have you; do you understand?

THE WITNESS: I do.

THE COURT: Okay.

THE WITNESS: So I don't understand --

THE COURT: Okay. Well, wait for his question, and then --

THE WITNESS: Okay.

THE COURT: -- again --

MR. SANTACROCE: Maybe we'll clear it up.

THE WITNESS: Okay.

THE COURT: -- if you can't answer it with the information you have just tell him --

THE WITNESS: Okay.

THE COURT: -- I can't answer that with the information I have.

THE WITNESS: I'm sorry.

BY MR. SANTACROCE:

Q And I don't mean to be disrespectful --

A No. No, I'm sorry. I'm sorry.

Q -- ordinarily I'd answer anything you had to say but --

A My apologies.

Q -- I can't do it in this forum because --

A I understand.

Q -- the rules don't allow that, okay?

A I understand. I'm sorry.

Q Okay. Again, we're clear on -- now, this is the State's exhibit. The State prepared this documentation purportedly from reviewing the same patient files that you guys all reviewed.

A Okay.

Q Okay?

A Yes, sir.

Q So you see you have three -- three patients in green up there in room 1, and the CRNA was Mr. Mathahs; do you see that?

A So this is by room?

Q Yes.

A Okay. I'm sorry.

Q You're asking questions again.

A I know. I'm sorry. I'm sorry.

MR. STAUDAHER: Your Honor, I'm going to ask that if -- that --

THE COURT: Yeah.

MR. STAUDAHER: -- since he's giving a lot of information, he's got to define things for her so that she understands to even answer the question.

MR. SANTACROCE: Fine. I'll be happy to.

THE COURT: Right. If you don't -- again --

THE WITNESS: I'm sorry.

THE COURT: -- if you don't understand something, that's fine. You can say -- the worst thing to do, or what we don't want you to do is to make assumptions that may be erroneous. So if you don't understand, you know, how the information is broken up or you don't agree with it or something like that, then of course, say that.

Go on, Mr. Santacroce.

BY MR. SANTACROCE:

Q Okay. So these are broken up by room. So this is all one room, correct? I mean -- you wouldn't know, but I'm telling you that's what the State alleges, okay?

A Yes.

Q And you'll see -- if you move over a couple of

column,s, you'll see the CRNA -- see that?

A Can you move it over, please.

Q Oh, I'm sorry.

A I'm sorry. Yes, thank you.

Q Okay. Then we go down to here. It's Room 2, and I'll move it over -- CRNA Lakeman, okay?

A Yes.

Q And in Lakeman's room three people are reported to have hep C allegedly from the source patient in Room 1.

A Okay.

Q Okay? Now, everybody that you talked to or interviewed said that propofol didn't go from room to room, correct?

A Correct.

Q Okay. Now, I want to show you another chart here because what we were talking about when I sort of got sidetracked was these IV saline flushes, okay?

A Yes, sir.

Q And I'm going to show you this document here -- and I'll try to zoom out so we can get most of it in. The top row are the patients in Room 1 that contracted hep C on September 25, 2007. The bottom row are the patients that contracted hep C in Room 2 on the same day; do you see that?

A Yes, sir.

Q Now, the records indicate that one nurse started

the saline -- or started the heplocks and saline flushes for all of the patients except -- all of the infected patients and the source patient in Room 1 and that nurse was Lynette Campbell, initials LC; do you see that?

A Yes, sir.

Q And Lynette Campbell also started the heplock and flushed those heplocks on patients infected in Room 2, Patty Aspinwall and Carole Grueskin. The other person -- nurse who started heplocks on that day, who shared the same saline multidose vials, was Jeff Krueger, and he started --

MR. STAUDAHER: Objection. Assumes facts not in evidence. Not that he shared the same --

MR. SANTACROCE: It does --

MR. STAUDAHER: -- multiuse vials on those patients.

THE COURT: Well, state --

MR. SANTACROCE: I think Lynette Campbell testified to that.

THE COURT: -- state your -- state your question again.

BY MR. SANTACROCE:

Q I said the other RN who started heplocks on that same day for the patients in question was Jeff Krueger, and there was testimony that Jeff Krueger let Lynette Campbell share the same saline vials, okay? My question --

THE COURT: And again, ladies -- as you know, this

comes up a lot with what the testimony actually was. It's your recollection of the testimony. So if Mr. Santacroce says, oh, this was the testimony and you don't remember it that way, then of course, disregard what Mr. Santacroce or any other lawyer or myself even says what the testimony was. It's what you remember that's important here.

BY MR. SANTACROCE:

Q So this is a commonality that you would be interested in, isn't it?

A I mean, it would be something that we abstracted.

Q Did you recognize and identify this commonality?

A It would be something that we abstracted, so we would have looked at that.

Q I'm asking you if you have an independent recollection of looking at this?

A I don't recall. I don't recall.

Q Is there anywhere in the reports that identify this commonality?

A I mean, we would have documented, again, in that -- the trip report the IV start information. So there would be the only other location that we would have --

Q Okay.

A -- looked at.

Q But you had the wrong information about that?

A We had incorrect information for -- for July 2007, correct.

Q So you don't recall identifying this commonality; is that correct?

A I don't recall -- no.

Q Okay. Would this have affected your conclusion in any way?

A No.

Q Okay. I want to talk to you about your conversations with Mr. Lakeman, okay?

