

1 Q What other publication goes out of CDC?

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

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

7 A Correct.

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

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

13 Q Who publishes this MMWR?

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

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

18 A Yes, sir.

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

21 A Clinical Infectious Diseases accepted that.

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

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

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

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

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

9 BY MR. WRIGHT:

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

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

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

22 A Yes. The MMWR is May 16.

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

25 A It's freely accessible on the Internet.

1 Q Okay.

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

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

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

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

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

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

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

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

1 A My conclusions about how transmission --
2 Q Likely cause.
3 A -- occurred in the facility? No.
4 Q Okay. And so it wasn't something where a later
5 report came out, this is it?
6 A This is it.
7 Q Okay. Now, I want to go back to the trip
8 report. You talked about likely causes of the transmission.
9 Okay. And without focusing on August -- July 25 or September
10 21, just combining it in general, you're there looking for
11 hepatitis C, okay?
12 A Okay.
13 Q Cause of transmission.
14 A Okay.
15 Q The -- the likely causes you considered, let's
16 just tick them off.
17 A So again, you know, confirming the diagnosis in
18 these patients to confirm that transmission likely occurred in
19 the facility, and then we're looking at, you know, the
20 possible ways they could be exposed. So things that I think
21 about are as we talked about before, it's a blood-borne
22 pathogen, so blood to blood. So looking to see, you know, did
23 they have any finger stick testing where you prick the finger
24 to get blood.
25 Q And that -- the answer to that was no --

1 A Correct.

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

5 A Right. They did not do that testing.

6 Q Okay. Go ahead.

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

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

14 A Right. Correct.

15 Q But we also had saline we looked at.

16 A We looked at, we -- go ahead.

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

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

23 Q Okay.

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

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

4 A That is my recollection.

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

7 A None of the healthcare personnel did.

8 Q So that like -- that ruled out that.

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

13 Q Okay. And go ahead and --

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

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

21 A Okay.

22 Q Likely cause of transmission of Hep C?

23 A No.

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

1 viral blood to blood infection?

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

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

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

13 Q Correct. Just by if I --

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

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

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

21 Q Okay. And --

22 A Again, barring issues related to --

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

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

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

5 A Not in isolation.

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

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

12 Q Okay. Bite blocks --

13 A So --

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

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

19 Q Yes.

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

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

24 A No.

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

1 cheapskate?

2 A No.

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

11 A Correct.

12 Q -- is that fair?

13 A Correct.

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

18 A That is our goal and intent, yes.

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

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

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

1 were there?

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

4 Q A lie. They like said --

5 A Yes.

6 Q Okay. What was that?

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

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

13 A Correct.

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

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

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

20 A Well, so --

21 Q I mean, it could have been previous reuse.

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

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

2 A So that's what I'm --

3 Q Okay.

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

6 Q Well, you can't go --

7 A -- some of that.

8 Q -- there.

9 A Right. So it's hard --

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

15 A Right. So --

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

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

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

5 A Yes.

6 Q -- in the efforts?

7 A Yes.

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

10 A Yes.

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

14 A Right. Correct.

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

17 A I did.

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

20 A Right.

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

23 A Correct.

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

1 changing the enzymatic detergent every two scopes.

2 A Correct.

3 Q And the detergent said change it every single
4 scope.

5 A Correct.

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

8 A Correct.

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

11 A Right.

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

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

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

18 A Right.

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

23 A Correct.

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

1 A That sounds accurate.

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

5 A Okay.

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

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

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

15 A Yes.

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

20 A Yes.

21 Q And so those scopes had to have been clean.

22 A Yes.

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

1 happen?

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

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

10 Q Okay. So that's less likely?

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

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

18 A Yes, sir.

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

21 A Right.

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

24 A Yes.

25 Q Okay. And the cleaning problem, if there was

1 one?

2 A Yes.

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

6 A Yes.

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

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

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

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

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

21 A Yes.

22 Q Okay. And lidocaine injection practices being
23 less likely?

24 A Yes.

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

1 A Both labeled as multi use, yes.

2 Q Right. And being used multi use?

3 A Yes.

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

6 A Yes.

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

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

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

19 A Correct.

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

22 A That was my understanding.

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

25 A Then used.

1 Q Dangerous word that, reused.

2 A Right. Then used the next day.

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

6 A No. The --

7 Q How's it work?

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

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

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

18 Q Yes.

19 A And then what was the question?

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

22 A Mistakes can be made, sure.

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

1 correct?

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

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

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

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

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

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

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

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

11 A That was my --

12 Q -- they being the --

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

15 Q Okay. They being the CRNA?

16 A Correct.

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

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

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

25 MR. STAUDAHER: Say evidence showed or something to

1 that effect.

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

3 THE COURT: Well, state your question.

4 BY MR. WRIGHT:

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

9 A Okay.

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

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

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

18 A So, yeah.

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

21 A There could be, sure.

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

25 A Okay. I hadn't heard that before.

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

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

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

13 A Yes, sir.

14 Q Was there anything I've overlooked --

15 A I don't think so.

16 Q -- as a possible?

17 A I think --

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

20 A Right.

21 Q Meaning coming from a healthcare worker.

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

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

1 intent, someone doing something purposefully bad.

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

4 Q Correct.

5 THE COURT: An intentional malicious act.

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

8 BY MR. WRIGHT:

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

11 A No.

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

14 A Yes.

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

17 A By phone and by email, yes.

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

20 A Correct.

21 Q -- and offering to do any additional testing?

22 A Correct.

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

1 A [No audible response.]

2 Q And then I think thereafter --

3 A Lawsuits. Well, sure, yes.

4 Q Is that right?

5 A Well, the last page is our quasi species

6 analysis. But I get your intent, which is we had the

7 discussion section here on page 8 and 9, where we're --

8 Q Oh. My last page of the --

9 A So this didn't have like our conclusions and

10 summary on it; isn't that what you're saying?

11 Q I thought this was done after --

12 A After we -- right. Right. I think it was in

13 progress while we were there, completed after we left, yes.

14 Q Okay. Now, your -- you were not conducting a

15 criminal investigation?

16 A No.

17 Q You had no idea that what you were doing would

18 result in criminal charges, correct?

19 A No.

20 Q Yes?

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

22 Q Correct, yes?

23 A Correct, yes. I had no idea.

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

25 A I apologize.

1 Q We go by the record.

2 A Yes, sir. I had no idea.

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

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

8 A Right. Sorry.

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

11 A I try to practice what we preach, yeah.

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

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

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

17 A Correct.

18 Q -- the practice?

19 A Yes.

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

22 A Sure.

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

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

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

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

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

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

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

21 A Correct.

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

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

3 A Okay.

4 Q Were you aware of that?

5 A I don't recall that, no.

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

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

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

16 A That is a misperception out there, yes.

17 Q Right. A widespread misperception?

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

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

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

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

24 A Coming up where?

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

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

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

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

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

8 THE COURT: -- pressure plunger idea?

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

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

16 BY MR. WRIGHT:

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

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

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

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

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

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

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

15 A Correct.

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

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

21 Q Yes. Right at the bottom.

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

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

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

4 A Right.

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

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

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

1 do that.

2 Q So I can freely ignore your best practice?

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

5 Q Or I might be sitting here.

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

8 Q But I cough like this too [indicating].

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

13 Q I'm not suggesting --

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

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

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

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

3 A Centers for Medicare and Medicaid Services, so
4 Medicare.

5 Q Okay. What's their initials?

6 A CMS.

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

11 A Right. If you want to get paid --

12 Q Right.

13 A -- here's the rules.

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

16 A Right.

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

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

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

1 A Okay.

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

5 A We --

6 Q -- during the visit?

7 A Yeah. Sometimes not --

8 Q Like don't do this --

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

14 Q Okay. So this was like a recap?

15 A Yes.

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

17 A Yes, sir.

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

21 A Correct.

22 Q "Never pool medications from individual vial."

23 And that's the using the leftovers, pooling into one, correct?

24 A Correct.

25 Q "Never use single use vials for multiple

1 patients."

2 A Correct.

3 Q "Never recap needles," right?

4 A Yes.

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

7 A Yes.

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

11 A Correct.

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

14 A Yes, sir.

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

17 A Yes.

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

20 A Okay.

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

25 A We don't recommend that at CDC.

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

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

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

7 A I am.

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

14 A I'm disappointed.

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

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

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

19 A Yes.

20 Q And what is it, like 28 percent --

21 A So --

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

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

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

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

10 A I have friends who do though.

11 Q I'll bet.

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

13 BY MR. WRIGHT:

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

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

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

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

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

4 A Why buy a 50 cc if you --

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

12 A But if you're --

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

16 MR. WRIGHT: I didn't --

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

18 THE COURT: Okay.

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

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

22 MR. WRIGHT: Okay. What size --

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

24 Go ahead.

25

1 BY MR. WRIGHT:

2 Q What size do you think propofol comes in?

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

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

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

13 Q You tell me if I'm wrong.

14 A So the only --

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

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

19 MR. WRIGHT: You tell --

20 THE COURT: Okay.

21 BY MR. WRIGHT:

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

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

4 Q Okay. And what were the results of that?

5 A I don't recall.

6 Q Other clinics were doing the same thing,
7 correct?

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

10 Q Other -- you --

11 A I'm willing --

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

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

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

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

1 THE COURT: Well --

2 MR. WRIGHT: I'm asking.

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

7 MR. WRIGHT: You can answer.

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

10 BY MR. WRIGHT:

11 Q Can you give me an educated guess?

12 A I mean, I can --

13 MR. STAUDAHER: Objection. Speculation.

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

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

21 MR. WRIGHT: 2000 --

22 THE WITNESS: '10 maybe.

23 MR. WRIGHT: '10.

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

1 multiple patients.

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

3 THE WITNESS: But that's not --

4 MR. WRIGHT: You were the author.

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

8 MR. WRIGHT: You knew.

9 MR. STAUDAHER: Objection. Argumentative.

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

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

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

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

18 (Pause in proceeding.)

19 THE WITNESS: That's it.

20 MR. WRIGHT: That's it.

21 BY MR. WRIGHT:

22 Q Who's the lead author?

23 A I am.

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

1 somewhat prompted by what happened here.

2 A True.

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

6 A Yes.

7 Q Okay. And concerns were raised?

8 A Yes.

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

13 A That's fair.

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

17 A Yes.

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

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

22 Q Okay. And did those things prompt this study?

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

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

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

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

11 Q Okay. And the four states agreed?

12 A It was three states in this.

13 Q Three?

14 A Yes, sir.

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

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

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

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

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

7 A Yes. That's correct.

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

9 A Okay.

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

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

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

14 BY MR. WRIGHT:

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

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

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

21 A Yeah.

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

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

1 lapse was noted.

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

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

12 Q But you all were looking for both, correct?

13 A Correct. Yep.

14 Q And like in your survey, you found both?

15 A In this pilot?

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

18 A The one here at the clinic in Las Vegas?

19 What --

20 Q No.

21 A I don't understand.

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

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

25 THE COURT: -- states that were studied?

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

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

7 THE WITNESS: So 2276? Okay.

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

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

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

14 THE WITNESS: Okay. Sorry.

15 BY MR. WRIGHT:

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

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

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

25 A Correct.

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

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

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

11 A Correct.

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

14 MR. WRIGHT: Okay.

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

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

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

25 THE WITNESS: Thank you.

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

2 THE COURT: Yeah, you go this way.

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

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

10 (Outside the presence of the jury.)

11 THE COURT: Bring them in.

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

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

17 MR. SANTACROCE: No.

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

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

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

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

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

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

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

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

1 the staff every day.

2 MS. WECKERLY: That's nice.

3 MR. SANTACROCE: Not for the lawyers.

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

6 MR. STAUDAHER: That's fine.

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

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

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

19 (Pause in proceeding.)

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

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

23 CROSS-EXAMINATION (continued)

24 BY MR. WRIGHT:

25 Q The infection control assessment of ambulatory

1 surgical centers --

2 A Yes.

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

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

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

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

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

10 A Right.

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

13 A Where --

14 Q I'll find it.

15 A Okay. Thank you.

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

19 A Yes. Correct.

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

21 A Yes.

22 Q -- and then they do their survey?

23 A Yes.

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

1 vials.

2 A Yes.

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

8 A Correct.

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

12 A Yes.

13 Q Okay. And why is that?

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

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

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

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

1 admitting the --

2 MR. WRIGHT: Yes.

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

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

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

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

9 BY MR. WRIGHT:

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

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

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

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

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

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

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

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

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

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

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

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

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

20 THE COURT: No, pursue it.

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

22 THE COURT: Pursue --

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

24 THE COURT: No, no. Wait a minute.

25 MR. WRIGHT: -- further.

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

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

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

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

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

13 MR. WRIGHT: Okay.

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

17 MR. WRIGHT: That wasn't my point.

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

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

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

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

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

12 THE COURT: State.

13 MR. WRIGHT: -- to hearsay.

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

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

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

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

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

17 MR. WRIGHT: Why is that?

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

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

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

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

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

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

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

1 allowed --

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

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

6 THE COURT: Mr. Wright, I am --

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

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

20 THE COURT: No, I --

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

24 THE COURT: State.

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

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

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

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

15 MR. WRIGHT: It's a civil case.

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

17 MR. WRIGHT: There's no confrontation clause.

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

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

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

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

7 MS. WECKERLY: Sure.

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

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

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

25 THE COURT: That they can't testify truthfully.

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

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

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

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

25 MR. WRIGHT: Okay.

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

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

8 THE COURT: I agree.

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

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

23 THE COURT: First of all --

24 MR. WRIGHT: So if I cross --

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

1 MR. WRIGHT: It's the state statute.

2 THE COURT: Okay. It is a --

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

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

5 MR. WRIGHT: -- created a privilege --

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

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

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

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

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

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

1 everything else.

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

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

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

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

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

5 MR. WRIGHT: It is.

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

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

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

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

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

6 THE COURT: Well, Mr. --

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

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

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

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

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

22 THE COURT: Well, no.

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

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

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

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

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

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

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

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

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

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

3 THE COURT: Right.

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

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

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

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

23 THE COURT: Right. Of course.

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

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

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

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

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

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

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

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

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

1 you're going.

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

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

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

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

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

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

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

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

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

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

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

5 Let's take two minutes and then bring --

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

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

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

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

14 MR. WRIGHT: No. What --

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

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

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

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

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

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

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

9 MR. WRIGHT: Okay.

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

14 MR. WRIGHT: Yeah. Was that a witness?

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

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

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

20 MS. WECKERLY: We can endorse her today.

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

23 MR. STAUDAHER: We'll have to look.

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

1 Kenny, let the jury know.

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

3 (Outside the presence of the jury.)

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

6 MS. WECKERLY: I hope so.

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

9 MS. WECKERLY: He's tomorrow.

10 THE COURT: Okay.

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

13 MS. STANISH: Who?

14 MS. WECKERLY: Nancy.

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

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

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

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

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

1 camp or -- I don't know.

2 (Pause in proceeding.)

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

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

6 MELISSA SCHAEFER, STATE'S WITNESS, SWORN

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

9 MR. WRIGHT: Thank you.

10 CROSS-EXAMINATION (Continued)

11 BY MR. WRIGHT:

12 Q Good morning.

13 A Good morning.

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

16 A Yes, sir. I do.

17 Q Or your three documents?

18 A Yes, sir.

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

22 A Okay.

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

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

1 the -- yes.

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

4 A Yes.

5 Q Okay. And the -- any major changes?

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

10 Q Okay. You were showing the last page.

11 A Yes, sir.

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

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

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

18 A Correct.

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

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

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

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

6 A To the health department.

7 Q Right. And so --

8 A That's the typical.

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

10 A It's not.

11 Q -- through CDC?

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

15 Q Okay.

16 A -- of Information Act.

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

19 A Yes, sir.

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

21 A Yes. That's correct.

22 Q And if -- this is the publication?

23 A Is one of the publications.

24 Q One of the publications.

25 A Correct.

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

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

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

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

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

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

7 I can acquire it. I could get it.

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

9 MR. WRIGHT: I don't have to.

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

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

15 THE COURT: Well --

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

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

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

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

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

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

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

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

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

5 MR. STAUDAHER: No, these --

6 THE COURT: -- identified? Are they part of the
7 60,000 --

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

9 THE COURT: -- that went in for testing?

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

15 THE COURT: Quest or whatever.

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

18 THE COURT: Okay.

19 MR. STAUDAHER: So --

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

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

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

3 THE COURT: Right.

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

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

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

16 THE COURT: Okay.

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

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

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

9 MR. STAUDAHER: Essentially, yes. That --

10 THE COURT: Okay.

11 MR. STAUDAHER: -- was their one --

12 THE COURT: And my understanding --

13 MR. STAUDAHER: -- common risk factor.

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

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

18 THE COURT: Right.

19 MR. STAUDAHER: -- asked for.

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

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

1 we actually had were on just the two incident days. The
2 126-odd -- or 109 people are from the investigation from the
3 notification. We don't have any of those names.

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

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

12 THE COURT: Right.

13 MR. STAUDAHER: -- unnamed victims.

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

15 MR. STAUDAHER: Right. But --

16 THE COURT: -- everybody knew him.

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

20 THE COURT: Okay. Now --

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

23 THE COURT: -- one of --

24 MR. STAUDAHER: -- from getting them.

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

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

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

5 THE COURT: Yeah, filed --

6 MR. STAUDAHER: -- to maybe go back?

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

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

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

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

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

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

17 THE COURT: -- not all of them --

18 MR. WRIGHT: -- wagon.

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

22 MR. STAUDAHER: There's over 150 cases. That's to my
23 --

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

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

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

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

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

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

1 obviate, you know, get around that right.

