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DIPAK KANTILAL DESAI, Appellant, vs.

THE STATE OF NEVADA,

Respondent.

CASE NO. 64591

APPELLANT'S APPENDIX VOLUME 40

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observed by her fellow employees, she was observed to have
 been following the correct procedures.

The other reason why the saline flush, of course, was eliminated was because Mr. Ziyad, the source patient on July the 25th, didn't get a saline flush. His hep-lock was administered by R.L., Ron Lakeman, and that makes sense because he was the first procedure of the day.

8 He just went straight into the procedure room. He 9 didn't go into pre-op. And so Mr. Lakeman is the one who 10 administered the hep-lock. The CRNAs didn't really use 11 saline, certainly not the same saline the nurses would have 12 used. And what happens after that? Well, Mr. Washington 13 ultimately gets hepatitis C.

What was important to both investigations ultimately was the propofol going from room to room. But the CDC and the Southern Nevada Health District actually had kind of a different way of assessing this, that, you know, the disease infection, how did it move into two rooms on -- on September the 21st? They didn't seem too tied up in that fact or too concerned about it.

They are -- they were more like of course it moved into the other room, it must have happened, it doesn't affect our analysis one way or another. We're able to reach our conclusions without knowing that because the -- they just made, I guess, a conclusion that in some way it went from room

to room and that was obvious by the perpetuation of infection
 in the second room.

Now, what the Las Vegas Metropolitan Police Department and Detective Whitely, that kind of conclusion, you know, there's no witness for that. You have to flush that out a little. And so you heard from people he interviewed that talked about propofol moving from room to room.

8 Ann Lobiondo talked about it. Linda Hubbard talked 9 about it. Ralph McDowell talked about it. And Marion 10 Vandruff talked about it, how propofol moved from room to 11 room. So you actually heard from witnesses that described 12 that phenomena, which, of course, explains how it ended up in 13 the second room.

Now, the multi-use, multi-patient use of propofol vials, obviously that was important to both investigations and that's really not in dispute that the clinic was using maybe three to -- two or three to one ratio of vials to patients, and that was part of the problem, obviously, the first half of how the disease got perpetuated. And the CDC got that information from their visits to the clinic.

21 Metro went and did supply counts for the days, which 22 are reflected showing that the number of patients versus the 23 vials of propofol indicate certainly that there's a lot fewer 24 vials of propofol than there are of patients on a particular 25 day. And they did it for the year or two. And you'll have

1 the ability literally to count out the logs every single day 2 if you want to when you're in the deliberation room.

So what was the last piece that caused 3 contamination? And that was syringe reuse to redose a single 4 patient. Now, the CDC and the Southern Nevada Health District 5 saw this occur with Keith Mathahs on a single patient. They 6 saw him unscrewing the needle, putting a new needle on, and 7 re-accessing a vial of propofol that he would ultimately --8 and ultimately intended to use on the next patient. So the 9 dangerous practice they observed with one CRNA. 10

Now, the Metro investigation, of course, was 11 broader. You heard from Ruta Russom. She was a GI tech. She 12 saw syringe reuse by Mr. Lakeman within a single patient. You 13 heard from -- statements from Linda Hubbard that talked about 14 syringe reuse. You heard from Keith Mathahs. He talked about 15 syringe reuse of the same syringe from -- within the same 16 patient. Which, of course, is the first step; right? 17 I mean, you either -- you either need to have many, 18 many, many vials of propofol, one for each patient, or you 19 20 need to be using a whole lot of syringes in order to accomplish the administration of the anesthesia aseptically. 21 And the endoscopy center was wrong on both ends. They didn't 22

23 have enough vials of propofol, and they didn't have enough 24 syringes. So that's why the disease occurred.

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Now, both of -- as you heard the instructions read

1 to you by Judge Adair, both of the crimes relating to the 2 patients deal with an aspect of recklessness. There's the 3 crime of performance of an act in reckless disregard of 4 persons or property, which requires the person to know a risk 5 and -- and disregard it in an unreasonable manner.