A Yes.

Q What day did that occur?

A I don't recall. I don't have the date documented on my notes, so I don't recall. It was back -- it occurred after I had returned to Atlanta.

Q Okay. Well, let's talk about these notes. These were contemporaneous notes?

A Correct.

Q And you're telling me that you don't have the date on that -- on the notes?

A No, sir.

Q That wouldn't be something that was important?

A No, sir.

Q Tell me how you initiated contact with Mr. Lakeman.

A I looked him up on the Internet and found a number and called it. I think I spoke to his wife once or twice and tried to find him and ultimately got, I think, his cell phone number and then connected with him via cell phone.

Q Okay. And how did you identify yourself?

A That I was a working CDC employee and -- and that we had done an investigation at the clinic where he had worked previously.

Q Okay. Did he express concern as to who you were, why you were calling him out of the blue?

A I mean, I recall that -- again, going back asking if I was recording the call, and I said I wasn't, and I explained, you know, that we wouldn't be using his name in things that we put out. So I don't recall more specifics than that.

Q So in other words, you called him, you said, I'm Melissa Schaefer from the CDC and I want to talk to you about an outbreak of hepatitis C at a previous clinic you worked for --

A Yes.

Q -- and he started talking?

A Ultimately, yes.

Q Okay. Tell me about some of the promises that you made him before questioning or talking to him, asking him questions.

A So again, I told him that I was not tape-recording the call. And again, since I didn't realize this was going to be a criminal investigating, you know, explaining how we typically do things as far as, you know, any reports -- don't list his name; we assign, you know, a number or something else for the information that's provided.

Q And you promised anonymity, correct?

A I don't know if I said I promise that we will never, but I think, you know, I said we -- we would -- wouldn't use his name. I don't know if the words, I promise, were used or not, but I did say, you know, we wouldn't use your name in reports.

Q Well, in your grand jury transcript you talk about how important anonymity is to the CDC in order to gain information for public safety.

A Right.

Q Okay. So tell me about that.

A So, you know, when we do these investigations, we rely on healthcare providers to be transparent with us and to perhaps tell us things that they wouldn't tell their employer or that they don't want others to know, you know; to take us aside and say, you know, I -- please know that -- this -- I don't want my employer to know this, but this is really what's happening here.

And so that's helpful to get honest information for

public safety so that if there's a bad practice identified, we can stop it. And so, yeah, that's --

Q Okay. And you explained that to Mr. Lakeman, correct?

A I don't know if I went into the detail that I am explaining here, but I did communicate that we wouldn't be using his name in any -- anything that we generated.

Q And that, in fact, didn't happen because when you got off the phone you used his name right away, didn't you?

A I didn't use his name in any reports that we generated. I communicated with our team, who has to -- you know, who has to know who the different players are. I mean, we are the ones who assigned CRNA 1 or 4. So it's more of a public thing as opposed to what our team -- the information our team needs.

Q Well, you called the Georgia Public Health Department before you talked to Mr. Lakeman --

A I did --

Q -- correct?

A -- yes.

Q And you knew that Mr. Lakeman was working at a hospital in Columbus, Georgia, correct?

A Yes, I did.

Q Did you call the hospital at Columbus, Georgia?

A I did not.

Q And Mr. Lakeman expressed concern about talking to you for those reasons; isn't that correct?

A I don't know that he gave any reasons. I don't recall that.

Q Well, he made the statement to you to the effect that, well, if -- I'm going to deny talking to you if -- you tell me what he said because I don't remember.

A It was something along the lines of denying that he had said these things to me if it came down to it.

Q And the point in the conversation when he said that was prior to you asking him any questions whatsoever; isn't that correct?

A I don't recall. I know he asked if I -- when we started talking, at some point he asked if I was recording, and -- because it was -- so we stopped and I said no, and then I don't recall at what point that came up, if it was after we had started going through some of this or before.

Q I'm going to show you your grand jury transcript on page 85 and 86.

MR. STAUDAHER: Is there a question?

MR. SANTACROCE: Yes, as to when in the conversation he made the statement as to denying that it ever took place.

THE COURT: Okay. That's the part of the grand jury transcript that you're going to show her?

MR. SANTACROCE: Yes.

THE COURT: All right. Go ahead.

BY MR. SANTACROCE:

Q Page 85 and 86. I'm just asking you to take a look at this portion here. The highlight is my stuff so...

A Okay.

THE COURT: Just read it quietly to yourself, and then let us know if that refreshes --

THE WITNESS: Yes.

THE COURT: -- your recollection.

THE WITNESS: Yes, ma'am. (Witness complied.) Okay.

BY MR. SANTACROCE:

Q Does that indicate to you when in the conversation he said that?

A That indicates it was early, but I think in that transcript I said -- you know, I started asking some questions, and then at that point, you know, we were going back and forth with the questions and he took a pause at that point. But it would have been early.

Q And it would have been before you asked him about any kind of injection practices, correct?

A I don't recall.

Q Okay. And that statement by Mr. Lakeman is fairly common, isn't it, when you interview people?

A I don't know -- I don't know that anyone has

specifically said I'll deny this, but certainly, you know, as I said, healthcare workers share things with us that they don't want their employer to know or others to know.

Q Okay. And, in fact, you made other comments to the grand jury regarding why people have that sort of attitude; do you recall what those were?