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

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

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

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

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

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

9 So, you know, I think that --

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

13 THE COURT: Well, accurately --

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

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

19 MR. WRIGHT: Right. And I --

20 THE COURT: -- is coming --

21 MR. WRIGHT: -- yeah.

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

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

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

6 MR. WRIGHT: I want them --

7 THE COURT: That's it exactly.

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

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

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

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

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

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

1 witness on the stand as an --

2 THE COURT: I'm not putting --

3 MR. WRIGHT: -- expert --

4 THE COURT: -- anybody on the stand.

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

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

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

1 MR. WRIGHT: I'm not --

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

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

20 There is no such case. The remedy is those cases
21 are dismissed if that's the option of the State to proceed
22 with it. They -- they're the ones that have created this
23 mess. They -- and why didn't -- on the prior question on the
24 107, was any follow-up done? Were they interviewed? Were
25 they tested? Was genetic testing done? The answer to that,

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

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

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

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

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

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

1 MR. WRIGHT: That 107?

2 THE COURT: -- the Health District --

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

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

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

11 MR. STAUDAHER: -- a single one --

12 MR. WRIGHT: -- the State?

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

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

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

4 MR. WRIGHT: I didn't --

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

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

14 MR. STAUDAHER: No, that's not what was said and what
15 was meant at all. It's that this issue was litigated with
16 them present. There was not a mention that they required the
17 --

18 MR. WRIGHT: I don't remember --

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

21 MR. WRIGHT: -- filing anything.

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

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

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

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

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

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

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

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

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

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

23 THE COURT: Or in -- other infected patients?

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

1 THE COURT: Yes.

2 MR. STAUDAHER: No, we did not.

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

7 MR. STAUDAHER: One of the issues --

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

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

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

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

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

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

14 MR. STAUDAHER: But it's medical records.

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

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

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

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

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

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

25 So certainly the jury can weigh the weight of what

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 THE COURT: Right.

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

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

19 MS. WECKERLY: Right.

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

24 MR. STAUDAHER: Right.

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

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

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

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

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

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

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

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

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

12 MR. WRIGHT: But what I --

13 THE COURT: That's the truth.

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

15 THE COURT: It's fine.

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

20 THE COURT: Yeah, but you can --

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

23 THE COURT: Well, you can --

24 MR. WRIGHT: So how do I challenge it?

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

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

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

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

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

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

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

11 MR. WRIGHT: -- reveals it.

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

18 MR. WRIGHT: I want to cross them.

19 THE COURT: Well --

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

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

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

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

13 THE COURT: All right. Going forward --

14 MR. STAUDAHER: -- those people.

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

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

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

23 MR. WRIGHT: -- for hearsay.

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

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

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

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

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

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

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

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

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

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

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

21 MS. WECKERLY: Yeah.

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

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

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

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

6 MR. WRIGHT: I'm curious.

7 MR. SANTACROCE: I'm curious.

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

9 MR. STAUDAHER: Well, the civil --

10 THE COURT: -- is it --

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

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

22 MS. WECKERLY: We can ask them.

23 THE COURT: I mean --

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

1 because he was the same CRNA who had these supposedly unsafe
2 practices puts me in a bind because now they want to bring up
3 107 other people to infer that somehow my client was involved
4 in their treatment without allowing me to find out if he was
5 doing the treatment.

6 THE COURT: Well, I --

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

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

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

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

19 THE COURT: -- or really bad for you.

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

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

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

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

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

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

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

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

23 MS. STANISH: Right.

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

25 MS. STANISH: Right.

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

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

12 MS. STANISH: Your Honor, this is --

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

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

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

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

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

1 report has been -- been here.

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

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

8 MS. STANISH: -- how --

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

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

18 MS. STANISH: I understand.

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

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

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

7 MR. SANTACROCE: Yeah.

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

10 MR. SANTACROCE: Exactly.

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

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

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

AFFIRMATION

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

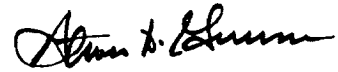
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TRAN



CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 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.

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

2 * * * * *

3 (Outside the presence of the jury.)

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

7 MS. WECKERLY: With regard to what issue?

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

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

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

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

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

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

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

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

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

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

8 MS. WECKERLY: I think so.

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

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

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

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

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

4 THE COURT: Then their testing is we tested --

5 MR. WRIGHT: Why not say 10,000?

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

8 MR. WRIGHT: What evidence?

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

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

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

1 rights.

2 THE COURT: State.

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

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

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

15 MR. WRIGHT: Can so. I can too.

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

19 MS. WECKERLY: Right.

20 MR. WRIGHT: I can say that.

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

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

24 THE COURT: You can say just what I said.

25 MR. WRIGHT: Right.

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

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

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

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

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

23 THE COURT: And you've opened the door.

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

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

2 THE COURT: No, because --

3 MR. WRIGHT: This is summary evidence.

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

9 MR. WRIGHT: Which I am entitled to.

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

12 MR. WRIGHT: Everything --

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

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

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

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

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

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

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

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

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

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

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

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

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

7 THE COURT: I'll look at the cases on the report. I
8 mean, to me looking at the report, it's a 300-page report.
9 It's more of an investigative type report. The report is one
10 thing. The issue is does the information come in about the
11 109 other people; does it come in because they open the door
12 to it, does it come in because it's in the report? I mean,
13 just because it's in the report, if it's not admissible, then
14 I don't think you can sort of bootstrap it into the report.

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

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

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

1 notification that's --

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

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

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

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

15 MR. WRIGHT: Well, first I want to object to me being
16 told that I can't fully cross-examine a witness who's
17 testifying because if I do, I'm opening the door to hearsay
18 and evidence that will not be presented to me. This is just
19 like a witness who has state secrets or some privilege, and so
20 I'm supposed to dance around them because the State put us in
21 this box, and tread carefully and not fully cross-examine.

22 So when this witness says, when I say why do you call
23 July a cluster when it's two and why do you even link it to
24 September, well, because the same CRNA was involved in both
25 days. And so to me that's preposterous, because the same CRNA

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

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

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

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

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

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

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

20 THE COURT: No, pursue it.

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

22 THE COURT: Pursue --

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

24 THE COURT: No, no. Wait a minute.

25 MR. WRIGHT: -- further.

1 sending updates and what we're seeing and finding.

2 Q Okay.

3 A And so Joe Perris was my supervisor in my
4 division, and that's who responded.

5 Q Okay. Now, when you and -- you and Gayle come
6 out. And you're the field team?

7 A Correct.

8 Q And you are the only two members of CDC here?

9 A Correct.

10 Q Okay. And you came out on January 9?

11 A Correct.

12 Q Report had been received to CDC on January 2?

13 A That is my understanding, but I didn't receive
14 that --

15 Q Right.

16 A -- report.

17 Q But it was, like, two cases and then jumped to
18 three --

19 A Yes.

20 Q -- and the commonality for that was all three of
21 them are -- had a procedure done at the same clinic and two of
22 them on actually the same date --

23 A Correct.

24 Q -- correct? And that raises a great big red
25 flag to begin with that -- it would be might coincidental that

1 three acute hep C cases, all one clinic, two on one day?

2 A Correct.

3 Q And so that bears further investigation, right?

4 A Correct.

5 Q And the CDC is at the beck and call of the
6 states to come to help?

7 A They contacted us for assistance, and so we were
8 happy to provide assistance.

9 Q Okay. But you -- you all don't have
10 jurisdiction. Even though you're the feds, you can't just
11 jump in without an invitation?

12 A Correct.

13 Q Okay. And so you were invited by the
14 appropriate authorities --

15 A Yes.

16 Q -- to come and participate?

17 A Yes.

18 Q And as you understand it when you -- and did --
19 was Gayle or yourself higher in -- who was the boss between
20 the team?

21 A Well, so it's very collaborative but Gayle was a
22 second-year officer, I was a first-year officer, and so the
23 Division of Viral Hepatitis was taking the lead in the
24 investigation. So, you know, I think it was -- we worked
25 great together, it was a joint investigation, but I would

1 consider her the lead author; she's the senior author on our
2 publications --

3 Q Okay.

4 A -- et cetera.

5 Q And she had one more year than -- than you?

6 A Correct, at CDC and that training program, yes.

7 Q Okay. And each of you were beyond the
8 fellowship training and are now called what?

9 A What is my position now?

10 Q Yeah.

11 A I'm a medical officer.

12 Q Okay. And Gayle also?

13 A Yes.

14 Q Okay. Now -- as you understood it when you
15 arrived, you already had been doing background investigation
16 and research in preparation?

17 A I mean, we had been meeting with our supervisors
18 to get ready to travel and that also involved, you know,
19 generating early drafts of abstraction forms that we would use
20 to review medical records and questionnaires that we can
21 modify in the field so that we would have stuff ready to go to
22 hit the ground running.

23 Q Okay. And you -- you understood that no contact
24 had been made by local -- what I'll call the local health
25 authorities with the clinic?

1 A That is my understanding.

2 Q And you arrived and so that the first notice to
3 the clinic of the investigation and the fact of hepatitis C
4 transmission there would have been when you all walked in the
5 door on January 9?

6 A Right. So at that time it was potential
7 transmission, right --

8 Q Right.

9 A -- we hadn't confirmed anything, and the phone
10 call from the health department when we arrived before we got
11 to the clinic, I think was the first notice that the clinic
12 had that we were there doing an investigation.

13 Q Okay. And the phone call was -- were -- as you
14 understand it, was we're coming over?

15 A Yes. I don't know what additional information
16 was --

17 Q Okay.

18 A -- provided, but yes.

19 Q And so then the we're coming over, it was you
20 and Gayle, Brian Labus, you recall --

21 A Yes.

22 Q -- Southern Nevada Health District --

23 A Yes.

24 Q -- and a representative or more from BLC, a
25 state licensing agency?

1 A I -- I'm certain about Gayle and myself and
2 Brian and I'm fairly certain, but couldn't tell you the name
3 of the BLC person.

4 Q Okay. And you weren't -- you were doing a, what
5 I'd call a public health investigation?

6 A Yes, sir.

7 Q And so you -- you were not keeping reports of
8 who's present at a meeting, who said what, like a
9 law-enforcement investigator might do?

10 A Correct.

11 Q Okay. So, like, when -- when you say that first
12 meeting probably late afternoon on Wednesday, that was the
13 9th --

14 A Is that the 9th?

15 Q -- was a Wednesday.

16 A Okay.

17 Q You don't have any report you can go to on that
18 to determine who all was present and who said what?

19 A So I have the notes that I took, which you all
20 have which I think, you know, I wrote, Tonya and, you know,
21 had some question marks of other names; but I didn't write
22 date, time, you know, documenting name and title of everyone
23 present, no.

24 Q Okay. And is -- and is that -- on those 32
25 pages of notes is that first 7 pages just typed, right?

1 A Yes. So -- so page 1 of that --

2 Q Yes?

3 A -- is where, I think that reflects on the people
4 that were initially there at that meeting when we walked in.
5 And so, you know, I -- you have my handwritten notes, and then
6 these were notes that I had typed up to help Dr. Fischer and
7 others as she's writing reports, you know, so she can review.

8 Q Okay.

9 A So there's overlap and repetition here, but that
10 -- where it says, Roster --

11 Q Yes?

12 A -- is the folks who would have been at that
13 first meeting.

14 Q Okay.

15 A And where we went over -- well, sorry, I'll let
16 you ask.

17 Q But the -- and so the -- the first seven pages,
18 the typed --

19 A Yeah.

20 Q -- was a later compilation recollection putting
21 into written form using all your notes?

22 A Yeah. So this typed document is not from that
23 first-day entrance conference, it's, you know, taking stuff
24 that you have that's scribbled and handwritten here, and
25 trying to clean it up a little bit and -- and, you know, to

1 help us when we're drafting -- we were writing the trip report
2 while we were in the field, so help with that.

3 Q Okay. And so the -- you all arrive, you're --
4 you end up in the upstairs office of Tonya Rushing?

5 A Yes.

6 Q You knew her to be, like, a chief executive
7 officer?

8 A I think she was their chief financial officer, I
9 think.

10 Q Okay.

11 A Yeah, she was a -- yes, some --

12 Q Okay. And Dr. Clifford Carrol was there?

13 A Yes.

14 Q And we -- Jeff K. -- Krueger -- and Katie,
15 question mark. From being here in the court, we know that's
16 Katie Maley --

17 A Okay.

18 Q -- I mean, the charge nurse.

19 A Okay.

20 Q And when you all walk in, who mainly does the
21 talking?

22 A I think Brian did a lot of the talking. I think
23 Gayle also chimed in. I think those were the two folks who
24 were -- who were primarily leading the --

25 Q Okay. And the -- I presume -- you said -- you

1 told them why we're here and what we're going to do?

2 A Correct.

3 Q And that was a generic description of it. So
4 I'm presuming you told them that there is a -- been a
5 hepatitis C cluster. Is that the word that's used, or?

6 A I don't know if that word was used then, but
7 that we had these three reports of acute infection --

8 Q Okay.

9 A -- in patients who had had procedures within the
10 incubation period at their clinic and that we were concerned
11 about possible transmission in the facility and wanted to do
12 an investigation.

13 Q Okay. And the -- you tell them it's three
14 patients and it's patients from their clinic and two on the
15 same date?

16 A I believe so. I don't --

17 Q Okay.

18 A -- recall specifically, but yes.

19 Q Okay. But it was -- I mean, I'm guessing the
20 meeting took hour or something?

21 A I -- honestly I can't recall the duration of the
22 meeting.

23 Q Okay. But you need to explain why you all were
24 there, and the fact that this was going forward and to seek
25 their assistance and cooperation?

1 A Yes.

2 Q Okay. And what -- what was the reaction of
3 Tonya, the charge nurse -- the two nurses and Dr. Carroll?

4 A So I can't speak about individual reactions, but
5 my, you know, best recollection is there was surprise and
6 concern on their part.

7 Q Okay. And did -- did they pledge cooperation?
8 Not in those words --

9 A Yes --

10 Q -- but --

11 A -- they agreed to cooperate with the
12 investigation, yes.

13 Q Okay. And any -- any questioning that comes to
14 mind about, Are you sure? How could this happen? I mean --

15 A I think Dr. Carroll had some questions about how
16 we made the diagnosis of acute hepatitis C in these folks. I
17 don't recall other specifics because we hadn't launched the
18 investigation yet, and we didn't go in saying, we're certain
19 transmission happened here, this way, done. You know, it was
20 a, we're looking into this. These are these reports.

21 Q Okay. And at this stage in the investigation do
22 -- do you have -- and assuming, I mean, part of your
23 investigation is going to be to determine that these three
24 people -- and the number grew --

25 A Right.

1 Q -- but those three got their hepatitis C at the
2 clinic, correct?

3 A Sorry, I missed the beginning part of the
4 question, so --

5 Q Okay. Part of the investigation is, did they
6 get the hep C --

7 A Yes.

8 Q -- at the --

9 A Yes.

10 Q -- clinic; and then if they did, how did they
11 get it?

12 A How did they get it, and how can we keep it from
13 continuing?

14 Q Right.

15 A Yes.

16 Q Okay. So as you went in at the inception, the
17 three patients had already been screened in the sense they
18 didn't have it before and they didn't have any known risk
19 factors?

20 A So I believe the Health Department had done
21 interviews with each of those three, which is a standardized
22 questionnaire about -- because these folks had acute
23 disease -- so risk factors during that six-month window that
24 we usually consider as the incubation period from exposure to,
25 you know, symptom onset. That's the time period back that we

1 go. So any risk factors during that time period, any prior
2 positives, yes.

3 Q Okay. And so the acute -- just because we --
4 we're not as knowledgeable about this as you are -- and so
5 the -- on the -- the three having acute, I mean, that in
6 layman's terms mean they just got it within six months?

7 A Well, so acute --

8 Q Normally?

9 A -- acute means they are symptomatic --

10 Q Okay.

11 A -- so they're showing they have symptoms. And
12 so there is a time period that we usually look at from when we
13 do these investigations where, you know, on this date you have
14 symptom onset, what we consider the likely exposure period of
15 when you are exposed to the virus to become infected. And so
16 the upper range of that is six months.

17 Q Okay.

18 A The very upper range.

19 Q And so -- and just so I'm making sure I
20 understand, I -- just suppose I have hep C and don't know it;
21 you know, I've had it for six years, just one day it doesn't
22 turn acute?

23 A Right. I mean, these people had a discrete
24 onset of symptoms suggesting acute inflammation for them.

25 Q Okay. And suggesting that it was newly acquired

1 because --

2 A Yes.

3 Q -- it's acute?

4 A Yes.

5 Q Okay. So we -- going in you know they've got
6 hep C recently, they have no risk factors that are known by
7 questioning them within that time frame, so it's a -- you go
8 in already with a pretty good inclination that it may be
9 clinic-related?

10 A Right. So that's part of the interview that the
11 Health District did, and as part of that interview they asked
12 about, you know, healthcare exposure during that time period.
13 I don't have the questionnaire in front of me --

14 Q Okay.

15 A -- but the endoscopy procedure was during that
16 window, and then, you know, they are the people getting these
17 reports and so the same person was, like, wow, I just did an
18 interview with this patient -- oh, this person said the clinic
19 too --

20 Q Okay.

21 A -- so that --

22 Q Okay. Was -- and did you go in with any
23 preconceived inkling, notion, as to method of transmission?

24 A Well, I mean, so before we went out and
25 obviously our supervisors, you know, in both divisions have,

1 you know, quite a bit of experience with these types of
2 investigations and the literature are talking about, you know,
3 how transmission has previously been documented in these
4 outbreaks, and so we were going to make sure to look at those
5 things when we went there.