A I think it goes back again to, you know, typically in our reports we don't even name the healthcare facility. We say A or B or clinic C, and, you know, when we do healthcare worker stuff, we, in our reports, don't put the names to -- so that down the line healthcare workers will continue to want to communicate with us and talk to us.

Q And didn't you also say that the -- the employee is in fear of retribution from their current employer?

A I don't -- I don't recall that.

Q Okay. Let me show you your grand jury transcript, page 87. I want you to take a look at this portion here.

A Okay. (Witness complied.) Sir, I said that in a generality. I don't know -- I didn't attribute that specifically to Mr. Lakeman or why he -- why he --

Q No, we're talking about the attitude of --

A Oh.

Q -- a lot of people that you interview, when you call them up and say I'm from the CDC, that has a very

powerful effect on people, doesn't it?

A You know, I can't speak to the effect it has on them.

Q Okay. Fair enough. And when you're investigating and talking to these individuals, you said in your grand -- what did you say in your grand jury transcript -- or to the grand jury about that issue?

A That -- again, that we need healthcare workers to be honest with us and to tell us things and to do -- you know, the best we can with -- with any public reports that we generate or put out to not list names.

Q Didn't you say that they don't want retribution from their current employer for reporting someone else's actions, so I guess I wasn't entirely surprised by the statement?

A I did say that, correct.

Q Now, I'm going to ask you to take a look at the -- you felt this statement was important or the DA felt it was important?

A I asked a question that was asked of me, so I can't comment on --

Q Okay. It wasn't such an important statement that you put it in your notes, though, was it?

A No.

Q It's nowhere to be found in your notes, is it?

A Correct.

Q However, there is something in your notes that you did record that you thought was important, and that was the term "double dip," correct?

A Correct.

Q And double dip, is that your term or Mr. Lakeman's term?

A I believe that was Mr. Lakeman's term.

Q Have you heard that term before?

A I have.

Q And how was it used aside from your analogy with the chips?

A It's also used to reuse a syringe, to enter a medication vial for an additional dose -- taking a syringe that's already been used on a patient and going back into a vial to get more medication.

Q And you used that -- you have used that word yourself, haven't you, in seminars that you've given?

A I have.

Q I want to talk about some of the -- at least one of those seminars. Did you give a seminar on infection prevention in outpatient surgery centers on February 22, 2012?

A Where? Can you -- I may have. I --

Q Well, let me just show you this.

MR. STAUDAHER: Actually, would Counsel provide a

copy for the State, please?

MR. SANTACROCE: If you want to make a copy before I ask her, yeah.

MR. STAUDAHER: Can I just see it, what you're showing her.

THE COURT: Are you just showing that to refresh her recollection --

MR. SANTACROCE: Correct.

THE COURT: -- if she did a seminar?

MR. SANTACROCE: Correct. I guess I should mark this before I show her.

THE COURT: Well, if you're just going to use it to refresh her recollection --

MR. SANTACROCE: That's all.

THE COURT: -- then you don't need to.

MR. SANTACROCE: Okay.

THE COURT: Is that, like, some sort of a syllabus or something you're showing her?

MR. SANTACROCE: Actually, it came off of the -- her website.

THE COURT: Okay. Just look at that and see if it refreshes your recollection as to whether you gave a seminar on the date Mr. Santacroce --

THE WITNESS: I gave a webinar, yes.

BY MR. SANTACROCE:

Q A webinar. What's a webinar?

A It is a presentation that I can give from my office, calling in on the phone and other people can call in from wherever they are and log in to look at the slides that get advanced and listen to me by phone as I'm presenting.

Q And in that webinar you identified some common breaches; do you recall what they were?

A I don't.

Q Let me show you -- see if this refreshes your recollection.

A (Witness complied.) Okay.

Q What were some of the common breaches you identified?

A Sir, I think that needs some more context of the common breaches for what?

Q Okay. Tell me.

A So we looked at outbreaks of both bacteria and viruses in healthcare settings, and some of the common breaches were reuse of needles and syringes, either from patient to patient or to go back into shared medication vials. Reuse of single-dose vials for multiple patients regardless of syringe reuse, and I think, you know, poor hand hygiene or lack of aseptic technique was on there. Common saline bags or multidose vials that again -- sorry, it's already left my mind. I'd have to --

Q Okay.

A -- look at it.

Q Well, the viral -- you talked about viral and bacterial outbreaks, correct?

A Correct.

Q And the viral outbreaks was in specific reference to hepatitis, correct?

A Right.

Q And one of the breaches you noted was use of a single-dose vial of saline bags for one patient?

A Well, so the heading for that was viral and bacterial. And so outbreaks and then common breaches, and you're not going to see an outbreak of viral hepatitis just from reuse of a vial or just from reuse of a bag unless you have syringe reuse as part of that.

I typically would think, you know, reuse of a bag or reuse of a vial absent syringe reuse being more of a bacterial concern.

Q The -- when you identified the common breach of single-dose vials of saline bags for one patient, you didn't mention anything about reuse of syringes in that.

A So again, I'd have to look through all of the slides --

Q Okay.