6 Q Okay. And you know, as you've said, I mean,
7 it's blood-to-blood transmission --

8 A Right.

9 Q -- for hepatitis C, and so those are the areas
10 you're going to be focusing on and paying attention to what
11 we've historically learned have been the likely causes in the
12 past?

13 A Yes.

14 Q Okay. And so you prepare your abstract, your
15 chart, and you're going to go in, get the patient charts for
16 both days?

17 A Right.

18 Q Okay. And the -- I think there were, like, 126
19 is what I recall from your trip report, or 120, I don't know.

20 A I can check the report but that sounds -- that
21 sounds about right --

22 Q Okay.

23 A -- for those two dates.

24 Q And so you -- you-all, first day tell them
25 here's what we're going to need, and that, I'm presuming it

1 was the first day because, as I understand it, you all were
2 back there the next day reviewing all the charts --

3 A Right. So --

4 Q -- patient charts?

5 A -- right. So we, you know, we're telling them
6 this is the investigation we're going to be doing, you know,
7 we're going to need a space to work, we're going to need
8 medical records brought to us, we're going to need access to
9 review procedures and talk to your staff.

10 Q Okay. And it's going to be -- make staff
11 available to -- for interviews, as needed?

12 A Right.

13 Q Make -- make the place available for
14 observations of everything from start to finish?

15 A Right. We try to be as unobtrusive as possible,
16 but, you know, and watch while they're doing their patient
17 care so that we're not forcing them to stop seeing patients,
18 but yes, that's correct.

19 Q Okay. And you -- your understanding is that the
20 clinic -- oh, wait, you were there Wednesday the 9th, chart
21 reviews -- all of the charts were presented, meaning all the
22 patient charts for all the patients on the 25th of July and
23 the 21st of September, correct?

24 A Yeah, so we asked for their medical chart, which
25 is at one side of the clinic, and then the procedure chart,

1 which is the other side of the clinic. I don't know if they
2 were all provided that first day, or if they were getting
3 them, but they eventually provided them.

4 Q Okay. There were no records not made available
5 to your knowledge?

6 A Not that I recall.

7 Q Okay. And so when all this is provided you and
8 Gayle and/or others are pouring over them --

9 A Correct.

10 Q -- and you do not copy them?

11 A I don't recall copying or taking any of them
12 with us. No, we -- I think we were, you know, transcribing
13 onto the abstraction form.

14 Q Okay.

15 A I don't recall.

16 Q Because on your abstraction you are going to
17 gather out of the patient charts everything that you believed
18 was significant for those patients?

19 A For what was documented in the medical records,
20 yes.

21 Q Right. And so the -- having those -- what
22 you've -- and I don't want to lock you in on time frames or
23 anything, but your first task was to look at all of the
24 charts, abstract them, looking for what we've called
25 commonalities. Gee, was it one -- one doctor on each of these

1 or was it one this or that?

2 A Well, so part of what we're doing is not just
3 looking for commonalities, but we're also looking for any
4 other cases. You know, are there any other acute infections
5 that weren't reported to the Health Department that, you know,
6 so getting names to cross-match with their surveillance data
7 and see if anybody pops up. We're looking for potential
8 source patients, people who are known to be hepatitis C
9 positive before they come in for their procedure.

10 And, you know, I don't think that we abstracted the
11 totality of all those patients before we started doing
12 observations. I think we started with the people that we knew
13 were our case; you know, people who had acute disease, looking
14 at that, and I -- again, I can't --

15 Q Okay.

16 A -- tell you when we finished versus that, but I
17 don't think that we finished everybody before we started
18 observing.

19 Q Okay. And did the -- at some point, and I can't
20 remember the evolution of the other cases coming up --

21 A Right.

22 Q -- but as you were there, patients on the 21st
23 of November -- additional patients with hepatitis C were
24 identified, correct?

25 A So September 21st?

1 Q Yes --

2 A Not November? And yes, so eventually we did
3 find other cases --

4 Q Okay.

5 A -- on September 21st.

6 Q Okay. And while you were there the number grew
7 from three to four to five to six?

8 A Yes, the number grew. Yes.

9 Q Okay. And the -- and so knowing -- you were
10 knowing all of that, and so then observations start -- or --

11 A Yeah, I don't know --

12 Q -- so --

13 A -- if we knew about these others before we
14 started observing. I can't tell you in proximity, but
15 observations started in the midst of this, yes.

16 Q Okay. And are -- how -- are patients --
17 patients are told. I mean, do they get consents? How does
18 this work?

19 A Yeah, I don't -- so we typically rely on the
20 clinic to get consent and to tell the patient, you know --
21 because I want to give them the opportunity to explain who we
22 are and what we're doing there and in whatever terms they want
23 to; and so I don't remember how that happened, but I do know
24 that patients were told that we were there and gave
25 permission, but I don't know how that was recorded or

1 documented.

2 Q Okay.

3 A And we certainly weren't hiding. We were
4 standing in the room as they were wheeled in while they're
5 awake.

6 Q And the -- do you all -- do you wear uniforms or
7 anything?

8 A No.

9 Q Okay.

10 A I have my, you know, badge around my neck which
11 I think I wore during the time, but I'm in clothes like I am
12 here today.

13 Q Okay. And you were -- you made various
14 observations over a nine-or ten-day period --

15 A Yes --

16 Q -- correct?

17 A -- we did.

18 Q Okay. And you, I think from reading everything,
19 each of you, you and Gayle, like, totally observed at least
20 one of everything?

21 A Yes.

22 Q Okay. And so you observed in the preop area?
23 You observed procedures in the procedure room, whether it's
24 uppers or colonoscopies?

25 A Yes.

1 Q Okay. And you have testified already to
2 observing what we've been calling multi-patient use of
3 propofol vials?

4 A Yes.

5 Q Okay. And that was an early-on observation of
6 yourself of Linda Hubbard?

7 A Yes.

8 Q Okay. And you observed Linda Hubbard -- and do
9 you recall what size of propofol vials were being used?

10 A I don't. I -- off the top of my head, I don't
11 know if I've written it down. I -- I don't want to say the
12 wrong thing so I think they were the 20cc, I'm pretty --

13 Q Okay.

14 A -- sure about that. But I'd have to --

15 Q Okay.

16 A -- dig through notes.

17 Q But you were aware, I mean, that the clinic was
18 using what we call 20s and 50s?

19 A Yes.

20 Q Okay. And Linda Hubbard -- you're observing
21 multiple procedures --

22 A Yes.

23 Q -- correct?

24 A Yes.

25 Q Do you know who the doctor was during those

1 procedures?

2 A I don't recall, no.

3 Q Okay. And she -- she was taking new propofol
4 vials, drawing up, injecting patient, setting it aside -- it
5 has partial propofol still in it --

6 A The vial not the --

7 Q -- yes --

8 A -- syringe --

9 Q -- the vial?

10 A -- yes.

11 Q Syringe she would use and appropriately discard?

12 A Yes.

13 Q Other than maybe -- wasn't there a needle issue
14 or something?

15 A Yes, so she was observed, you know, walking
16 through the room with an uncapped needle at one point, and I
17 also observed her recapping a needle at one point, which is
18 not safe for her.

19 Q Okay. If the -- just on the needle thing,
20 recapping a needle?

21 A Yes.

22 Q Is that good or bad?

23 A It's --

24 Q I mean, I -- I hear you say it was dangerous to
25 walk around the room with a needle and it's also dangerous to

1 recap the needle?

2 A So the right thing to do is when you're done,
3 drop it in the Sharps container and not wander through the
4 room with it. So you shouldn't have to recap it, and you
5 shouldn't have to walk through the room with it.

6 Q Okay. And the recapping it just means she is at
7 risk of sticking herself --

8 A Correct.

9 Q -- while trying to put the cap on?

10 A Correct.

11 Q So use, drop --

12 A Yes.

13 Q -- in Sharps container?

14 A Yes.

15 Q Okay. And she was dropping -- she was using
16 clean syringes, what we call clean -- clean needle and syringe
17 every time?

18 A So she was using a clean needle and syringe each
19 time she went into a vial of propofol. I did not see her
20 reusing needles and syringes to enter propofol or from patient
21 to patient.

22 Q Okay. So she wasn't what we'd call double
23 dipping?

24 A No, not that --

25 Q Okay.

1 A -- I -- not that I saw.

2 Q Okay. And you were watching multiple procedures
3 and while others had other tasks to do, your task was to watch
4 and see what she was doing?

5 A Yes.

6 Q Okay. And the -- so then after a few patients
7 she has a few -- and it was three or four, whatever you've
8 explained -- you have partially filled propofol vials still
9 remaining?

10 A Yes.

11 Q And so then she took new needle, syringe,
12 pooled -- meaning she filled up, like, the 10cc syringe by
13 using the remnants of three or four propofol vials?

14 A By using remnants of more than one. I don't
15 know how --

16 Q Okay.

17 A -- I can't recall if it was two, three, four,
18 yes.

19 Q Okay. So -- and then -- I mean, and what her --
20 she was obviously doing was then using all of the propofol,
21 was going to throw them away and use the leftovers in one
22 final syringe?

23 A Right. So using up all the propofol so that the
24 vials would be empty.

25 Q Okay.

1 A Yes.

2 Q And so her transgression was -- and what she was
3 doing, aside from ignoring the label on the propofol vial,
4 what she was doing was safe?

5 A Well, I don't consider that practice safe, but
6 as you said, the main transgression there is using these vials
7 for more than one patient. I also have concerns when you
8 start pooling from -- again, from -- it's kind of doing --
9 saying the same thing. One, you know, you're using these
10 vials for multiple patients, which shouldn't have happened;
11 and then, two, the pooling -- again, it's still using the vial
12 for more than one patient, but if something happens in one
13 vial, you know, you've -- to get the sufficient dose you're,
14 you know, pooling it or potentially -- you know, if this vial
15 is contaminated and I drop some and then I need just a couple
16 more cc from this vial and I go in, I've contaminated that
17 vial and anything left -- potentially contaminated that vial
18 and anything left if I haven't drawn up the whole thing.

19 Q All right. But, I mean, that would require a
20 mistake on her part? I mean, if she is -- if she is sitting
21 there using new needle, new syringe every single time she
22 entered the vial --

23 A So focusing just on viral hepatitis
24 transmission, yes, I would not -- I would not -- without
25 syringe reuse or without having those vials in a really bloody

1 environment where blood is, you know, getting on the top and
2 introduced that way, I'm more concerned with bacteria with --

3 Q Okay.

4 A -- with the multi --

5 Q And on the bacteria, I mean, you've explained
6 these -- these propofol vials are labeled single --

7 A Patient use.

8 Q -- patient use?

9 A Yes.

10 Q Okay. And you're familiar from your training in
11 the emergency room, propofol use?

12 A Right. The -- right, it's for a single patient.
13 Each vial is --

14 Q Okay.

15 A -- for a single patient.

16 Q And the -- and for single patient that doesn't
17 mean single use, meaning you can only enter it and use it
18 once?

19 A Well --

20 Q It means single-patient use even if I use it
21 four times within the time frame on the same patient, correct?

22 A Right. So CDC's recommendation about that is
23 that, you know, the best practice is to draw up the entire
24 contents in your syringe from the vial and administer to the
25 patient. And we have some caveat that if you feel like you

1 have to go -- that that's not safe, that you can't safely
2 titrate the dose, that if you have to reenter a vial it's
3 within -- for that patient, that procedure, with a new needle,
4 with a new syringe, and you -- you recognize the risk/benefit
5 that you're taking with multiple entries into a vial.

6 Q Okay. But the -- I mean, the actual labeling,
7 see, I just look at these things simplistically --

8 A Sure.

9 Q -- and if I see single use, that means I can go
10 in, use it one time, and then throw it away? That to me would
11 mean single use. I can only use it once. But if it's
12 single-patient use --

13 A So I'd have to look at the label of propofol if
14 it says single patient use, single use, or single dose. I
15 think we at CDC consider those the same, but healthcare
16 personnel may have other interpretations of that. But we
17 consider single patient use, single dose, single use as for
18 that individual patient, for that procedure, draw it up and
19 administer it is the best practice.

20 Q I'm not sure I'm clear on that. I mean, do you
21 understand what I -- do you see the difference that I do
22 between single use of an item?

23 A So all I can tell you is we equate those terms
24 as the same thing, single dose, single use, single patient
25 use, to us at CDC means, and to me means the same thing. It's

1 for that patient and their -- that distinct procedure. And
2 I -- and the best practice is you draw it all up and you give
3 it to the patient in one syringe --

4 Q Okay.

5 A -- and that you don't --

6 Q Well, I've got to --

7 A -- do reentry.

8 Q -- I've got a 10cc syringe --

9 A Right.

10 Q -- and I've got a 20cc vial, okay? And I --
11 I've been understanding through five -- four weeks of this
12 trial that I can -- I can draw out two syringes, I can take
13 two separate, clean syringes and draw it out and then use it
14 on a patient, and I'm in heaven with CDC, BLC, every other
15 agency I can think of. Now, you're telling me --

16 A Well, I'm telling --

17 Q -- from CDC's perspective --

18 A -- no, I --

19 Q -- I can't do that.

20 A -- sorry. No, I guess I'm -- I'm not saying
21 that. I'm saying that we want you to use the right vial size
22 for your patient and your procedure. So if you typically
23 administer 100 milligrams, I'd want you to get 100-milligram
24 vial and draw it up so that you don't have to take multiple
25 syringes out. But what you're describing would not be a

1 concern for me for viral hepatitis transmission.

2 Q Okay. And if -- and what Linda Hubbard was
3 doing, setting aside the bacterial issue on shelf life, my
4 term, for once it's opened she was not administering propofol
5 in any method that would have led to transmission of hepatitis
6 C?

7 A She was not reusing syringes or needles, which
8 is what would be my predominant concern, and I didn't see
9 blood contamination.

10 Q Okay. So if -- if all we had was Linda
11 Hubbard's method and that's what she did all of the time, you
12 know, if she -- if her conduct you observed is what her
13 conduct had been the two and a half years over there, she
14 didn't -- any of her patients wouldn't have gotten hepatitis C
15 because --

16 A Unless a vial she used had been contaminated by
17 someone else, no.

18 Q Okay.

19 A Not that I can -- can see.

20 Q Now, on the contamination -- the bacterial issue
21 of propofol, it's single use -- I'll call it single patient
22 use --

23 A Okay.

24 Q -- single patient use vial because it does not
25 have any preservatives, layman's term?

1 A More or less, yes.

2 Q Okay. Meaning once I start using it, it has
3 nothing in it by which is going to inhibit bacterial growth or
4 something?

5 A Correct.

6 Q So I'm presuming saline and lidocaine multiuse
7 bottles have a preservative that they can -- no bacteria grow.

8 A If they are truly labeled multidose and not
9 single dose or single use, then they should have some type of
10 bacteriostatic preservative. It has nothing to do with
11 viruses but would prevent or is supposed to prevent the
12 multiplication of bacteria in them.

13 Q Okay. And so would -- would -- the propofol
14 we've heard here in the courtroom has a use time of a maximum
15 of six hours. Other more safe CRNAs viewed it as one or two
16 hours.

17 A That's my understanding from the label, yes.

18 Q Okay. So that means that what Linda Hubbard was
19 doing, all within an hour or so?

20 A Yeah, I think the procedures were pretty
21 quick --

22 Q Okay.

23 A -- for that time period, so...

24 Q It was a pretty busy place?

25 A Yeah. So --

1 Q Okay.

2 A -- I think that that sounds like it would --
3 probably within an hour, I think so.

4 Q Okay. So as far as -- there wasn't a bacterial
5 growth issue or anything? I mean, because it was rampant
6 pooling?

7 A Well, I mean, every time you reenter a vial
8 you're potentially introducing bacteria and contamination, but
9 no, that wasn't a high concern for me for those particular
10 patients.

11 Q Okay. And so her -- I mean, just to repeat, her
12 transgression was using a single-use labeled vial as a
13 multiuse vial?

14 A Yes.

15 Q Okay. And you observed other CRNAs?

16 A So I think I observed one procedure with Mr.
17 Mathahs, but it was the last case of the day, so he'd kind of
18 drawn up the meds already, and then I don't recall
19 specifically if I observed others. I don't recall.

20 Q Okay. The -- in your either -- what we call
21 your Metropolitan Police interview or your grand jury
22 interview, you said you observed other CRNAs and you just
23 can't recall, other than Mathahs, who else it would have been.

24 A Well, I know there was a CRNA that's first name
25 was Vinny.

1 Q Vinny?

2 A I think there were -- I think there were two
3 Vinny's, and --

4 Q Okay. Vinny Sagendorf?

5 A I don't recall the last name that -- I will, if
6 that's who was there. So I know there were two Vinny's and I,
7 you know, today I can't recall; I might have observed him, but
8 I don't recall specifics.

9 Q Okay. And in observing did you -- did you ever
10 see any reuse of syringes?

11 A I didn't -- as far as from patient to patient or
12 reentering vials, I did not, no.

13 Q Okay. And first of all, patient to patient,
14 just so we can make sure we're on the same terminology, that
15 would mean somebody used a syringe and vial on the patient
16 that's in there and then in rolls a new patient, you take and
17 use the same one on the next patient?

18 A Did not observe that --

19 Q Okay.

20 A -- at all.

21 Q And the -- and that happens out there in your
22 CDC world, correct?

23 A Yeah.

24 Q I mean, those instances?

25 A Yes.

1 Q Okay. And on the other type of reuse we're
2 talking about double dipping, would be reusing the same needle
3 and syringe to go back into the vial a second time.

4 A After it's been used on the patient, yes.

5 Q Okay. And to draw up again?

6 A Yes.

7 Q And so you saw none of that?

8 A I saw none of that.

9 Q Okay. But you -- but you did see -- I mean, you
10 were aware, other than Linda Hubbard, using the propofol vials
11 as multidose?