A -- to know what was said when. I can only --

you're just showing me what was a bullet on that slide, so I think that there would have been some more context in my talk. But, yes, when I'm talking about outbreaks in healthcare settings and I believe -- and again, if you put it in front of me, we have how --

I think we said something like 41 outbreaks, how many were viral, how many were bacterial, and then I go on to look at some of the common infection control breaches that have resulted in outbreaks like these in healthcare settings, not making the distinction between viral, bacterial, that kind of thing, on that slide.

Q You also identified instrument reprocessing as a breach.

A Okay.

Q Do you want to see it?

A If -- I'll -- if it's in front of you, then I --

So this slide is actually commenting on the titles on infection control worksheet components.

Q Okay.

A So this is use of a worksheet that's been developed to assess infection control practices in healthcare settings, and so it's focusing on five, you know, major areas of infection control in general for healthcare settings.

Q And one of those was instrument reprocessing?

A Yes.

Q And tell me about that. You specifically say in your example on this webinar, endoscope --

MR. STAUDAHER: Objection, Your Honor. He's reading from it now.

MR. SANTACROCE: I'm asking her.

THE COURT: State your question.

BY MR. SANTACROCE:

Q You identified it, endoscope reprocessing under that instrument reprocessing, correct?

A So that can be a type of breach. Endoscopes are a type of equipment, one of many. So that can be one example. You know, other surgical instruments are also an example. Without going through every slide and --

Q Okay.

A -- and relistening to the talk, I can't put what was said in context.

Q Okay.

A But I agree, equipment reprocessing is on that slide.

Q And important --

A Yes.

Q -- in controlling infections?

A Sure.

Q And you say -- what do you say in regard to endoscope reprocessing?

A Again, without seeing the slides in their --

Q Well, let me show you --

A -- totality --

Q -- this, maybe it will refresh your recollection.

A So again, this is focusing on an infection control worksheet which is looking at infection-control practices in healthcare settings. And so it's looking at five main areas, hand hygiene -- this is something that we developed with the centers from Medicare and Medicaid services so that when their regulatory folks go into an ambulatory surgery center, they're looking at things systematically.

And so it's looking at -- and the worksheet is available online, but they're looking at things like hand hygiene, use of personal protective equipment, injection safety, medication handling, instrument reprocessing including sterilization of critical devices or high-level disinfection of things like endoscopes, cleaning of the environment, so cleaning of environmental surfaces, and handling of point-of-care devices like the blood-glucose meter.

Q Okay. So the -- the endoscope reprocessing, you mentioned high-level disinfection --

A Yes.

Q -- and sterilization?

A So those were two separate kind of components.

So endoscopes are something called a semicritical device, meaning that it needs to go at a minimum under high-level disinfection before use on another patient. There are devices called critical devices that are things that you use kind of during a surgery when you cut into someone and it's going into that space, and that needs to undergo, at a minimum, sterilization.

So I was talking about different types of reprocessing.

Q Okay. Well, let's talk about the high-level disinfection.

A Okay.

Q That's for endoscopes, correct?

A At a minimum. You can also --

Q Well, I'm only talking --

A -- sterilize.

Q -- about endoscopes for now.

A Okay.

Q I mean, I -- and I know you can bring in a whole other bunch of equipment that I know nothing about, but at issue in this case are endoscopes. So that's why I'm talking to you about that.

A I understand --

Q Okay?

A -- that, but I'm trying to answer your question,

which is some endoscopes can also be sterilized. But at a minimum, yes, high-level disinfection.

Q And when would it require sterilization for an endoscope?

A It would depend on the manufacturer's instructions. I can't answer that.

Q Okay. In this clinic you looked at endoscopes?

A Yes.

Q And what was the manufacturer's recommendations for cleaning or sterilization?

A So it was a number of steps including a precleaning step and then high-level disinfection.

Q Okay. And how is that accomplished at the clinic?

A So again, it's a number of different steps starting from when the scope comes out of the patient and doing some initial cleaning, and then taking it into the -- a separate room in the facility where they do scope reprocessing and walking through a number of different steps. They check the scope, doing a leak test to make sure that none of the channels were broken during the procedure and that the scope is still functional. They will brush out the channels and actually clean it with a detergent and rinse the detergent out so that you get the initial, you know, debris that's on there, any stool or anything else off.

And then after it's gone through the initial precleaning and brushing and rinsing, it would go into an automated machine that does high-level disinfection. And so it gets hooked up to that machine to run the high-level disinfectant through it and on it, it alarms so that you do an alcohol, you know, drying step after it's been rinsed and dries, and then it comes out and gets hung now that it's been disinfected for use on the next patient.

THE COURT: You know what? Mr. Santacroce, I'm going to go ahead and interrupt your cross-examination. We're going to take our lunch break.

Ladies and gentlemen, we'll be in recess for the lunch break until 2:30.

During the recess you are reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person, or subject matter relating to the case. Don't do any independent research, and please don't form or express an opinion on the trial.

Notepads in your chairs. And follow Kenny through, I guess, the rear door.

And, ma'am, please don't discuss your testimony with anyone else during lunch break.

(Jury recessed at 12:55 p.m.)

THE WITNESS: Does that include the prosecution? I guess so.

THE COURT: They probably shouldn't be talking to you about the testimony --

THE WITNESS: Okay.

THE COURT: -- because you're in the middle of it --

THE WITNESS: Okay. I just wanted to make sure.

THE COURT: -- is the idea of -- yeah.

THE WITNESS: So I just have to be back here at 2:30?