12 A Yes.

13 Q Okay. And you understood that that was the
14 standard practice, the norm, as to what the CRNAs were doing?

15 A Yes.

16 Q Okay. And although you didn't see any reuse of
17 syringes you're aware Gayle did?

18 A Yes.

19 Q Okay. Because you all would talk about what
20 each other saw?

21 A Yes.

22 Q Okay. And the -- you -- and it's in your
23 reports, but I mean, she -- you were in observing in one room
24 and she was in a different room, and was she observing Mr.
25 Mathahs?

1 A Yes.

2 Q Okay. So it was Mr. Mathahs she saw double
3 dipping?

4 A Yes.

5 Q Okay. And not the other -- the other type of
6 reuse patient to patient?

7 A Correct. She did not report --

8 Q Okay.

9 A -- seeing that.

10 Q And this was early on in the ten-day
11 investigation?

12 A Yes.

13 Q And that -- that dual observation, I'll call it,
14 I mean, it -- this all happened -- this observation Mathahs
15 reusing by Gayle and of course, Gayle also saw or was aware of
16 propofol vial multi-patient use, right?

17 A She was aware of propofol being used for
18 multiple patients.

19 Q Okay. And you were. And so with these two,
20 this was immediately addressed with the clinic?

21 A Yes.

22 Q Okay. And that -- was that by yourself?

23 A No.

24 Q Okay. By Gayle?

25 A By Gayle and I believe Brian Labus.

1 Q Okay. And it was, as you understand it, it was
2 reporting to the clinic these are single-use propofol vials
3 and there is to be no multiuse whatsoever and there shall be
4 no reuse of syringes?

5 A That's my understanding, but I was not at that
6 meeting.

7 Q Okay. And the -- but the -- it was being
8 reported back to your superiors what had been found and what
9 actions you were taking?

10 A Yes.

11 Q Okay. And the -- I mean, your goal in the -- in
12 being there is figure out anything unsafe happening, and if it
13 is stop it, right?

14 A Yes.

15 Q And prevent it so that if that is causation, it
16 stops?

17 A Correct.

18 Q And the -- it -- and thereafter it did stop?

19 A Yes.

20 Q Okay. Because you all continued to observe?

21 A Correct.

22 Q Okay. And from then on there was no multiuse of
23 propofol vials?

24 A Correct.

25 Q And you saw no reuse of syringes in your

1 observations?

2 A Correct.

3 Q Okay. Now, at that time -- now, I want to take
4 it at the time where we are, and you just told them correct
5 this --

6 A Yes.

7 Q -- meaning, multidosing propofol and syringe
8 reuse, did you all reach a determination, ah-ha, we've solved
9 it?

10 A Well, we stayed there for several more days to
11 continue investigating, so I think, you know, we certainly
12 were, like, this could -- this could be it. I mean, this is
13 enough to, you know, test and -- this has been transitioned
14 before, the source of transmission before, so this could be
15 it.

16 But it required still some chart review to look and
17 see can we find a source on those days, was there, you know,
18 reuse on those days, you know, redosing, and then also
19 continuing to look at these other things just to make sure
20 they weren't also part of the problem.

21 Q Okay. And -- I mean, is it fair to say you
22 continued to further look at all of the options?

23 A Yeah, I mean --

24 Q Okay.

25 A -- right. Yes.

1 Q The likely causes, let me put it that way, of
2 the transmission?

3 A Yeah. I mean, we continued -- we still looked
4 at the endoscope reprocessing -- we were still looking -- I
5 don't remember at what point we looked at the saline flush,
6 whether it was before this or after. But yeah, I mean, I
7 can't -- I don't recall the order in which we identified
8 syringe reuse and propofol reuse versus if we'd already looked
9 at the scopes and the saline. I don't recall the order of
10 that.

11 Q Okay.

12 A But we still were reviewing records and, you
13 know --

14 Q Okay.

15 A -- additional observations.

16 Q At the time when you all are still there before
17 you leave and it's grown, I think to, like, six identified
18 hepatitis C cases, you all still don't have the rooms being
19 able to be segregated --

20 A Correct.

21 Q -- by patient?

22 A Correct.

23 Q And you aren't having to address the -- how the
24 hepatitis C went from room to room and skipped over people?

25 A So we haven't at this point tested all of the

1 patients seen on that day, so we don't know how many cases
2 we're going to find. You know, we've abstracted medical
3 records to plug that in later, but, you know, I don't have at
4 this point an order of people; we don't have a room
5 assignment; you know, we're trying to put people in order with
6 times, which is challenging, so yes, we --

7 Q Right.

8 A -- we're still missing some of those --

9 Q So yeah, I mean --

10 A -- components.

11 Q -- like, without a doubt -- I mean, it remained
12 one on July 25th?

13 A Correct.

14 Q And then, like, five or six on September 21st?

15 A So I think ultimately we ended up with, I think,
16 seven on September 21st --

17 Q Okay.

18 A -- and one on July 21st --

19 Q Right.

20 A -- I think is --

21 Q Okay.

22 A -- what we --

23 Q And -- but as of that time -- and I'm still here
24 before your trip report is written or anything, meaning in
25 Las --

1 A Yes --

2 Q -- Vegas.

3 A -- okay. I'm sorry.

4 Q It has grown, so I mean, now it's way more than
5 coincidental --

6 A Yes.

7 Q -- when you have half a dozen acute hepatitis C
8 patients all out of a clinic on the same day?

9 A Yes.

10 Q Then you're wanting to know, did they all get it
11 there, you know, is like the first big question. And of
12 course, that ended up -- that's when we got into -- what was
13 your fellow's name that was here, Yuri?

14 A Yes.

15 Q Okay. The -- all of that stuff that essentially
16 shows that the cluster -- and I'll talk about September 21st
17 -- the cluster on September 21st of those patients that got
18 hepatitis C, it was determined that their hepatitis C came
19 from source patients' hepatitis C?

20 A Correct.

21 Q Okay.

22 A From a source patient, yes.

23 Q Correct. And so -- but you didn't know all of
24 that when you were here?

25 A Right. We didn't have the results of that

1 quasi-species analysis, I don't believe, at that time because
2 we still had to test patients on that day.

3 Q Okay. And you all are looking to determine,
4 before you leave, the likely cause of transmission?

5 A Right. I mean, ultimately before I leave I want
6 to make sure that there's not any unsafe practices that are
7 putting people at risk. Ideally, yes, we, you know, are
8 looking to confirm the outbreak, to try to find all the cases
9 so people can get referred for care appropriately and to
10 identify how it might have occurred so we can stop it from
11 continuing.

12 Q Okay. And all of this speed is somewhat of the
13 essence because of the nature of the disease? I mean, on
14 getting people help, correct?

15 A Right. So, you know, we want to identify people
16 who have disease so that they can get referred for care and
17 their clinician can decide what, if any, treatment course they
18 may or may not need. But keeping in mind that we're now in
19 January and we're looking at dates from September and July.
20 So we're already several months past when they were exposed
21 and infected.

22 Q Okay. And the -- let's see, Gayle's the
23 hepatitis C specialist --

24 A She was from that division --

25 Q -- okay.

1 A -- yes.

2 Q All right. And the -- okay. Now, on your trip
3 report --

4 A Yes, sir.

5 Q -- I call it "your" but who wrote it?

6 A So we're talking about this, right?

7 Q Yes.

8 A Okay. So Gayle is again the lead author, but I
9 contributed to the content with her, and then it goes to our
10 supervisors to review it and edit and help fix or give
11 suggestions, and then it actually goes through a clearance
12 process at CDC where it goes through other people, and then we
13 send it to the Health Department.

14 Q Okay.

15 A Is when it's finalized.

16 Q And the -- on page 2 of objectives, now, this
17 report -- I may be repeating, but this is the report -- at the
18 end of your trip this is what's delivered back to the State --
19 the authorities that invited you --

20 A Yes --

21 Q -- correct?

22 A -- ultimately we generate a report summarizing
23 what we did while we were there, what still needs to be done,
24 what our recommendations are, and provide that to the Health
25 Department to do with what they'd like.

1 Q Okay. And on -- this is dated May 15, so you
2 all had left by approximately January 19, if it was a ten --
3 or January 18 or 19, who has input into this? Does the local
4 Health District of the State or just CDC?

5 A So this -- I think -- and again, Gayle would
6 potentially recall better than I do, we left -- we drafted an
7 early draft of this that we left behind, I think even before
8 we left in January, and then continued to refine as we had
9 additional information here for this report because at this
10 point, you know, we have some quasi species --

11 Q Okay.

12 A -- that we didn't -- so this is the May 18, and
13 so again, this is, you know, Gayle putting the draft together,
14 I'm providing some input, as I said, it goes to our
15 supervisors, it goes through CDC clearance. I don't recall if
16 we sent -- obviously the Health Department had a -- the
17 earlier version we left behind of this. I don't recall if
18 they provided any edits or additional input into this before
19 we sent --

20 Q Okay.

21 A -- it back to them.

22 Q Do you have the initial draft that was left
23 behind?

24 A I don't. No.

25 Q On the objectives, I'm looking at page 2.

1 Interview and collect specimens from identified hepatitis C
2 patients for phylogenetic analysis at CDC.

3 A Mm-hmm.

4 Q Okay. Now, part of you all coming out here was
5 to get those specimens for testing?

6 A Correct.

7 Q Okay. And then investigating infection-control
8 procedures at clinic A, that's the clinic here, especially use
9 with multidose vials, reuse of single-use vials, and
10 reprocessing of endoscopes?

11 A Right.

12 Q Okay. And was -- was that -- was this, like,
13 written out before you came out? I mean, this is from your
14 historical looking back, knowing what type of clinic it is.
15 This is what you're going to be looking for?

16 A So there's something called an Epi-1, which is
17 what -- when we're going to do an Epi-Aid or a field
18 investigation gets drafted to get approval at CDC for an
19 Epi-Aid to proceed. And so that gives a brief blurb about,
20 you know, this is the situation, these are the objectives of
21 the investigation, here's the team that's going.

22 And so typically when we do the trip reports, we
23 move objectives from the Epi-1 to here. I don't have a copy
24 of the Epi-1, and I don't recall what those objectives were in
25 it.

1 Q Okay. Clinic A generally appeared clean and
2 well organized.

3 A What page are you --

4 Q I'm on page 4.

5 A -- okay.

6 Q I'm just jumping around to highlight some
7 things.

8 A Yes.

9 Q And is that -- that's your opinion --

10 A Yes.

11 Q -- also?

12 A Yes.

13 Q Okay. There were issues with adequate hand
14 hygiene -- an inadequate hand hygiene, correct?

15 A Yes.

16 Q Well, page 5 you already talked about endoscope
17 reprocessing. Where it says, The biopsy equipment was
18 disposable and thrown out at the end of the procedure --

19 A Yes.

20 Q -- correct? The --

21 A That's what we observed, yes.

22 Q -- those were your observations?

23 A Yes.

24 Q And the -- a biopsy equipment is something that,
25 if reused patient to patient could cause blood-borne

1 transmission? These are my words.

2 A Right. So theoretically if you're doing a
3 biopsy and get blood from the device and then go and use it on
4 another patient with a blood-generating procedure, I suppose
5 theoretically it could. Not all of our cases had biopsies,
6 so --

7 Q Right.

8 A -- and we observed them discarding them.

9 Q Okay. Yeah, but I was looking at the chart when
10 you were looking at September 25.

11 A Yes, go ahead. September 21?

12 Q I'm sorry, these dates kill me.

13 A But yeah, no, I'm with you.

14 Q July 25 --

15 A Yes.

16 Q -- Mr. Washington --

17 A Yes.

18 Q -- with -- and the source patient?

19 A Yes.

20 Q Mr. Santacroce took you through hep saline --

21 A Yes.

22 Q -- and both patients had biopsies?

23 A Correct.

24 Q Okay. And the source patient first had a biopsy
25 and then Mr. Washington had a biopsy on the chart which you

1 have displayed?

2 A Yes, correct.

3 Q Okay.

4 A At some point after that, yes.

5 Q All right. You pointed out you -- on the source
6 patient had an upper endoscope. Mr. Washington had a
7 colonoscopy?

8 A I can -- so Mr. Washington was the case patient,
9 right, who became infected?

10 Q Yeah.

11 A Okay. So he had a colonoscopy and then our
12 potential source that day had an upper, yes.

13 Q Okay. And they both had biopsies?

14 A Yes.

15 Q Okay. And there's -- are the biopsies -- biopsy
16 equipment for an upper the same as a lower?

17 A I believe so, but I --

18 Q Okay.

19 A -- am not -- I believe they use the same, but I
20 couldn't say that with 100 percent certainty.

21 Q Okay. And so if I understand, you-all, meaning
22 the CDC and the Southern Nevada Health District, seem to have
23 married September 21st to July 25th as being some common
24 cause, correct?

25 A Yes. I mean, we saw a systematic poor practice

1 that was -- that we were told was routinely done and has been
2 tied to transmission previously. So yes, I think that what
3 caused transmission on the 21st was likely also what caused
4 transmission on the 25th.

5 Q Okay. But if you take that approach, you're
6 kind of -- you're lumping them together --

7 A True.

8 Q -- and ignoring the fact that there may have
9 been a hepatitis transmission in July from the source patient
10 to Mr. Washington that was unrelated to the propofol and the
11 method of injection, correct?

12 A True, but I'm also looking at the person -- the
13 nurse anesthetist who administered propofol on the 25th who
14 reported routinely reusing syringes to double dip. So that
15 again seems like the most likely source, but yes.

16 Q Okay. But this is the same -- the same nurse
17 anesthetist who has been working there -- you can find him
18 there every other 300 other days that year too, correct?

19 MR. STAUDAHNER: Your Honor, may we approach?

20 THE COURT: Sure.

21 (Off-record bench conference.)

22 THE COURT: Ladies and gentlemen, we had a request
23 from one of the jurors for a little bit early today, so we're
24 going to go ahead and take our evening recess at this point.
25 We'll reconvene tomorrow morning at 9 a.m.

1 During the evening recess, you are reminded that
2 you're not to discuss the case or anything relating to the
3 case with each other or with anyone else. You're not to read,
4 watch or listen to any reports of or commentaries on this
5 case, any person or subject matter relating to the case.
6 Don't do any independent research by way of the Internet or
7 any other medium, and please don't form or express an opinion
8 on the trial.

9 If you'd all place your notepads in your chairs and
10 follow the bailiff through the rear door, we'll see you back
11 tomorrow morning at 9.

12 (Jury recessed for the evening at 4:15 p.m.)

13 And, ma'am --

14 THE WITNESS: Yes, ma'am.

15 THE COURT: -- during the evening recess, please
16 don't discuss your testimony with anyone else.

17 THE WITNESS: Okay.

18 THE COURT: And then if you could be here a little
19 bit before 9 so we can start right at 9.

20 THE WITNESS: Yes, ma'am. And can -- should I leave
21 --

22 THE COURT: Yeah, just -- anything that's --

23 THE WITNESS: These are what I brought with me.

24 THE COURT: Oh, you keep those.

25 THE WITNESS: Okay.

1 THE COURT: Yeah, just bring them back with you
2 tomorrow.

3 THE WITNESS: Okay.

4 THE COURT: Yeah, I mean, if you get here, like, at
5 8:50 or 8:55 that's fine.

6 THE WITNESS: Okay.

7 THE COURT: And, State, may the witness be excused
8 for the day? All right.

9 All right. Why don't we all take a brief, you know,
10 few -- couple-minute break and then we'll come back and
11 address this issue on the record.

12 (Court recessed at 4:15 p.m. until 4:22 p.m.)

13 (Outside the presence of the jury.)

14 THE COURT: All right. We're on the record out of
15 the presence of the jury. The State had approached during Mr.
16 Wright's questioning with essentially the objection that the
17 question created the false impression that the only days that
18 there was hepatitis transmission appeared to be on the two
19 days that are at issue in this case, as opposed to other days
20 when other people were infected, but that those people have
21 never been linked genetically.

22 Is that essentially your objection, Mr. Staudaher?

23 MR. STAUDAHER: Yes, Your Honor.

24 THE COURT: All right. Mr. Wright?

25 MR. WRIGHT: Yes. I do -- I am hamstrung by the

1 State not investigating the case properly for a criminal
2 presentation and just adopting the Southern Nevada Health
3 District's report blindly, and the CDC report and not
4 following through like a normal criminal investigation would
5 do.

6 And I'm hamstrung by that because on the one hand
7 the inference I want to bring out the State's correct about.
8 I want to bring out that if the investigative transmission was
9 what -- like this witness thinks, and it's because, well, it
10 makes sense, we saw it, and on the 25th and on the 21st it's
11 the same CRNA and so therefore that must be the way it was
12 transmitted.

13 If in fact, the same CRNA is doing the same thing
14 every single day and there isn't any other transmission on
15 those other days, it makes it less probable that they've
16 identified the right method of transmission. And what the
17 State's saying is if I do that, they're going to want to bring
18 in the balance of the CD -- of the Southern Nevada Health
19 District report, which -- which says 107 other people may have
20 got it at the clinic in four years, but the only way we lumped
21 them in as saying they may have is because they were
22 interviewed and in being interviewed they deny the risk
23 factors. I mean, that's how they are clinic-associated.

24 And of course, if the State hadn't just stopped with
25 adopting -- by adopting the Southern Nevada Health District

1 report and just went ahead and investigated it, they would
2 have interviewed all of those people themselves. They would
3 call them as witnesses. They would allow me to confront them,
4 before they start putting in the hearsay-based
5 confrontationless-based, or lacking confrontation, conclusion
6 that they make.