THE COURT: Right. Exactly. 2:30 and you're free to go to lunch.

Before we take our lunch break -- is that door shut? Scheduling. Mr. Santacroce, how much more do you anticipate?

MR. SANTACROCE: Oh, probably a half-hour.

THE COURT: Who is doing this one? How long do you anticipate?

MR. WRIGHT: At least through the end of this day.

THE COURT: Okay. So we don't really need to worry, then, about you reviewing the new notes because you'll have all evening to do that?

MR. WRIGHT: Correct.

THE COURT: All right. But you have extra time anyways, so you can start reviewing those, if you want to. All right.

MR. WRIGHT: Extra time.

THE COURT: We do. We have an hour and a half. It's extra time. I mean --

MR. SANTACROCE: What time are you breaking this afternoon? Or was there another conflict?

THE COURT: Oh, yeah. There's another issue so we have to break -- what I said, 4:30?

MS. STANISH: Third-grade graduation?

THE COURT: Well, it's all these graduations and everything. After, what, Wednesday there should be nothing else, and we can stay later after Wednesday. So, you know. I mean, to me -- have to let people go to these graduations, you know, when you're in trial for weeks and weeks. So -- okay. So that's our schedule for today.

(Court recessed at 12:57 p.m. to 2:37 p.m.)

(Outside the presence of the jury.)

THE COURT: They're all back now, so we can get started. Let Kenny know we're ready to start.

(Pause in the proceedings.)

MR. STAUDAHER: Your Honor, would you like me to get the witness?

THE COURT: Oh, would you? Thank you, Mr. Staudaher.

(Jury entering at 2:45 p.m.)

THE MARSHAL: Everybody may be seated.

THE COURT: All right. Court is now back in session. And, Mr. Santacroce, you may resume your cross-examination.

MR. SANTACROCE: Thank you, Your Honor.

CROSS-EXAMINATION (Continued)

BY MR. SANTACROCE:

Q I believe we were talking about high-level disinfection for endoscopes, and you were explaining what that meant.

A Yes, sir.

Q So could you just go ahead and refresh our recollection as to what high-level disinfection means?

A It's multiple steps, a disinfection process for scopes to be used on subsequent patients. Do I need to go through the steps again?

Q I don't think so. Are there manufacturer's guidelines on how to clean these things?

A There are instructions for -- specific for each device, and then, CDC also has general guidelines for reprocessing of medical devices.

Q Did you observe the cleaning process when you were at the clinic --

A Yes --

Q -- all the --

A -- I did.

Q -- soaps?

A Yes, I did.

Q And can you tell me what you observed?

A So I'd like to refer back to our trip report just to refresh my memory, if that's okay?

THE COURT: That's fine.

BY MR. SANTACROCE:

Q If you can just tell us where you're looking?

A Sure. So I'm looking at the document that we've previously seen, which was the CDC trip report.

Q Okay. I'm having trouble hearing you. Can you speak --

A I'm sorry. I'm looking at the document that we previously reviewed, which is the CDC trip report --

Q Okay.

A -- and I'm looking starting on page 5 of that document.

Q Can you give me the Bates Stamp Number on the bottom? Do you have one of those?

A I do not, no.

Q Okay.

A Not on my copy. I'm sorry. But it's page 5 of our text.

Q Okay. I -- I don't want you to read that --

A Yeah --

Q -- out loud.

A -- I just want to look through it and then --

Q Okay.

A -- I'll answer. So, you know, what we observed was once the procedure was over, the scope would be handed off to a tech in the room who had some type of cleaner or detergent actually kept at the bedside that was changed between patients and would suck the detergent up through the channels and flush it out just to clear it before carrying it into a separate room that they had that was dedicated for scope reprocessing.

And so they would go into that room and they would do what I mentioned before, a leak test, which is making sure that there wasn't any damage to the -- the scope during the procedure, that none of the channels were damaged, and then if that passed, they would go ahead and do the precleaning, which would again be brushing the -- using a brush to brush through the channels, and then putting it in a bucket that contained detergent and hooking it up to this pump that would pump detergent through the channels, and then that would be for a set length of time and then it would be transferred to a water bucket that would flush the detergent out and rinse it off, and then that would be for a set length of time. And then once that was done, it would go into the machine or the automated endoscope reprocesser that they had, and so you connect it in the machine and that machine is an automated process to put high-level disinfectant through and around the scope for a set period of time.

So that does that. And then I think there's an alarm at some point that they have to push a button that alcohol goes through all the channels to kind of help dry it. It will do some forced-air drying, and then it comes out of the machine. And so now it's been cleaned and disinfected and it gets taken into another room where it's hung with all the other clean scopes.

Q Okay. i want to show you what's been admitted as State's Exhibit 126. Does that look like the reprocessing room?

A Yes.

Q Okay. And you personally observed this cleaning process, correct?

A Yes.

Q Now, do you know what these blue buckets were used for?

A I -- I'm not certain because it's been so long, but I'm guessing those were the buckets for the cleaning, but, you know, it's been so long.

Q Did you interview any GI techs that were employed on July 25, 2007, or September 21, 2007?

A I don't recall if the techs that were working on the days that we were there observing and speaking to were also techs that were working on the days -- those two dates in question. I don't recall.

Q Okay. And how many scopes did you observe them cleaning in a bucket before the solution was changed?