7 And so because they didn't do that, I -- I'm -- the
8 way I'm hearing it, I'm at peril if I use logic in my
9 cross-examination of their witness -- witnesses; I somehow
10 waive my hearsay objection and my right of confrontation to
11 have those 107 people present. And that's -- I don't think
12 that's a proper dilemma for me.

13 I don't mind creating what you call a false
14 inference. I create false inferences in courts every day, and
15 they're created because we have rules of evidence. Certain
16 things are admissible and some aren't. And I can sit and tell
17 a jury my client didn't possess a goddamn thing when I know he
18 did and it was suppressed. And I don't care if it's a false
19 inference. We play by the rules and the Constitution and
20 that's how evidence gets in. And that's all we're doing here
21 and I'm trying to do.

22 THE COURT: State?

23 MR. STAUDAHER: I mean, it opens the door to rebuttal
24 argument or rebuttal evidence when he prevent -- produces
25 evidence that he knows, in this particular case, there's been

1 no suppression. I mean, he knows it's a false impression, he
2 knows it's false in the fact that the jury isn't getting the
3 information that it could have, if, just even the Health
4 District report was in, let alone the fact that we know that
5 there were many other cases that were supposedly litigated and
6 all those cases are under some sort of confidentiality
7 agreement.

8 We were party to that to the degree that we could to
9 get at least some information from the civil defense attorneys
10 so that we could provide that to the Defense and did so. The
11 issue here is that it's not -- it's not just fundamental
12 fairness, it's what's proper. You cannot get up there and
13 argue or present evidence that he knows is false and leave the
14 jury with a false impression when, in fact, he's arguing on
15 the other side that that information shouldn't be coming in at
16 all in the case.

17 If he can go ahead and ask those questions, the
18 State's position is that if he does so, he does -- he
19 essentially opens the door to that information coming in in
20 rebuttal from the State, either through the documentary
21 evidence that we have, or, you know, through the witnesses
22 that are going to be coming in and testifying, like Brian
23 Labus and others who were actually present for the
24 investigation.

25 I will note for the record that the reports that

IN THE SUPREME COURT OF THE STATE OF NEVADA

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Tracie K. Lindeman
Clerk of Supreme Court

DIPAK KANTILAL DESAI,)	CASE NO. 64591
)	
Appellant,)	
)	
vs.)	
)	
THE STATE OF NEVADA,)	
)	
Respondent.)	
_____)	

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1 Q -- all right?

2 A Yes.

3 Q And before I ask you the conclusions, a
4 peer-reviewed journal means what? When something goes out for
5 peer review when it's published for the scientific population
6 to look at or anybody else, what do you have to do?

7 A So that's what I was talking about. You submit
8 it to the editor, and then they send it out blinded to
9 reviewers so they don't know who wrote the article, and they
10 read the article and determine, you know, was it a well-done
11 study, is it valid, is there -- do they have questions that
12 aren't answered and, you know, need followup.

13 And so -- and is it appropriate for the journal that
14 you're submitting it to. Is it appropriate for that audience.
15 And then based on the responses from reviewers, it goes back
16 to the editor and they decide, yep, we're going to publish it,
17 yes, we'll publish it but we need you to make some revisions,
18 or you know what, no, we're not publishing it. Sorry.

19 And so that's kind of how they use the peer review
20 process to inform if it's a well-designed study if it -- an
21 answer is any, you know, appropriate for the journal and the
22 audience is of interest at the time.

23 THE COURT: Let me ask you this: Was this the only
24 journal you sent this to for peer review -- for publication,
25 or do you send it like to, you know, Journal of the American

1 Medical Association and other journals; if you know?

2 THE WITNESS: I don't recall. Since I'm not --
3 typically, whoever is the first author takes responsibility
4 for submitting and dealing with any editorial comments or
5 responses and revisions. So I honestly don't recall.

6 THE COURT: Okay. And that was kind of up to that
7 person to determine what journals to send it to and if they --

8 THE WITNESS: Yeah, I mean, I -- I'm sure our
9 supervisors, you know, had some input because people sometimes
10 want to go to one journal versus the other, but I don't
11 remember.

12 THE COURT: Okay. Go on, Mr. Staudaher.

13 BY MR. STAUDAHER:

14 Q So what were the conclusions?

15 A So the conclusion was that we had essentially
16 documented two separate dates where transmission of hepatitis
17 C virus occurred at this facility, and we believe that
18 transmission resulted from reuse of syringes to access vials
19 that were then used for multiple patients.

20 Q So the two different clusters that you looked at
21 on those two different days, did they relate to each other?

22 A No.

23 Q Was that another reason why you believe that the
24 practices that you observed, are in the report, were based on
25 unsafe injection practices?

1 A Right.

2 Q And that that's what caused the infection?

3 A Right. Yes.

4 MR. STAUDAHER: Pass the witness, Your Honor.

5 THE COURT: All right. Who would like to begin with
6 cross? I guess, Mr. Santacroce, can you begin?

7 CROSS-EXAMINATION

8 BY MR. SANTACROCE:

9 Q Good morning, Ms. Schaefer. I represent Mr.
10 Lakeman. I want to talk to you about the methodology you --
11 when I say "you," I mean the CDC -- employed in reaching your
12 conclusion that you just testified to.

13 I believe you testified that you did a period of
14 record review --

15 A Correct.

16 Q -- correct?

17 A Yes.

18 Q And then observation?

19 A Yes.

20 Q And then interviews?

21 A Yes.

22 Q And anything else that the CDC did in its
23 methodology to reach its conclusion?

24 A Well, there was testing of patients and
25 specialized testing done at CDC. There was also testing of --

1 blood testing of the healthcare workers and interviews of
2 patients and providers. I assume when you say "interviews"
3 that's what you mean, but --

4 Q Correct.

5 A -- that's -- that's the gist of things, yes.

6 Q And bottom line you mention the word
7 "commonalities" a couple of times in your testimony.

8 A Correct.

9 Q Commonalities are important to you in
10 determining how an infection is transmitted; isn't that
11 correct?

12 A They are a factor that we look at for -- yes,
13 they're a factor that we look at as part of our investigation.

14 Q When you talk about commonalities, what are you
15 talking about?

16 A Like I mentioned, looking to see did the source
17 patient in cases all get the same scope used on them, or did
18 they all have biopsies. Did they all get the same type of
19 medication. Things like that.

20 Q Okay. I want to take you through some of the
21 areas that you looked at in reaching your conclusion. You
22 talked about reviewing the charts, so let's talk about that
23 for a minute. What particular information did you glean from
24 the chart that led you -- or contributed to your conclusion?

25 A So can I pull up one of the reports to

1 reference?

2 Q You can refresh your recollection.

3 A Okay. So I'm going back to our trip report,
4 that same page 13 --

5 Q Okay.

6 A -- we've put up previously.

7 Q All right. Well, why don't I put that up here.
8 Has that been displayed already?

9 A Yes, sir.

10 THE COURT: Yeah, and that's admitted.

11 MR. SANTACROCE: Okay.

12 THE COURT: Okay. Was that 164, Mr. Staudaher?

13 MR. STAUDAHER: No, I believe that 79 is down there.

14 THE COURT: It's 92 according to the court clerk.

15 BY MR. SANTACROCE:

16 Q And what page are you looking at?

17 A Page 13, sir. So again, the top table here is
18 looking at -- the bottom table is looking at those that were
19 the sources or the people who were known previously infected
20 when they came in and we believe were the source of the virus
21 that was transmitted to patients.

22 Q And now which date is this, then, both dates?

23 A Both dates are on here.

24 Q Okay.

25 A Was there one date you'd like to focus on?

1 Q Well, let's start with the 25th of July.

2 A So for the 25th of July we documented a single
3 instance of transmission from source patient to one case, so
4 you see case one here and you see potential source one here.

5 Q Okay.

6 A And so again, same date of procedure. We look
7 at the start time and we see that the source patient preceded
8 the case patient, which you would expect. They had different
9 types of procedures so one had a colonoscopy, one had an upper
10 endoscopy. So that wasn't the same procedure type. They had
11 different scopes used on them, so there wasn't a shared scope
12 in common. They both did have biopsies. They both had the
13 same nurse anesthetist. And you'll note that the potential
14 source patient had multiple doses of propofol administered.
15 And so as I mentioned, that's important because that would
16 have been reuse of syringes on that patient to contaminate the
17 vial and then that vial being used for the next patient to
18 transmit the infection.

19 Q Okay.

20 A So that's what I'm getting at.

21 Q Well, let's talk about each of these, then.

22 A Sure. Do you need me to clear it?

23 Q No. No.

24 A Okay.

25 Q Yeah, if you would, please.

1 A Okay.

2 Q The endoscope number 155 and 301.

3 A Correct.

4 Q Now, how did you arrive at those endoscope
5 numbers?

6 A So that was -- is what was documented in the
7 record and also through interviews with the facility. And
8 again, I'd have to find it in the report -- I think it's in
9 the trip report. They told us how many scopes, how many
10 colonoscopes they had and how many endoscopes they had, you
11 know, at the facility, and then they had numbers that were
12 recorded, and so that was what was documented in the medical
13 record.

14 Q And I recall in your grand jury testimony that
15 you said you had some problems documenting the number of the
16 scopes, correct?

17 A No. The scope was documented consistently. I
18 think we had a couple instances where it looked like the same
19 scope was documented back to back for --

20 Q In other words, used on two people, one after
21 another?

22 A Right. Right. And so it looked like there
23 wouldn't have been sufficient time to disinfect, so we asked
24 the facility about that. They went back and looked and said
25 that they had some electronic way to show that it was just

1 misrecorded.

2 Q Did you see that electronic way?

3 A I don't recall. I don't recall if they brought
4 it in or not. I don't remember.

5 Q So you accepted their explanation. Now, in
6 these commonalities, if there's one predicate that's false, it
7 could change the entire conclusion; isn't that correct?

8 A Well, can you expand on what you mean?

9 Q Yeah. In other words -- let's just take the
10 scopes, for example. Let's say that -- you didn't verify that
11 this electronic recording process actually verified that they
12 were different scopes you used on back-to-back patients,
13 correct?

14 A Well, my understanding is, you know, one of them
15 had a colonoscopy, so it goes up your bottom, and one had the
16 upper endoscopy that goes down your throat, and that they used
17 different types of scopes for those procedures is -- was my
18 understanding.

19 Q But I'm asking you, did you see documentation to
20 that effect?

21 A I saw documentation of the scope that was
22 recorded for the -- in the record.

23 Q And you saw those recordings that showed that a
24 same scope was used back to back, correct?

25 A I think -- I don't know how many occasions. I

1 think it was one and it was not this instance.

2 Q Okay. But my -- my question to you was if
3 there's a break in the link of the chain, the commonalities,
4 it could throw off a conclusion, your conclusion?

5 A I don't think even if the same scope was used it
6 would change my conclusions. Again, it goes back to, you
7 know, looking at the reprocessing procedures there and then
8 looking at the unsafe injection practices which were observed
9 and reported to us and looking at the literature of where we
10 have seen transmission previously. So --

11 Q Well, you've seen transmission through
12 endoscopes before, haven't you?

13 A I haven't linked to the specific scope. I
14 haven't seen it definitively documented, no.

15 Q At the time that you did this investigation, how
16 long had you been an investigator?

17 A I had worked at CDC for about six months.

18 Q Okay. And was this your first investigation?

19 A This was my second Epi-Aid. This was probably,
20 I think, my first outbreak field investigation.

21 Q So when you say you haven't seen it, you are
22 aware of literature that indicates that transmission can come
23 from that, correct?

24 A Well, I'm not so comfortable with that
25 literature, to be honest. I think -- I don't know. I don't

1 want to expand on it.

2 Q Did you see literature or not? Whether you're
3 comfortable or not is not my question. Did you see literature
4 that indicated that the transmission of hepatitis C could come
5 from endoscopes?

6 A I have seen literature suggesting that, yes.

7 Q Okay. And the particular -- and it was the area
8 that you looked at specifically and you dismissed --

9 A Correct. We looked at it and did not think that
10 it was the source of transmission here, correct.

11 Q Now, another area that you looked at was the
12 preop area, correct?

13 A Correct.

14 Q And the commonality would be who started the IV
15 heplocks, correct?

16 A Well, so we look at the use of saline flush
17 there and the practices of saline flush. And so there was no
18 repeat flushing that was observed or reported. So --

19 Q On what day?

20 A While we were doing observations. So whatever
21 day we were there.

22 Q In January of 2008?

23 A Correct.

24 Q You had no way to verify or observe what
25 happened on January -- or September 21, 2007, or July 25th of

1 2007, in regard to how the heplocks were started and flushed?

2 A I was not there on those dates, but that's part
3 of why when we do the investigation. We ask, Have practices
4 changed since those times? Are you doing anything
5 differently? And got no indication that that was the case.

6 Q So if nurses came here and testified that
7 changes were made at that time, that would be contrary to
8 what --

9 MR. STAUDAHER: Objection, Your Honor.
10 Mischaracterizes the testimony.

11 THE COURT: Yeah, that's -- that's sustained.
12 BY MR. SANTACROCE:

13 Q So on this January date when you observed the
14 installation of the heplocks and the saline flushes, there was
15 no particular concern to you?

16 A No.

17 Q Were they using multidose saline bottles?

18 A Yes, they were.

19 Q Okay. And that didn't present a concern to you?

20 A Well, the vials were labeled as multidose, so
21 technically they can be used for multiple patients. And we
22 did not observe any reuse of syringes or needles into those
23 vials, which would be how I would believe that transmission of
24 hepatitis virus would occur, or direct reuse of needles and
25 syringes. I didn't observe that. So I was not concerned.

1 Q On that particular day you didn't observe that?

2 A Correct.

3 Q Okay. Now, you're aware of literature that
4 suggests that there has been hepatitis C infection outbreaks
5 due to reuse of multidose saline bottles, correct?

6 A Correct. Through reuse of syringes and needles
7 to go into those vials.

8 Q And the CDC has documented those outbreaks,
9 correct?

10 A Well, with our Health Department colleagues,
11 yes, we have investigated.

12 Q Well, in this particular chart it was of concern
13 to you to note who started the IV start; isn't that correct?

14 A Correct.

15 Q And on case 1, which you talked about on July
16 25, CRNA 4, who you've identified as Ron Lakeman, started both
17 on case 1 and the potential source patient, correct?

18 A That's what we documented, but I think, Mr.
19 Staudaheer -- the record he showed contradicted that, if I'm
20 recalling.

21 Q Showed you an error in that documentation,
22 didn't he?

23 A Correct.

24 Q I'll represent to you this is Exhibit -- State's
25 Exhibit 2. This is Michael Washington's patient file. And

1 I'm going to show you Bates Stamp No. --

2 MR. SANTACROCE: 2350 for Counsel.

3 THE WITNESS: And, sir, can you refresh my memory.
4 Is Mr. Washington who we defined as Case 1, or was he the
5 potential source? I don't recall.

6 MR. SANTACROCE: Okay. I'll be happy to do that
7 right now.

8 THE WITNESS: Thank you.

9 BY MR. SANTACROCE:

10 Q As soon as I find this Bates stamp.

11 A Sure.

12 Q Well, let's talk about who Mr. Washington was.

13 A Thank you.

14 Q I'll show you State's Exhibit No. 157. Okay.
15 Do you see that?

16 A Yes, sir.

17 Q I'm going to step over here so I can see it, but
18 you can look on your monitor.

19 A Yep.

20 Q The blue strip there is both the -- well, it was
21 the source patient for Michael Washington. Do you see that?

22 A Okay. So Mr. Washington was an -- became
23 infected?

24 Q Became infected by the source patient; we've
25 marked it in blue.

1 A Okay. And --

2 Q Go ahead.

3 A -- is there any possibility to see what -- or
4 you can walk me through what the headers for these different
5 columns are so I know --

6 Q Oh, sure.

7 A -- who is --

8 Q I'll have to move that down --

9 A -- what -- I'm sorry. Thank you.

10 Q I can't fit it all on one screen, so we'll have
11 to look at the headers.

12 A Okay.

13 Q And tell me when you've -- would you just like
14 to look at the chart instead of being on the screen? Would
15 that help you?

16 A Well, whatever you all need for them to see --

17 Q Well, you look at it and then I'll put it back
18 up on the screen, okay?

19 A Okay. Thank you. I appreciate it. So is it
20 correct to say, then, that this does not list who was the IV
21 start in the headers? It's just who was in the procedure
22 area?

23 Q That's correct.

24 A Okay.

25 Q It does not list who the IV start was.

1 A Okay.

2 Q But we'll get to that.

3 A Okay.

4 Q Okay?

5 A Okay.

6 Q So are you familiar with this chart now, do you
7 think?

8 A I think so.

9 Q Okay.

10 A Let's see.

11 Q Because I'm going to show you now Mr.

12 Washington's patient chart, which I believe you reviewed in
13 order to get certain information on your Chart 13, okay?

14 A Somebody from our team would have.

15 Q Okay.

16 A I don't know if it was me specifically, but...

17 Q Okay. But it was information that you relied on
18 in reaching a conclusion, correct?

19 A It was information we used in our conclusions,
20 correct.

21 Q So now I'm going to show you Bates Stamp 2350.
22 This tells us -- this is the patient chart for Michael
23 Washington. This tells us who started the IV; do you see
24 that?

25 A I do.

1 Q And it wasn't Mr. Lakeman, correct?

2 A Correct.

3 Q It was someone by the initials of LC; do you see
4 that?

5 A I do.

6 Q Okay. So when we go back to your chart, you
7 have some erroneous information here on which you base some
8 conclusions.

9 A Well, so I don't -- so you're correct. We have
10 documented incorrectly that Mr. Lakeman started the IV on Mr.
11 Washington, but I don't think that that impacts the
12 conclusions that we make, because assuming that you don't have
13 any information suggesting that we had a documentation error
14 for the potential source patient -- for there to be
15 transmission through a saline vial -- there would have had to
16 have been saline used on the source patient and syringe reuse
17 to get that source patient's blood into the saline to then be
18 used on Mr. Washington.

19 So if indeed Mr. Lakeman started the source
20 patient's IV and our understanding is that the CRNAs don't use
21 saline, that couldn't have been a source for Mr. Washington
22 because the source patient didn't get saline. Does that make
23 sense?

24 Q It doesn't to me, but maybe to the jury. So in
25 any event, the fact that I'm bringing this out is that you

1 have erroneous information on this chart, which you testified
2 to; you relied on this information to reach your conclusion?

3 A I'm -- I still disagree that -- I will stipulate
4 or I agree that you have demonstrated that we had erroneous
5 information on the IV start for Mr. Washington, our case
6 patient 1, but even with that it doesn't impact my conclusions
7 because our source patient 1, unless you have other
8 information, still had an IV start from CRNA 4.

9 And our understanding, as I said, is that the nurse
10 anesthetist when they placed the IV didn't use saline flush
11 because they went ahead and gave this sedative. So in order
12 for saline flush to have even been a factor, which I don't
13 think it was regardless because we didn't observe or have
14 reports, the potential source didn't have saline used on them.

15 So that common source of saline couldn't have become
16 contaminated if -- when the saline was used on Mr. Washington
17 it wouldn't have had this person's blood in it.

18 So it doesn't change my conclusions even -- even
19 with this information.

20 Q Okay. I'm going to ask you to take a look at
21 State's Exhibit 156. This is a similar chart from September
22 21, 2007.

23 A Thank you. Okay. So same format, just
24 different --

25 Q Yeah. I just want you to look at it and make

1 sure that you understand the columns and things of that
2 nature, okay?

3 A I think so, yep.

4 Q Okay. Let's talk about this for a minute.
5 Let's start at the top here.

6 A So can I just orient for a quick second?

7 Q Absolutely.

8 A So the top -- well, you orient me. I'm sorry.
9 I'll --

10 Q Okay. The orange strips are -- is the source
11 patient. Yellow strip is a patient that cannot be genetically
12 linked to the cluster. The green strips are the people that
13 are alleged to have been infected at the clinic, okay?

14 A Yes.

15 Q Got it?

16 A So the yellow is someone who has hepatitis, but
17 genetic testing could not have been performed on them.

18 Q Couldn't be linked to the clusters.

19 A Okay.

20 Q Okay? So now, on this top section you have a
21 source patient who is Kenneth Rubino.

22 A Yes, sir.

23 Q And then you have another patient, then you have
24 an infected patient, Rudolfo Meano -- Meana, then you have
25 one, two, three, four, five people who haven't reported it,

1 having hepatitis.

2 A Okay.

3 Q Then you have another infected patient, then you
4 have another patient who hasn't reported, and then you have
5 another infected patient, and --

6 A So can -- can I ask --

7 Q -- three clusters of that, okay?

8 A So can I ask one question, or --

9 Q No --

10 A -- okay.

11 Q -- you can't.

12 A Okay. I just wanted to clarify --

13 Q Okay.

14 A -- something you said.

15 Q I ask the questions, you answer them, and then
16 we'll get along great, okay?

17 A I just don't understand when -- when you're
18 talking about the five who are not recorded as being infected,
19 does that mean they were negative or you don't have results on
20 them?

21 Q You're asking me questions.

22 THE COURT: Yeah.

23 THE WITNESS: I'm sorry.

24 THE COURT: Basically --

25 THE WITNESS: I'm sorry. I just didn't understand

1 what he meant.

2 THE COURT: -- a lot of witnesses like to do that,
3 but the lawyers ask the questions --

4 THE WITNESS: Okay. I just didn't understand. I'm
5 sorry.

6 THE COURT: Here's the thing though. If Mr.
7 Santacroce asks you a question and you don't understand the
8 question or you can't answer the question with the information
9 you have or Mr. Santacroce's question, you know, he says
10 something in his question that's wrong or you don't agree
11 with, then of course, you can say I can't answer the question
12 or I don't understand the question or what have you; do you
13 understand?

14 THE WITNESS: I do.

15 THE COURT: Okay.

16 THE WITNESS: So I don't understand --

17 THE COURT: Okay. Well, wait for his question, and
18 then --

19 THE WITNESS: Okay.

20 THE COURT: -- again --

21 MR. SANTACROCE: Maybe we'll clear it up.

22 THE WITNESS: Okay.

23 THE COURT: -- if you can't answer it with the
24 information you have just tell him --

25 THE WITNESS: Okay.

1 THE COURT: -- I can't answer that with the
2 information I have.

3 THE WITNESS: I'm sorry.

4 BY MR. SANTACROCE:

5 Q And I don't mean to be disrespectful --

6 A No. No, I'm sorry. I'm sorry.

7 Q -- ordinarily I'd answer anything you had to say
8 but --

9 A My apologies.

10 Q -- I can't do it in this forum because --

11 A I understand.

12 Q -- the rules don't allow that, okay?

13 A I understand. I'm sorry.

14 Q Okay. Again, we're clear on -- now, this is the
15 State's exhibit. The State prepared this documentation
16 purportedly from reviewing the same patient files that you
17 guys all reviewed.

18 A Okay.

19 Q Okay?

20 A Yes, sir.

21 Q So you see you have three -- three patients in
22 green up there in room 1, and the CRNA was Mr. Mathahs; do you
23 see that?

24 A So this is by room?

25 Q Yes.

1 A Okay. I'm sorry.

2 Q You're asking questions again.

3 A I know. I'm sorry. I'm sorry.

4 MR. STAUDAHER: Your Honor, I'm going to ask that if
5 -- that --

6 THE COURT: Yeah.

7 MR. STAUDAHER: -- since he's giving a lot of
8 information, he's got to define things for her so that she
9 understands to even answer the question.

10 MR. SANTACROCE: Fine. I'll be happy to.

11 THE COURT: Right. If you don't -- again --

12 THE WITNESS: I'm sorry.

13 THE COURT: -- if you don't understand something,
14 that's fine. You can say -- the worst thing to do, or what we
15 don't want you to do is to make assumptions that may be
16 erroneous. So if you don't understand, you know, how the
17 information is broken up or you don't agree with it or
18 something like that, then of course, say that.

19 Go on, Mr. Santacroce.

20 BY MR. SANTACROCE:

21 Q Okay. So these are broken up by room. So this
22 is all one room, correct? I mean -- you wouldn't know, but
23 I'm telling you that's what the State alleges, okay?

24 A Yes.

25 Q And you'll see -- if you move over a couple of

1 column,s, you'll see the CRNA -- see that?

2 A Can you move it over, please.

3 Q Oh, I'm sorry.

4 A I'm sorry. Yes, thank you.

5 Q Okay. Then we go down to here. It's Room 2,
6 and I'll move it over -- CRNA Lakeman, okay?

7 A Yes.

8 Q And in Lakeman's room three people are reported
9 to have hep C allegedly from the source patient in Room 1.

10 A Okay.

11 Q Okay? Now, everybody that you talked to or
12 interviewed said that propofol didn't go from room to room,
13 correct?

14 A Correct.

15 Q Okay. Now, I want to show you another chart
16 here because what we were talking about when I sort of got
17 sidetracked was these IV saline flushes, okay?

18 A Yes, sir.

19 Q And I'm going to show you this document here --
20 and I'll try to zoom out so we can get most of it in. The top
21 row are the patients in Room 1 that contracted hep C on
22 September 25, 2007. The bottom row are the patients that
23 contracted hep C in Room 2 on the same day; do you see that?

24 A Yes, sir.

25 Q Now, the records indicate that one nurse started

1 the saline -- or started the heplocks and saline flushes for
2 all of the patients except -- all of the infected patients and
3 the source patient in Room 1 and that nurse was Lynette
4 Campbell, initials LC; do you see that?

5 A Yes, sir.

6 Q And Lynette Campbell also started the heplock
7 and flushed those heplocks on patients infected in Room 2,
8 Patty Aspinwall and Carole Grueskin. The other person --
9 nurse who started heplocks on that day, who shared the same
10 saline multidose vials, was Jeff Krueger, and he started --

11 MR. STAUDAHER: Objection. Assumes facts not in
12 evidence. Not that he shared the same --

13 MR. SANTACROCE: It does --

14 MR. STAUDAHER: -- multiuse vials on those patients.

15 THE COURT: Well, state --

16 MR. SANTACROCE: I think Lynette Campbell testified
17 to that.

18 THE COURT: -- state your -- state your question
19 again.

20 BY MR. SANTACROCE:

21 Q I said the other RN who started heplocks on that
22 same day for the patients in question was Jeff Krueger, and
23 there was testimony that Jeff Krueger let Lynette Campbell
24 share the same saline vials, okay? My question --

25 THE COURT: And again, ladies -- as you know, this

1 comes up a lot with what the testimony actually was. It's
2 your recollection of the testimony. So if Mr. Santacroce
3 says, oh, this was the testimony and you don't remember it
4 that way, then of course, disregard what Mr. Santacroce or any
5 other lawyer or myself even says what the testimony was. It's
6 what you remember that's important here.

7 BY MR. SANTACROCE:

8 Q So this is a commonality that you would be
9 interested in, isn't it?

10 A I mean, it would be something that we
11 abstracted.

12 Q Did you recognize and identify this commonality?

13 A It would be something that we abstracted, so we
14 would have looked at that.

15 Q I'm asking you if you have an independent
16 recollection of looking at this?

17 A I don't recall. I don't recall.

18 Q Is there anywhere in the reports that identify
19 this commonality?

20 A I mean, we would have documented, again, in that
21 -- the trip report the IV start information. So there would
22 be the only other location that we would have --

23 Q Okay.

24 A -- looked at.

25 Q But you had the wrong information about that?

1 A We had incorrect information for -- for July
2 2007, correct.

3 Q So you don't recall identifying this
4 commonality; is that correct?

5 A I don't recall -- no.

6 Q Okay. Would this have affected your conclusion
7 in any way?

8 A No.

9 Q Okay. I want to talk to you about your
10 conversations with Mr. Lakeman, okay?

11 A Yes.

12 Q What day did that occur?

13 A I don't recall. I don't have the date
14 documented on my notes, so I don't recall. It was back -- it
15 occurred after I had returned to Atlanta.

16 Q Okay. Well, let's talk about these notes.
17 These were contemporaneous notes?

18 A Correct.

19 Q And you're telling me that you don't have the
20 date on that -- on the notes?

21 A No, sir.

22 Q That wouldn't be something that was important?

23 A No, sir.

24 Q Tell me how you initiated contact with Mr.
25 Lakeman.

1 A I looked him up on the Internet and found a
2 number and called it. I think I spoke to his wife once or
3 twice and tried to find him and ultimately got, I think, his
4 cell phone number and then connected with him via cell phone.

5 Q Okay. And how did you identify yourself?

6 A That I was a working CDC employee and -- and
7 that we had done an investigation at the clinic where he had
8 worked previously.

9 Q Okay. Did he express concern as to who you
10 were, why you were calling him out of the blue?

11 A I mean, I recall that -- again, going back
12 asking if I was recording the call, and I said I wasn't, and I
13 explained, you know, that we wouldn't be using his name in
14 things that we put out. So I don't recall more specifics than
15 that.

16 Q So in other words, you called him, you said, I'm
17 Melissa Schaefer from the CDC and I want to talk to you about
18 an outbreak of hepatitis C at a previous clinic you worked
19 for --

20 A Yes.

21 Q -- and he started talking?

22 A Ultimately, yes.

23 Q Okay. Tell me about some of the promises that
24 you made him before questioning or talking to him, asking him
25 questions.

1 A So again, I told him that I was not
2 tape-recording the call. And again, since I didn't realize
3 this was going to be a criminal investigating, you know,
4 explaining how we typically do things as far as, you know, any
5 reports -- don't list his name; we assign, you know, a number
6 or something else for the information that's provided.

7 Q And you promised anonymity, correct?

8 A I don't know if I said I promise that we will
9 never, but I think, you know, I said we -- we would --
10 wouldn't use his name. I don't know if the words, I promise,
11 were used or not, but I did say, you know, we wouldn't use
12 your name in reports.

13 Q Well, in your grand jury transcript you talk
14 about how important anonymity is to the CDC in order to gain
15 information for public safety.

16 A Right.

17 Q Okay. So tell me about that.

18 A So, you know, when we do these investigations,
19 we rely on healthcare providers to be transparent with us and
20 to perhaps tell us things that they wouldn't tell their
21 employer or that they don't want others to know, you know; to
22 take us aside and say, you know, I -- please know that --
23 this -- I don't want my employer to know this, but this is
24 really what's happening here.

25 And so that's helpful to get honest information for

1 public safety so that if there's a bad practice identified, we
2 can stop it. And so, yeah, that's --

3 Q Okay. And you explained that to Mr. Lakeman,
4 correct?

5 A I don't know if I went into the detail that I am
6 explaining here, but I did communicate that we wouldn't be
7 using his name in any -- anything that we generated.

8 Q And that, in fact, didn't happen because when
9 you got off the phone you used his name right away, didn't
10 you?

11 A I didn't use his name in any reports that we
12 generated. I communicated with our team, who has to -- you
13 know, who has to know who the different players are. I mean,
14 we are the ones who assigned CRNA 1 or 4. So it's more of a
15 public thing as opposed to what our team -- the information
16 our team needs.

17 Q Well, you called the Georgia Public Health
18 Department before you talked to Mr. Lakeman --

19 A I did --

20 Q -- correct?

21 A -- yes.

22 Q And you knew that Mr. Lakeman was working at a
23 hospital in Columbus, Georgia, correct?

24 A Yes, I did.

25 Q Did you call the hospital at Columbus, Georgia?

1 A I did not.

2 Q And Mr. Lakeman expressed concern about talking
3 to you for those reasons; isn't that correct?

4 A I don't know that he gave any reasons. I don't
5 recall that.

6 Q Well, he made the statement to you to the effect
7 that, well, if -- I'm going to deny talking to you if -- you
8 tell me what he said because I don't remember.

9 A It was something along the lines of denying that
10 he had said these things to me if it came down to it.

11 Q And the point in the conversation when he said
12 that was prior to you asking him any questions whatsoever;
13 isn't that correct?

14 A I don't recall. I know he asked if I -- when we
15 started talking, at some point he asked if I was recording,
16 and -- because it was -- so we stopped and I said no, and then
17 I don't recall at what point that came up, if it was after we
18 had started going through some of this or before.

19 Q I'm going to show you your grand jury transcript
20 on page 85 and 86.

21 MR. STAUDAHER: Is there a question?

22 MR. SANTACROCE: Yes, as to when in the conversation
23 he made the statement as to denying that it ever took place.

24 THE COURT: Okay. That's the part of the grand jury
25 transcript that you're going to show her?

1 MR. SANTACROCE: Yes.

2 THE COURT: All right. Go ahead.

3 BY MR. SANTACROCE:

4 Q Page 85 and 86. I'm just asking you to take a
5 look at this portion here. The highlight is my stuff so...

6 A Okay.

7 THE COURT: Just read it quietly to yourself, and
8 then let us know if that refreshes --

9 THE WITNESS: Yes.

10 THE COURT: -- your recollection.

11 THE WITNESS: Yes, ma'am. (Witness complied.) Okay.

12 BY MR. SANTACROCE:

13 Q Does that indicate to you when in the
14 conversation he said that?

15 A That indicates it was early, but I think in that
16 transcript I said -- you know, I started asking some
17 questions, and then at that point, you know, we were going
18 back and forth with the questions and he took a pause at that
19 point. But it would have been early.

20 Q And it would have been before you asked him
21 about any kind of injection practices, correct?

22 A I don't recall.

23 Q Okay. And that statement by Mr. Lakeman is
24 fairly common, isn't it, when you interview people?

25 A I don't know -- I don't know that anyone has

1 specifically said I'll deny this, but certainly, you know, as
2 I said, healthcare workers share things with us that they
3 don't want their employer to know or others to know.

4 Q Okay. And, in fact, you made other comments to
5 the grand jury regarding why people have that sort of
6 attitude; do you recall what those were?

7 A I think it goes back again to, you know,
8 typically in our reports we don't even name the healthcare
9 facility. We say A or B or clinic C, and, you know, when we
10 do healthcare worker stuff, we, in our reports, don't put the
11 names to -- so that down the line healthcare workers will
12 continue to want to communicate with us and talk to us.

13 Q And didn't you also say that the -- the employee
14 is in fear of retribution from their current employer?

15 A I don't -- I don't recall that.

16 Q Okay. Let me show you your grand jury
17 transcript, page 87. I want you to take a look at this
18 portion here.

19 A Okay. (Witness complied.) Sir, I said that in
20 a generality. I don't know -- I didn't attribute that
21 specifically to Mr. Lakeman or why he -- why he --

22 Q No, we're talking about the attitude of --

23 A Oh.

24 Q -- a lot of people that you interview, when you
25 call them up and say I'm from the CDC, that has a very

1 powerful effect on people, doesn't it?

2 A You know, I can't speak to the effect it has on
3 them.

4 Q Okay. Fair enough. And when you're
5 investigating and talking to these individuals, you said in
6 your grand -- what did you say in your grand jury
7 transcript -- or to the grand jury about that issue?

8 A That -- again, that we need healthcare workers
9 to be honest with us and to tell us things and to do -- you
10 know, the best we can with -- with any public reports that we
11 generate or put out to not list names.

12 Q Didn't you say that they don't want retribution
13 from their current employer for reporting someone else's
14 actions, so I guess I wasn't entirely surprised by the
15 statement?