A Two.

Q If there was testimony by GI techs that there were up to 11 scopes cleaned at a time with that solution, would that -- how would you react to that?

A It's inappropriate.

Q I'm going to show you what's been marked as State's Exhibit 149. Do you recognize what this is?

A That looks like the clean supply cabinet, but again --

Q Okay. I'm going to show you 150. Do you recognize that?

A That's another cabinet with scopes hanging. I'm not -- you know, I don't have any context around it, so...

Q And when -- did you witness these scopes hanging?

A I don't recall. Probably. But I can't say with certainty. I think we did look at scopes that were hanging.

Q Did you -- did you notice any feces coming from the clean scopes or on the chux that were below the scopes?

A Not that I recall, no.

Q If you had, would that be a concern?

A Yes.

Q And you'd be concerned about that because that

could be a mode of transmission, correct?

A I'd be concerned because that reflects improper reprocessing. I'd want to know more to determine if that was a mechanism of transmission.

Q Okay. A point to which you addressed in your webinar.

A What point?

Q About the instrument reprocessing and the high-level disinfection?

A So my webinar was about -- in general, not specific to reprocessing for this facility.

Q Oh, I understand that.

A Okay.

Q Okay?

A Sorry.

Q But those sterilization practices apply to every ASC, right?

A All healthcare facilities should be doing appropriate reprocessing of medical equipment, yes.

Q So the practices and points that you put out in your webinar are applicable throughout the United States, if not the world?

A Certainly.

Q Now, in your webinar you talked about, quote, double dipping, a term that you obviously used because it's in

your --

A Yes, it's in my presentation. I did --

Q -- presentation --

A -- use it there.

Q -- correct?

A Correct.

Q And do you remember how you defined double dipping in your webinar presentation?

A I think it's the same way I've defined it here, which is taking a syringe, using it on a patient, and then using that syringe to go back into the medication vial for that patient, and then that vial is then used for subsequent patients.

Q Okay. I'm going to show you a slide from that presentation. See if this refreshes your recollection.

A (Witness complied.) Okay.

Q Okay. And what did -- what did you say in that webinar regarding double dipping?

A So what I just said here, that a syringe is used on a patient and goes back into a medication vial.

Q This specifically addressed IV medication into a patient, did it not?

A I would have -- I don't recall. I'd have to look again. I'm sorry. I didn't focus on that word, but that would make sense, sure.

Yes.

Q And you particularly focused on IV medication because there happened to be an outbreak due to contamination through IV medication, correct?

A So I'd have to look at the headline, I don't know if that was an outbreak or if that was actually a notification event that resulted from that practice. CDC's recommendations are if that practice is identified, it is what we consider a Category A lapse that can and has resulted in disease transmission and patients should be notified and tested.

Q Take a look at the second bullet point.

A (Witness complied.) Correct.

Q Okay. It refers to patient note -- 2,000 patients being notified of a blood-borne pathogen in relation to this double-dipping practice, correct?

A Correct.

Q Where did that occur?

A Whatever it says on there, San Pedro -- I can't read the headline.

Q San Pedro, California?

A I don't know. I can't read the headline that's on there to refresh my memory.

Q Okay. And you recall the result of what happened due to that outbreak due to double dipping for IV

medication?

A So as you said, it resulted in a notification and a recommendation for blood-borne pathogen testing of patients.

Q I'm going to show you another slide from that presentation, and ask you to take a look at it.

A (Witness complied.) Mm-hmm.

Q Can you explain to me what that means?

A So this is a slide that's addressing --

Q Are you done with that?

A -- do you mind, so you don't have to walk back and forth?

Q Okay.

A Do you mind if I just keep it? I'm sorry.

Q I don't mind staying here.

A That's not a problem for me, if you want to share it.

Q Okay. We'll share.

A So it's a slide looking at prior reports of lapses and reprocessing of medical equipment. And so it looks at reports that have been filed at the Food & Drug Administration, and it also looks at a study or pilot that -- that I, the folks at CDC did, along with the centers for Medicare and Medicaid services, looking at infection-control practices and ambulatory -- a sample of ambulatory surgery

centers, and then also summarizes some publicly available data from the California Department of Health Services about endoscope reprocessing.

Q And tell me what you specifically found.

A So in the pilot for ambulatory surgery centers the surveyors found that about 28 percent of facilities had some type of lapse in reprocessing of medical equipment. It varied across the board, was not just limited to endoscopes or high-level disinfection.

And then what else -- do you want to specify or --

Q No, you can just tell me what else you found in the reports.

A So FDA --

Q What is -- what is this?

A So the Food & Drug Administration over about a three-year period from 2007 to 2010 reported about 80 reports to them of inadequate reprocessing of some type of medical device that was filed with their agency, and they deemed that 28 reports of infection may have occurred from inadequate reprocessing, but I don't know what types of infections those were.

Q Okay. Fair enough. And these reprocessing of these medical devices include endoscopes, correct?

A I can't speak specifically for the FDA because I don't think it specifies on there. On the ambulatory surgery

center one, I think there is mention of high-level disinfection lapses, and I think the California one was focused on endoscopes as well, but you've taken it, so...

Q What other items did you find in the clinic that were being reused?