16 A I did say that, correct.

17 Q Now, I'm going to ask you to take a look at the
18 -- you felt this statement was important or the DA felt it was
19 important?

20 A I asked a question that was asked of me, so I
21 can't comment on --

22 Q Okay. It wasn't such an important statement
23 that you put it in your notes, though, was it?

24 A No.

25 Q It's nowhere to be found in your notes, is it?

1 A Correct.

2 Q However, there is something in your notes that
3 you did record that you thought was important, and that was
4 the term "double dip," correct?

5 A Correct.

6 Q And double dip, is that your term or Mr.
7 Lakeman's term?

8 A I believe that was Mr. Lakeman's term.

9 Q Have you heard that term before?

10 A I have.

11 Q And how was it used aside from your analogy with
12 the chips?

13 A It's also used to reuse a syringe, to enter a
14 medication vial for an additional dose -- taking a syringe
15 that's already been used on a patient and going back into a
16 vial to get more medication.

17 Q And you used that -- you have used that word
18 yourself, haven't you, in seminars that you've given?

19 A I have.

20 Q I want to talk about some of the -- at least one
21 of those seminars. Did you give a seminar on infection
22 prevention in outpatient surgery centers on February 22, 2012?

23 A Where? Can you -- I may have. I --

24 Q Well, let me just show you this.

25 MR. STAUDAHNER: Actually, would Counsel provide a

1 copy for the State, please?

2 MR. SANTACROCE: If you want to make a copy before I
3 ask her, yeah.

4 MR. STAUDAHER: Can I just see it, what you're
5 showing her.

6 THE COURT: Are you just showing that to refresh her
7 recollection --

8 MR. SANTACROCE: Correct.

9 THE COURT: -- if she did a seminar?

10 MR. SANTACROCE: Correct. I guess I should mark this
11 before I show her.

12 THE COURT: Well, if you're just going to use it to
13 refresh her recollection --

14 MR. SANTACROCE: That's all.

15 THE COURT: -- then you don't need to.

16 MR. SANTACROCE: Okay.

17 THE COURT: Is that, like, some sort of a syllabus or
18 something you're showing her?

19 MR. SANTACROCE: Actually, it came off of the -- her
20 website.

21 THE COURT: Okay. Just look at that and see if it
22 refreshes your recollection as to whether you gave a seminar
23 on the date Mr. Santacroce --

24 THE WITNESS: I gave a webinar, yes.

25 BY MR. SANTACROCE:

1 Q A webinar. What's a webinar?

2 A It is a presentation that I can give from my
3 office, calling in on the phone and other people can call in
4 from wherever they are and log in to look at the slides that
5 get advanced and listen to me by phone as I'm presenting.

6 Q And in that webinar you identified some common
7 breaches; do you recall what they were?

8 A I don't.

9 Q Let me show you -- see if this refreshes your
10 recollection.

11 A (Witness complied.) Okay.

12 Q What were some of the common breaches you
13 identified?

14 A Sir, I think that needs some more context of the
15 common breaches for what?

16 Q Okay. Tell me.

17 A So we looked at outbreaks of both bacteria and
18 viruses in healthcare settings, and some of the common
19 breaches were reuse of needles and syringes, either from
20 patient to patient or to go back into shared medication vials.
21 Reuse of single-dose vials for multiple patients regardless of
22 syringe reuse, and I think, you know, poor hand hygiene or
23 lack of aseptic technique was on there. Common saline bags or
24 multidose vials that again -- sorry, it's already left my
25 mind. I'd have to --

1 Q Okay.

2 A -- look at it.

3 Q Well, the viral -- you talked about viral and
4 bacterial outbreaks, correct?

5 A Correct.

6 Q And the viral outbreaks was in specific
7 reference to hepatitis, correct?

8 A Right.

9 Q And one of the breaches you noted was use of a
10 single-dose vial of saline bags for one patient?

11 A Well, so the heading for that was viral and
12 bacterial. And so outbreaks and then common breaches, and
13 you're not going to see an outbreak of viral hepatitis just
14 from reuse of a vial or just from reuse of a bag unless you
15 have syringe reuse as part of that.

16 I typically would think, you know, reuse of a bag or
17 reuse of a vial absent syringe reuse being more of a bacterial
18 concern.

19 Q The -- when you identified the common breach of
20 single-dose vials of saline bags for one patient, you didn't
21 mention anything about reuse of syringes in that.

22 A So again, I'd have to look through all of the
23 slides --

24 Q Okay.

25 A -- to know what was said when. I can only --

1 you're just showing me what was a bullet on that slide, so I
2 think that there would have been some more context in my talk.
3 But, yes, when I'm talking about outbreaks in healthcare
4 settings and I believe -- and again, if you put it in front of
5 me, we have how --

6 I think we said something like 41 outbreaks, how
7 many were viral, how many were bacterial, and then I go on to
8 look at some of the common infection control breaches that
9 have resulted in outbreaks like these in healthcare settings,
10 not making the distinction between viral, bacterial, that kind
11 of thing, on that slide.

12 Q You also identified instrument reprocessing as a
13 breach.

14 A Okay.

15 Q Do you want to see it?

16 A If -- I'll -- if it's in front of you, then I --

17 So this slide is actually commenting on the titles
18 on infection control worksheet components.

19 Q Okay.

20 A So this is use of a worksheet that's been
21 developed to assess infection control practices in healthcare
22 settings, and so it's focusing on five, you know, major areas
23 of infection control in general for healthcare settings.

24 Q And one of those was instrument reprocessing?

25 A Yes.

1 Q And tell me about that. You specifically say in
2 your example on this webinar, endoscope --

3 MR. STAUDAHNER: Objection, Your Honor. He's reading
4 from it now.

5 MR. SANTACROCE: I'm asking her.

6 THE COURT: State your question.

7 BY MR. SANTACROCE:

8 Q You identified it, endoscope reprocessing under
9 that instrument reprocessing, correct?

10 A So that can be a type of breach. Endoscopes are
11 a type of equipment, one of many. So that can be one example.
12 You know, other surgical instruments are also an example.
13 Without going through every slide and --

14 Q Okay.

15 A -- and relistening to the talk, I can't put what
16 was said in context.

17 Q Okay.

18 A But I agree, equipment reprocessing is on that
19 slide.

20 Q And important --

21 A Yes.

22 Q -- in controlling infections?

23 A Sure.

24 Q And you say -- what do you say in regard to
25 endoscope reprocessing?

1 A Again, without seeing the slides in their --

2 Q Well, let me show you --

3 A -- totality --

4 Q -- this, maybe it will refresh your
5 recollection.

6 A So again, this is focusing on an infection
7 control worksheet which is looking at infection-control
8 practices in healthcare settings. And so it's looking at five
9 main areas, hand hygiene -- this is something that we
10 developed with the centers from Medicare and Medicaid services
11 so that when their regulatory folks go into an ambulatory
12 surgery center, they're looking at things systematically.

13 And so it's looking at -- and the worksheet is
14 available online, but they're looking at things like hand
15 hygiene, use of personal protective equipment, injection
16 safety, medication handling, instrument reprocessing including
17 sterilization of critical devices or high-level disinfection
18 of things like endoscopes, cleaning of the environment, so
19 cleaning of environmental surfaces, and handling of
20 point-of-care devices like the blood-glucose meter.

21 Q Okay. So the -- the endoscope reprocessing, you
22 mentioned high-level disinfection --

23 A Yes.

24 Q -- and sterilization?

25 A So those were two separate kind of components.

1 So endoscopes are something called a semicritical device,
2 meaning that it needs to go at a minimum under high-level
3 disinfection before use on another patient. There are devices
4 called critical devices that are things that you use kind of
5 during a surgery when you cut into someone and it's going into
6 that space, and that needs to undergo, at a minimum,
7 sterilization.

8 So I was talking about different types of
9 reprocessing.

10 Q Okay. Well, let's talk about the high-level
11 disinfection.

12 A Okay.

13 Q That's for endoscopes, correct?

14 A At a minimum. You can also --

15 Q Well, I'm only talking --

16 A -- sterilize.

17 Q -- about endoscopes for now.

18 A Okay.

19 Q I mean, I -- and I know you can bring in a whole
20 other bunch of equipment that I know nothing about, but at
21 issue in this case are endoscopes. So that's why I'm talking
22 to you about that.

23 A I understand --

24 Q Okay?

25 A -- that, but I'm trying to answer your question,

1 which is some endoscopes can also be sterilized. But at a
2 minimum, yes, high-level disinfection.

3 Q And when would it require sterilization for an
4 endoscope?

5 A It would depend on the manufacturer's
6 instructions. I can't answer that.

7 Q Okay. In this clinic you looked at endoscopes?

8 A Yes.

9 Q And what was the manufacturer's recommendations
10 for cleaning or sterilization?

11 A So it was a number of steps including a
12 precleaning step and then high-level disinfection.

13 Q Okay. And how is that accomplished at the
14 clinic?

15 A So again, it's a number of different steps
16 starting from when the scope comes out of the patient and
17 doing some initial cleaning, and then taking it into the -- a
18 separate room in the facility where they do scope reprocessing
19 and walking through a number of different steps. They check
20 the scope, doing a leak test to make sure that none of the
21 channels were broken during the procedure and that the scope
22 is still functional. They will brush out the channels and
23 actually clean it with a detergent and rinse the detergent out
24 so that you get the initial, you know, debris that's on there,
25 any stool or anything else off.

1 And then after it's gone through the initial
2 precleaning and brushing and rinsing, it would go into an
3 automated machine that does high-level disinfection. And so
4 it gets hooked up to that machine to run the high-level
5 disinfectant through it and on it, it alarms so that you do an
6 alcohol, you know, drying step after it's been rinsed and
7 dries, and then it comes out and gets hung now that it's been
8 disinfected for use on the next patient.

9 THE COURT: You know what? Mr. Santacroce, I'm going
10 to go ahead and interrupt your cross-examination. We're going
11 to take our lunch break.

12 Ladies and gentlemen, we'll be in recess for the
13 lunch break until 2:30.

14 During the recess you are reminded that you're not
15 to discuss the case or anything relating to the case with each
16 other or with anyone else. You're not to read, watch, listen
17 to any reports of or commentaries on the case, person, or
18 subject matter relating to the case. Don't do any independent
19 research, and please don't form or express an opinion on the
20 trial.

21 Notepads in your chairs. And follow Kenny through,
22 I guess, the rear door.

23 And, ma'am, please don't discuss your testimony with
24 anyone else during lunch break.

25 (Jury recessed at 12:55 p.m.)

1 THE WITNESS: Does that include the prosecution? I
2 guess so.

3 THE COURT: They probably shouldn't be talking to you
4 about the testimony --

5 THE WITNESS: Okay.

6 THE COURT: -- because you're in the middle of it --

7 THE WITNESS: Okay. I just wanted to make sure.

8 THE COURT: -- is the idea of -- yeah.

9 THE WITNESS: So I just have to be back here at 2:30?

10 THE COURT: Right. Exactly. 2:30 and you're free to
11 go to lunch.

12 Before we take our lunch break -- is that door shut?
13 Scheduling. Mr. Santacroce, how much more do you anticipate?

14 MR. SANTACROCE: Oh, probably a half-hour.

15 THE COURT: Who is doing this one? How long do you
16 anticipate?

17 MR. WRIGHT: At least through the end of this day.

18 THE COURT: Okay. So we don't really need to worry,
19 then, about you reviewing the new notes because you'll have
20 all evening to do that?

21 MR. WRIGHT: Correct.

22 THE COURT: All right. But you have extra time
23 anyways, so you can start reviewing those, if you want to.
24 All right.

25 MR. WRIGHT: Extra time.

1 THE COURT: We do. We have an hour and a half. It's
2 extra time. I mean --

3 MR. SANTACROCE: What time are you breaking this
4 afternoon? Or was there another conflict?

5 THE COURT: Oh, yeah. There's another issue so we
6 have to break -- what I said, 4:30?

7 MS. STANISH: Third-grade graduation?

8 THE COURT: Well, it's all these graduations and
9 everything. After, what, Wednesday there should be nothing
10 else, and we can stay later after Wednesday. So, you know. I
11 mean, to me -- have to let people go to these graduations, you
12 know, when you're in trial for weeks and weeks. So -- okay.
13 So that's our schedule for today.

14 (Court recessed at 12:57 p.m. to 2:37 p.m.)

15 (Outside the presence of the jury.)

16 THE COURT: They're all back now, so we can get
17 started. Let Kenny know we're ready to start.

18 (Pause in the proceedings.)

19 MR. STAUDAHER: Your Honor, would you like me to get
20 the witness?

21 THE COURT: Oh, would you? Thank you, Mr. Staudaher.

22 (Jury entering at 2:45 p.m.)

23 THE MARSHAL: Everybody may be seated.

24 THE COURT: All right. Court is now back in session.
25 And, Mr. Santacroce, you may resume your cross-examination.

1 MR. SANTACROCE: Thank you, Your Honor.

2 CROSS-EXAMINATION (Continued)

3 BY MR. SANTACROCE:

4 Q I believe we were talking about high-level
5 disinfection for endoscopes, and you were explaining what that
6 meant.

7 A Yes, sir.

8 Q So could you just go ahead and refresh our
9 recollection as to what high-level disinfection means?

10 A It's multiple steps, a disinfection process for
11 scopes to be used on subsequent patients. Do I need to go
12 through the steps again?

13 Q I don't think so. Are there manufacturer's
14 guidelines on how to clean these things?

15 A There are instructions for -- specific for each
16 device, and then, CDC also has general guidelines for
17 reprocessing of medical devices.

18 Q Did you observe the cleaning process when you
19 were at the clinic --

20 A Yes --

21 Q -- all the --

22 A -- I did.

23 Q -- soaps?

24 A Yes, I did.

25 Q And can you tell me what you observed?

1 A So I'd like to refer back to our trip report
2 just to refresh my memory, if that's okay?

3 THE COURT: That's fine.

4 BY MR. SANTACROCE:

5 Q If you can just tell us where you're looking?

6 A Sure. So I'm looking at the document that we've
7 previously seen, which was the CDC trip report.

8 Q Okay. I'm having trouble hearing you. Can you
9 speak --

10 A I'm sorry. I'm looking at the document that we
11 previously reviewed, which is the CDC trip report --

12 Q Okay.

13 A -- and I'm looking starting on page 5 of that
14 document.

15 Q Can you give me the Bates Stamp Number on the
16 bottom? Do you have one of those?

17 A I do not, no.

18 Q Okay.

19 A Not on my copy. I'm sorry. But it's page 5 of
20 our text.

21 Q Okay. I -- I don't want you to read that --

22 A Yeah --

23 Q -- out loud.

24 A -- I just want to look through it and then --

25 Q Okay.

1 A -- I'll answer. So, you know, what we observed
2 was once the procedure was over, the scope would be handed off
3 to a tech in the room who had some type of cleaner or
4 detergent actually kept at the bedside that was changed
5 between patients and would suck the detergent up through the
6 channels and flush it out just to clear it before carrying it
7 into a separate room that they had that was dedicated for
8 scope reprocessing.

9 And so they would go into that room and they would
10 do what I mentioned before, a leak test, which is making sure
11 that there wasn't any damage to the -- the scope during the
12 procedure, that none of the channels were damaged, and then if
13 that passed, they would go ahead and do the precleaning, which
14 would again be brushing the -- using a brush to brush through
15 the channels, and then putting it in a bucket that contained
16 detergent and hooking it up to this pump that would pump
17 detergent through the channels, and then that would be for a
18 set length of time and then it would be transferred to a water
19 bucket that would flush the detergent out and rinse it off,
20 and then that would be for a set length of time. And then
21 once that was done, it would go into the machine or the
22 automated endoscope reprocessor that they had, and so you
23 connect it in the machine and that machine is an automated
24 process to put high-level disinfectant through and around the
25 scope for a set period of time.

1 So that does that. And then I think there's an
2 alarm at some point that they have to push a button that
3 alcohol goes through all the channels to kind of help dry it.
4 It will do some forced-air drying, and then it comes out of
5 the machine. And so now it's been cleaned and disinfected and
6 it gets taken into another room where it's hung with all the
7 other clean scopes.

8 Q Okay. i want to show you what's been admitted as
9 State's Exhibit 126. Does that look like the reprocessing
10 room?

11 A Yes.

12 Q Okay. And you personally observed this cleaning
13 process, correct?

14 A Yes.

15 Q Now, do you know what these blue buckets were
16 used for?

17 A I -- I'm not certain because it's been so long,
18 but I'm guessing those were the buckets for the cleaning, but,
19 you know, it's been so long.

20 Q Did you interview any GI techs that were
21 employed on July 25, 2007, or September 21, 2007?

22 A I don't recall if the techs that were working on
23 the days that we were there observing and speaking to were
24 also techs that were working on the days -- those two dates in
25 question. I don't recall.

1 Q Okay. And how many scopes did you observe them
2 cleaning in a bucket before the solution was changed?

3 A Two.

4 Q If there was testimony by GI techs that there
5 were up to 11 scopes cleaned at a time with that solution,
6 would that -- how would you react to that?

7 A It's inappropriate.

8 Q I'm going to show you what's been marked as
9 State's Exhibit 149. Do you recognize what this is?

10 A That looks like the clean supply cabinet, but
11 again --

12 Q Okay. I'm going to show you 150. Do you
13 recognize that?

14 A That's another cabinet with scopes hanging. I'm
15 not -- you know, I don't have any context around it, so...

16 Q And when -- did you witness these scopes
17 hanging?

18 A I don't recall. Probably. But I can't say with
19 certainty. I think we did look at scopes that were hanging.

20 Q Did you -- did you notice any feces coming from
21 the clean scopes or on the chux that were below the scopes?

22 A Not that I recall, no.

23 Q If you had, would that be a concern?

24 A Yes.

25 Q And you'd be concerned about that because that

1 could be a mode of transmission, correct?

2 A I'd be concerned because that reflects improper
3 reprocessing. I'd want to know more to determine if that was
4 a mechanism of transmission.

5 Q Okay. A point to which you addressed in your
6 webinar.

7 A What point?

8 Q About the instrument reprocessing and the
9 high-level disinfection?

10 A So my webinar was about -- in general, not
11 specific to reprocessing for this facility.

12 Q Oh, I understand that.

13 A Okay.

14 Q Okay?

15 A Sorry.

16 Q But those sterilization practices apply to every
17 ASC, right?

18 A All healthcare facilities should be doing
19 appropriate reprocessing of medical equipment, yes.

20 Q So the practices and points that you put out in
21 your webinar are applicable throughout the United States, if
22 not the world?

23 A Certainly.

24 Q Now, in your webinar you talked about, quote,
25 double dipping, a term that you obviously used because it's in

1 your --

2 A Yes, it's in my presentation. I did --

3 Q -- presentation --

4 A -- use it there.

5 Q -- correct?

6 A Correct.

7 Q And do you remember how you defined double
8 dipping in your webinar presentation?

9 A I think it's the same way I've defined it here,
10 which is taking a syringe, using it on a patient, and then
11 using that syringe to go back into the medication vial for
12 that patient, and then that vial is then used for subsequent
13 patients.

14 Q Okay. I'm going to show you a slide from that
15 presentation. See if this refreshes your recollection.

16 A (Witness complied.) Okay.

17 Q Okay. And what did -- what did you say in that
18 webinar regarding double dipping?

19 A So what I just said here, that a syringe is used
20 on a patient and goes back into a medication vial.

21 Q This specifically addressed IV medication into a
22 patient, did it not?

23 A I would have -- I don't recall. I'd have to
24 look again. I'm sorry. I didn't focus on that word, but that
25 would make sense, sure.

1 Yes.

2 Q And you particularly focused on IV medication
3 because there happened to be an outbreak due to contamination
4 through IV medication, correct?

5 A So I'd have to look at the headline, I don't
6 know if that was an outbreak or if that was actually a
7 notification event that resulted from that practice. CDC's
8 recommendations are if that practice is identified, it is what
9 we consider a Category A lapse that can and has resulted in
10 disease transmission and patients should be notified and
11 tested.

12 Q Take a look at the second bullet point.

13 A (Witness complied.) Correct.

14 Q Okay. It refers to patient note -- 2,000
15 patients being notified of a blood-borne pathogen in relation
16 to this double-dipping practice, correct?

17 A Correct.

18 Q Where did that occur?

19 A Whatever it says on there, San Pedro -- I can't
20 read the headline.

21 Q San Pedro, California?

22 A I don't know. I can't read the headline that's
23 on there to refresh my memory.

24 Q Okay. And you recall the result of what
25 happened due to that outbreak due to double dipping for IV

1 medication?

2 A So as you said, it resulted in a notification
3 and a recommendation for blood-borne pathogen testing of
4 patients.

5 Q I'm going to show you another slide from that
6 presentation, and ask you to take a look at it.

7 A (Witness complied.) Mm-hmm.

8 Q Can you explain to me what that means?

9 A So this is a slide that's addressing --

10 Q Are you done with that?

11 A -- do you mind, so you don't have to walk back
12 and forth?

13 Q Okay.

14 A Do you mind if I just keep it? I'm sorry.

15 Q I don't mind staying here.

16 A That's not a problem for me, if you want to
17 share it.

18 Q Okay. We'll share.

19 A So it's a slide looking at prior reports of
20 lapses and reprocessing of medical equipment. And so it looks
21 at reports that have been filed at the Food & Drug
22 Administration, and it also looks at a study or pilot that --
23 that I, the folks at CDC did, along with the centers for
24 Medicare and Medicaid services, looking at infection-control
25 practices and ambulatory -- a sample of ambulatory surgery

1 centers, and then also summarizes some publicly available data
2 from the California Department of Health Services about
3 endoscope reprocessing.

4 Q And tell me what you specifically found.

5 A So in the pilot for ambulatory surgery centers
6 the surveyors found that about 28 percent of facilities had
7 some type of lapse in reprocessing of medical equipment. It
8 varied across the board, was not just limited to endoscopes or
9 high-level disinfection.

10 And then what else -- do you want to specify or --

11 Q No, you can just tell me what else you found in
12 the reports.

13 A So FDA --

14 Q What is -- what is this?

15 A So the Food & Drug Administration over about a
16 three-year period from 2007 to 2010 reported about 80 reports
17 to them of inadequate reprocessing of some type of medical
18 device that was filed with their agency, and they deemed that
19 28 reports of infection may have occurred from inadequate
20 reprocessing, but I don't know what types of infections those
21 were.

22 Q Okay. Fair enough. And these reprocessing of
23 these medical devices include endoscopes, correct?

24 A I can't speak specifically for the FDA because I
25 don't think it specifies on there. On the ambulatory surgery

1 center one, I think there is mention of high-level
2 disinfection lapses, and I think the California one was
3 focused on endoscopes as well, but you've taken it, so...

4 Q What other items did you find in the clinic that
5 were being reused?

6 A We -- we didn't, in the clinic, identify any
7 other items that we observed being reused. The propofol
8 vials, the multidose vials of saline, multidose vials of
9 lidocaine, the scopes. I think those were the only things
10 that I recall seeing that were used for more than one patient
11 in some fashion.

12 Q In your grand jury transcript, didn't you
13 mention bite blocks?

14 A We did not observe that while we were there. I
15 think that was identified or reported subsequent to us being
16 there, I think. I don't recall that.

17 Q Did your report -- or your investigating take
18 into consideration that bite blocks might be being reused when
19 they were single-use items?

20 A Well, we did but again, when you look at the
21 cases and their source, you only use a bite block if you have
22 an upper endoscopy. You don't use it if you're getting a
23 colonoscopy and not all of the patients had an upper
24 endoscopy. So that, in my mind, was not a potential source of
25 transmission here.

1 Q Were some of the ones that were infected, did
2 they have any uppers?

3 A I'd have to look back at our -- the trip report
4 again on that page 13.

5 Q Okay. Go ahead.

6 A And so -- do we need to put it up or can I --

7 Q No, you --

8 A Okay.

9 Q -- can just look at it.

10 A So for July 25, 2007, our potential source
11 patient had an upper endoscopy, but our case patient who
12 became infected had a colonoscopy so wouldn't have had a bite
13 block.

14 Q Well, the source patient would have.

15 A Right. But in order for there to be
16 transmission, I would expect that -- some sharing between the
17 source --

18 Q Okay.

19 A -- and the -- and the infected patient, and the
20 bite block wouldn't have been shared.

21 Q Okay.

22 A And honestly I don't think a bite block would be
23 a source anyway, but -- and then looking at September 21 -- so
24 our potential source patient that day who was the source of
25 virus that went to the other patients, had a colonoscopy so

1 wouldn't have had a bite block. And then our cases -- again,
2 looking at September 21, only one of them had an upper
3 endoscopy; the rest had colonoscopies.

4 Q Are you referring to page 13, that table?

5 A Yes, sir. I am.

6 Q Okay. Let's put that up here.

7 A Yes, sir. Do you want me to --

8 Q No, that's what you're --

9 A -- okay.

10 Q -- referring to?

11 A Yes, sir.

12 Q I'm going to point this date out to you here.

13 A Yes.

14 Q It says, September 20, what -- what is that --
15 why is that in there?

16 A That is because one of our patients, Case 2
17 there, had two separate procedures. One on the 21st was their
18 upper, and one on the 20th was their colonoscopy or lower. So
19 they were listed twice because they had procedures twice at
20 this clinic.

21 Q Okay. But can you pinpoint what day they were
22 infected?

23 A The 21st.

24 Q Okay. And then how about case 4, it says the
25 19th?

1 A Yeah. So Case 4 had an upper endoscopy on the
2 19th and then Case 4 had a colonoscopy on the 21st. Sorry.
3 It's not right next to it, but --

4 Q So the same thing, two procedures --

5 A Two procedures --

6 Q -- on different days?

7 A -- on different days, yes.

8 Q Okay. Also, while we're on this chart here --
9 on -- for the September 21st dates --

10 A Yes.

11 Q -- do you notice who started the IV's, who you
12 have on here? You have RN 1, 1, 3, 1, 2, and 5.

13 A Yes.

14 Q Who is RN 1?

15 A I don't know.

16 Q Who is RN 3?

17 A I don't know.

18 Q RN 2?

19 A I don't know.

20 Q If I were to tell you that the records that were
21 put together by the State only show two nurses giving IV's on
22 that particular day to those infected patients, would you have
23 an explanation for that?

24 A I would not.

25 Q Could it be a mistake on your part?

1 A It could be.

2 Q I want to talk to you now about some of your
3 conclusions. From looking at exhibit -- State's Exhibit 165,
4 this is your report, I believe?

5 A So this is the publication in the Clinical
6 Infectious Disease Journal. Okay.

7 Q Yes. And what was your conclusion that you
8 reached after your -- was it nine-day investigation?

9 A Nine or ten days.

10 Q How many days were spent at the clinic?

11 A Again, I think we were there all days, but I
12 can't say with certainty that on a Sunday if they were open or
13 not, but the majority of the days were there. And then
14 obviously, the investigation continued after we left; but if
15 you're focusing on the field, that was nine or ten days.

16 Q Okay. So tell me what conclusions you reached
17 after your investigation?

18 A So we concluded that a transmission of hepatitis
19 C virus occurred at this clinic on two separate dates, and
20 that transmission occurred through unsafe injection practices,
21 meaning reuse of syringes. So drawing up propofol,
22 administering it to a patient, reusing that syringe to go back
23 into a vial, and then using that vial on subsequent patients.

24 Q And I believe you said -- you used the word
25 "likely" means of transmission?

1 A Correct.

2 Q And what did you mean by likely means of
3 transmission?

4 A I was not present on -- on July 25th or
5 September 21st, so I am relying on the investigating we did
6 several months later and the information that -- of all the
7 totality of potential that we looked at and knowing that that
8 practice has been attributed to a disease transmission
9 previously, and it was witnessed as well as stated that it
10 happened to us; and looking at all the different possibilities
11 that's the one that makes sense.

12 Q Makes sense?

13 A Yes.

14 Q On page -- well, on this it says 272, but it
15 isn't that long. You say that the investigation and
16 conclusions reached are subject to unavoidable limitations?

17 A Correct.

18 Q What did you mean by that?

19 A It goes back to the fact that I was not there on
20 July 25th or September 21st to witness what happened on those
21 dates, and so I'm relying on review of records and the
22 information provided to us several months after the fact.

23 Q And you state that the investigating occurred
24 over a ten-day period five months after the initial
25 transmission occurred, correct?

1 A Correct.

2 Q And you said that the observations and
3 interviews were potentially subject to changed practices and
4 recall bias?

5 A Sure.

6 Q So those conclusions you reached are subject to
7 these limitations, correct?

8 A Correct.

9 MR. SANTACROCE: I have nothing further. Thank you.

10 THE COURT: All right. Thank you, Mr. Santacroce.
11 Is it you, Mr. Wright?

12 MR. WRIGHT: Yes, Your Honor.

13 CROSS-EXAMINATION

14 BY MR. WRIGHT:

15 Q My name is Richard Wright. I represent Dr.
16 Desai.

17 A Thank you.

18 Q In preparation for your testimony here in the
19 courtroom, what have you reviewed?

20 A So I have reviewed the three reports or
21 publications, whatever we're going to call them, that were
22 generated from CDC, the notes that have been provided to you,
23 my grand jury transcript, and my interview with law
24 enforcement before that have been the -- the main documents I
25 have here that I've looked at.

1 Q Okay. And have you discussed it with anyone,
2 your testimony?

3 A As far as what I'm planning to say, no. As far
4 as I'm traveling here to testify, yes.

5 Q Okay. And have you been preinterviewed by the
6 District Attorney's Office?

7 A Yes.

8 Q Okay. And preinterviewed -- and I mean in
9 preparation for your testimony?

10 A Yes, sir.

11 Q Okay. Prepared by anyone else other than the
12 prosecutor?

13 A No.

14 Q Okay. Now, do you -- because you're testifying
15 about a visit to the clinic for about ten days in January
16 2008, about five and a half years ago, do you have an accurate
17 recollection of the conversations, the people, the places, or
18 are you relying upon your report?

19 A I think a mixture of both. I think the reports
20 have helped refresh my memory of what I may have previously
21 stated in closer proximity to the investigation. There are
22 certain things that I have independent recollection of, so I'd
23 say it's a combination.

24 Q Okay. And the, like, on -- if we talk about the
25 placement of IV's with -- we've been calling them heplocks

1 here in the courtroom --

2 A Okay.

3 Q -- on the placement of those, do you have a
4 clear recollection of the days -- or day you spent in
5 observing it?

6 A Can I ask a -- when you say "placement," do you
7 mean on the body or in the location in the clinic where it was
8 placed? Like --

9 Q Okay.

10 A -- I'm sorry.

11 Q I mean insertion of it.

12 A So whether it was up here or down here or --

13 Q Right.

14 A -- I don't recall where on the body. I could
15 look through my notes and I may have documented that, but just
16 off the top of my head I don't recall if it was in the hand or
17 if it was in the -- the antecubital fossa.

18 Q Okay. And the -- do you recall, like, I can
19 read the report, you know, and read that a, what I would call
20 a multiuse saline bottle was used in the preop area?

21 A Yes, that is accurate.

22 Q Okay. And do you remember that, or are you just
23 reading the report like me?

24 A I remember that.

25 Q Okay. Do you remember when you were asked about

1 it by the police in your interview; that you were unclear on
2 the memory of it when they asked you about prefilled saline
3 syringes, you -- you had trouble recollecting whether it was
4 prefilled saline syringes or a multidose saline bottle that
5 was used for the heplock saline flushes?

6 A So I know what you're asking about, and I recall
7 that multidose vials of saline were used. When law
8 enforcement asked me about it, I think I somewhat
9 misinterpreted their question in asking if prefilled --
10 manufactured prefilled syringes of saline flush were also
11 used, and I did not observe that but was trying to remember
12 did they have those as well. But what I observed was the
13 multidose vial side of things.

14 I didn't -- I was trying to make sure that I wasn't
15 misremembering that there were also prefilled saline flushes,
16 and there weren't.

17 Q Okay. But you, I mean, you -- the -- so you
18 were -- any confusion that it looked like from just reading
19 the transcript, bear in mind, I wasn't there --

20 A Right.

21 Q -- at the interview -- that was simply confusion
22 about were they asking in addition to multidose saline, were
23 there also prefilled saline syringes?

24 A So in rereading the transcript in preparation
25 for this, that's how I am interpreting --

1 Q Okay.

2 A -- that exchange because I know that multidose
3 saline vials were used there.

4 Q Okay. And on there -- during that exchange and
5 -- did someone say something? Oh.

6 THE COURT: Bless you.

7 MR. WRIGHT: Maybe I'm hearing things.

8 BY MR. WRIGHT:

9 Q Did you see -- during that exchange -- someone
10 else -- I mean, it just has question marks as that's in the
11 report.

12 A Question marks where?

13 Q As to who the speaker is.

14 A So can -- can we open it up?

15 Q Sure.

16 A Is that okay? I'll show you when I find it.

17 Q I think it's around page 14 --

18 A Thank you.

19 Q -- that ought to help you out.

20 A So it's from page 12 or 13 here, right?

21 Q Correct.

22 A So place an IV flush --

23 Q See -- yeah, on a -- page 13, your -- your
24 recollection is exactly as you're testifying, and then what I
25 was asking about --

1 A Is here?

2 Q -- yeah, it says -- someone says, Yeah, our trip
3 report indicates the multidose saline flush --

4 A So that question mark is from my supervisor Joe
5 Perrrs [phonetic], who was also present in the interview. I
6 think the transcriptionist -- since he probably didn't say
7 this is Joe Perrrs, but the next statements lead me -- he
8 was -- he was present for the interview with me, and as you'll
9 note later in the document, actually was responding to some of
10 the questions since he supervised, was a co-author, approved
11 our report, talked to him every night, so he answered some
12 questions later.

13 So these question marks indicate to me that that was
14 Joe's responses.

15 Q Okay. And so you say, Yeah, and then said -- I
16 mean, he interrupt --

17 A He did.

18 Q -- you interrupted him -- multidose saline flush
19 was the norm, and that is correct?

20 A Right. So --

21 Q I mean, he -- he's still speaking. That was the
22 norm, at least the terms of what Gayle and Melissa observed
23 and recorded --

24 A Yes.

25 Q -- correct?

1 A And prior to this interview with law
2 enforcement, we had generated an earlier draft of the trip
3 report, which addressed that as well.

4 Q Okay. I -- I was just confused --

5 A I understand.

6 Q -- as to who -- who was prompt -- answering.

7 A Yes.

8 Q And so that's -- when you talked about the home
9 team --

10 A Yes.

11 Q -- you were the -- the road team --

12 A We were the --

13 Q -- is that --

14 A -- field team.

15 Q -- field team.

16 A They were the home team.

17 Q Okay. And so you would be reporting back -- you
18 and -- was -- and Gayle?

19 A Yes. So if you look at our -- at the trip
20 report you'll see language that says, Through, and those are
21 the two main supervisors of the investigation. There were
22 others involved, but those were the folks that were
23 speaking -- that were in communication with Southern Nevada
24 Health District before we left, are supervising, have -- you
25 know, the investigation and we're speaking with every day and