A We -- we didn't, in the clinic, identify any other items that we observed being reused. The propofol vials, the multidose vials of saline, multidose vials of lidocaine, the scopes. I think those were the only things that I recall seeing that were used for more than one patient in some fashion.

Q In your grand jury transcript, didn't you mention bite blocks?

A We did not observe that while we were there. I think that was identified or reported subsequent to us being there, I think. I don't recall that.

Q Did your report -- or your investigating take into consideration that bite blocks might be being reused when they were single-use items?

A Well, we did but again, when you look at the cases and their source, you only use a bite block if you have an upper endoscopy. You don't use it if you're getting a colonoscopy and not all of the patients had an upper endoscopy. So that, in my mind, was not a potential source of transmission here.

Q Were some of the ones that were infected, did they have any uppers?

A I'd have to look back at our -- the trip report again on that page 13.

Q Okay. Go ahead.

A And so -- do we need to put it up or can I --

Q No, you --

A Okay.

Q -- can just look at it.

A So for July 25, 2007, our potential source patient had an upper endoscopy, but our case patient who became infected had a colonoscopy so wouldn't have had a bite block.

Q Well, the source patient would have.

A Right. But in order for there to be transmission, I would expect that -- some sharing between the source --

Q Okay.

A -- and the -- and the infected patient, and the bite block wouldn't have been shared.

Q Okay.

A And honestly I don't think a bite block would be a source anyway, but -- and then looking at September 21 -- so our potential source patient that day who was the source of virus that went to the other patients, had a colonoscopy so

wouldn't have had a bite block. And then our cases -- again, looking at September 21, only one of them had an upper endoscopy; the rest had colonoscopies.

Q Are you referring to page 13, that table?

A Yes, sir. I am.

Q Okay. Let's put that up here.

A Yes, sir. Do you want me to --

Q No, that's what you're --

A -- okay.

Q -- referring to?

A Yes, sir.

Q I'm going to point this date out to you here.

A Yes.

Q It says, September 20, what -- what is that -- why is that in there?

A That is because one of our patients, Case 2 there, had two separate procedures. One on the 21st was their upper, and one on the 20th was their colonoscopy or lower. So they were listed twice because they had procedures twice at this clinic.

Q Okay. But can you pinpoint what day they were infected?

A The 21st.

Q Okay. And then how about case 4, it says the 19th?

A Yeah. So Case 4had an upper endoscopy on the 19th and then Case 4 had a colonoscopy on the 21st. Sorry. It's not right next to it, but --

Q So the same thing, two procedures --

A Two procedures --

Q -- on different days?

A -- on different days, yes.

Q Okay. Also, while we're on this chart here -- on -- for the September 21st dates --

A Yes.

Q -- do you notice who started the IV's, who you have on here? You have RN 1, 1, 3, 1, 2, and 5.

A Yes.

Q Who is RN 1?

A I don't know.

Q Who is RN 3?

A I don't know.

Q RN 2?

A I don't know.

Q If I were to tell you that the records that were put together by the State only show two nurses giving IV's on that particular day to those infected patients, would you have an explanation for that?

A I would not.

Q Could it be a mistake on your part?

A It could be.

Q I want to talk to you now about some of your conclusions. From looking at exhibit -- State's Exhibit 165, this is your report, I believe?

A So this is the publication in the Clinical Infectious Disease Journal. Okay.

Q Yes. And what was your conclusion that you reached after your -- was it nine-day investigation?

A Nine or ten days.

Q How many days were spent at the clinic?

A Again, I think we were there all days, but I can't say with certainty that on a Sunday if they were open or not, but the majority of the days were there. And then obviously, the investigation continued after we left; but if you're focusing on the field, that was nine or ten days.

Q Okay. So tell me what conclusions you reached after your investigation?

A So we concluded that a transmission of hepatitis C virus occurred at this clinic on two separate dates, and that transmission occurred through unsafe injection practices, meaning reuse of syringes. So drawing up propofol, administering it to a patient, reusing that syringe to go back into a vial, and then using that vial on subsequent patients.

Q And I believe you said -- you used the word "likely" means of transmission?

A Correct.

Q And what did you mean by likely means of transmission?

A I was not present on -- on July 25th or September 21st, so I am relying on the investigating we did several months later and the information that -- of all the totality of potential that we looked at and knowing that that practice has been attributed to a disease transmission previously, and it was witnessed as well as stated that it happened to us; and looking at all the different possibilities that's the one that makes sense.

Q Makes sense?

A Yes.

Q On page -- well, on this it says 272, but it isn't that long. You say that the investigation and conclusions reached are subject to unavoidable limitations?

A Correct.

Q What did you mean by that?

A It goes back to the fact that I was not there on July 25th or September 21st to witness what happened on those dates, and so I'm relying on review of records and the information provided to us several months after the fact.

Q And you state that the investigating occurred over a ten-day period five months after the initial transmission occurred, correct?

A Correct.

Q And you said that the observations and interviews were potentially subject to changed practices and recall bias?

A Sure.

Q So those conclusions you reached are subject to these limitations, correct?

A Correct.

MR. SANTACROCE: I have nothing further. Thank you.

THE COURT: All right. Thank you, Mr. Santacroce. Is it you, Mr. Wright?

MR. WRIGHT: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q My name is Richard Wright. I represent Dr. Desai.

A Thank you.

Q In preparation for your testimony here in the courtroom, what have you reviewed?

A So I have reviewed the three reports or publications, whatever we're going to call them, that were generated from CDC, the notes that have been provided to you, my grand jury transcript, and my interview with law enforcement before that have been the -- the main documents I have here that I've looked at.

Q Okay. And have you discussed it with anyone, your testimony?

A As far as what I'm planning to say, no. As far as I'm traveling here to testify, yes.

Q Okay. And have you been preinterviewed by the District Attorney's Office?

A Yes.

Q Okay. And preinterviewed -- and I mean in preparation for your testimony?

A Yes, sir.

Q Okay. Prepared by anyone else other than the prosecutor?

A No.

Q Okay. Now, do you -- because you're testifying about a visit to the clinic for about ten days in January 2008, about five and a half years ago, do you have an accurate recollection of the conversations, the people, the places, or are you relying upon your report?

A I think a mixture of both. I think the reports have helped refresh my memory of what I may have previously stated in closer proximity to the investigation. There are certain things that I have independent recollection of, so I'd say it's a combination.

Q Okay. And the, like, on -- if we talk about the placement of IV's with -- we've been calling them heplocks

here in the courtroom --

A Okay.

Q -- on the placement of those, do you have a clear recollection of the days -- or day you spent in observing it?

A Can I ask a -- when you say "placement," do you mean on the body or in the location in the clinic where it was placed? Like --

Q Okay.

A -- I'm sorry.

Q I mean insertion of it.

A So whether it was up here or down here or --

Q Right.

A -- I don't recall where on the body. I could look through my notes and I may have documented that, but just off the top of my head I don't recall if it was in the hand or if it was in the -- the antecubital fossa.

Q Okay. And the -- do you recall, like, I can read the report, you know, and read that a, what I would call a multiuse saline bottle was used in the preop area?

A Yes, that is accurate.

Q Okay. And do you remember that, or are you just reading the report like me?

A I remember that.

Q Okay. Do you remember when you were asked about

it by the police in your interview; that you were unclear on the memory of it when they asked you about prefilled saline syringes, you -- you had trouble recollecting whether it was prefilled saline syringes or a multidose saline bottle that was used for the heplock saline flushes?

A So I know what you're asking about, and I recall that multidose vials of saline were used. When law enforcement asked me about it, I think I somewhat misinterpreted their question in asking if prefilled -- manufactured prefilled syringes of saline flush were also used, and I did not observe that but was trying to remember did they have those as well. But what I observed was the multidose vial side of things.

I didn't -- I was trying to make sure that I wasn't misremembering that there were also prefilled saline flushes, and there weren't.

Q Okay. But you, I mean, you -- the -- so you were -- any confusion that it looked like from just reading the transcript, bear in mind, I wasn't there --

A Right.

Q -- at the interview -- that was simply confusion about were they asking in addition to multidose saline, were there also prefilled saline syringes?

A So in rereading the transcript in preparation for this, that's how I am interpreting --

Q Okay.

A -- that exchange because I know that multidose saline vials were used there.

Q Okay. And on there -- during that exchange and -- did someone say something? Oh.

THE COURT: Bless you.

MR. WRIGHT: Maybe I'm hearing things.

BY MR. WRIGHT:

Q Did you see -- during that exchange -- someone else -- I mean, it just has question marks as that's in the report.

A Question marks where?

Q As to who the speaker is.

A So can -- can we open it up?

Q Sure.

A Is that okay? I'll show you when I find it.

Q I think it's around page 14 --

A Thank you.

Q -- that ought to help you out.

A So it's from page 12 or 13 here, right?

Q Correct.

A So place an IV flush --

Q See -- yeah, on a -- page 13, your -- your recollection is exactly as you're testifying, and then what I was asking about --

A Is here?

Q -- yeah, it says -- someone says, Yeah, our trip report indicates the multidose saline flush --

A So that question mark is from my supervisor Joe Perrs [phonetic], who was also present in the interview. I think the transcriptionist -- since he probably didn't say this is Joe Perrs, but the next statements lead me -- he was -- he was present for the interview with me, and as you'll note later in the document, actually was responding to some of the questions since he supervised, was a co-author, approved our report, talked to him every night, so he answered some questions later.

So these question marks indicate to me that that was Joe's responses.

Q Okay. And so you say, Yeah, and then said -- I mean, he interrupt --

A He did.

Q -- you interrupted him -- multidose saline flush was the norm, and that is correct?

A Right. So --

Q I mean, he -- he's still speaking. That was the norm, at least the terms of what Gayle and Melissa observed and recorded --

A Yes.

Q -- correct?

A And prior to this interview with law enforcement, we had generated an earlier draft of the trip report, which addressed that as well.

Q Okay. I -- I was just confused --

A I understand.

Q -- as to who -- who was prompt -- answering.

A Yes.

Q And so that's -- when you talked about the home team --

A Yes.

Q -- you were the -- the road team --

A We were the --

Q -- is that --

A -- field team.

Q -- field team.

A They were the home team.

Q Okay. And so you would be reporting back -- you and -- was -- and Gayle?

A Yes. So if you look at our -- at the trip report you'll see language that says, Through, and those are the two main supervisors of the investigation. There were others involved, but those were the folks that were speaking -- that were in communication with Southern Nevada Health District before we left, are supervising, have -- you know, the investigation and we're speaking with every day and