6 Their conduct has to be willful and wanton or 7 indifference, indifferent to the consequences of the risk. 8 For the criminal neglect of patients, they have to be aware of 9 the risk, as well, and have disregard of it, which is -- which 10 is another way of saying that they were reckless, that they 11 saw a risk and that they chose to disregard it.

The issue for you to decide as criminal jurors is did they see the risk? And you know from Dr. Alter and all of the nurses that testified in this case that not using -reusing syringes is basically nursing 101. You learn that on your first day in nursing school.

And we brought in this trial a parade of nurses before you, Pauline Bailey, Janine Drury, Lynette Campbell, Jeff Krueger, Ann Lobiondo, Linda Hubbard. All of them, all of them knew that this practice of multi-use of propofol in combination with reusing a syringe on a single patient was a dangerous practice and could lead to contamination.

You had doctors testify, Dr. Carrera knew that that was dangerous. Dr. Carrol knew that that was dangerous. Dr. Herrero knew that that was dangerous. Even really early on in

1 this trial, Dr. Yee knew it was dangerous. Dr. Satish Sharma 2 said it was a dangerous practice. So all of these people knew 3 that you couldn't engage in this practice and that it was a 4 reckless practice, but you're to assume that these two 5 defendants were the ones that didn't know.

You all sat -- think of the -- think of the 6 testimony alone of just Dr. Miriam Alter, which was -- it was 7 -- it was a good chunk of the day, but not nearly as long as 8 9 nursing school, right, which would be several -- several months, years, endeavor. And she talked about syringe reuse 10 for maybe, you know, a certain amount of her testimony, a 11 12 certain portion of her testimony. I bet none of you have a doubt about the danger of syringe reuse, and you've heard less 13 than one day of testimony about it. How it escaped the 14 knowledge of Mr. Lakeman and Dr. Desai is just not -- is just 15 16 not reasonable.

The theory, though, of the defense seems to be that because when the CDC contacted Keith Mathahs and they saw him changing the needle on the syringe and he responded, oh, I didn't know you couldn't do that, that somehow that means that there really wasn't an understanding of a risk because he said he didn't know.

And this is a man who, at that time, had been working in anesthesia for 30 years and he hadn't reused syringes before, but because he comments to -- makes an

offhand comment of, oh, I didn't know, you're to assume that no one has any knowledge about the danger of syringe reuse, even though it's taught throughout nursing school and medical school. And that's kind of the -- one of the fundamental questions in civil versus criminal. Because to be criminal, this has to be a reckless act. To be criminal, they have to have known of the risk and disregarded it.

So the question is, is it plausible that they 8 wouldn't have known the risk? I mean, in Keith Mathahs's 9 case, if that had really been accurate that he just didn't 10 know up until that 30 year point in his career, that should 11 have been a pretty seminal moment in his working life. But 12 when he testified on the stand, he barely remembered the 13 conversation. More than that, he indicated that prior to that 14 conversation he had a discussion with Dr. Desai about the risk 15 of reusing syringes, indicating that he was aware of it. 16

So, you know, I didn't know is sort of a way of 17 avoiding responsibility. It's like saying there's a lot of 18 people that continue to have unsafe sex with -- with 19 strangers. They must not know that there's a danger of 20 disease transmission, or I didn't -- I'm sorry, officer, I 21 didn't know I was in a school zone. That's why I wasn't 22 driving slower. Or I didn't know I couldn't write that 23 expense off on my taxes. Sometimes I didn't know isn't an 24 excuse to lower your own responsibilities. And more 25

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1 accurately in this case, the I don't know could be something 2 like I didn't know that my anesthesia time related to 3 insurance billing.

. . **.** .

Now, Miriam Alter also testified about the history
of hepatitis C, which medical providers would be aware of.
There was the identification of it, which these defendants
were alive for. There was the outbreak in New York City,
which got a lot of public attention. There was the outbreak
in Oklahoma after that which got a lot of media attention, and
another after that, and another after that.

And all of this is telling people to not engage in unsafe injection practices, not to reuse needles, not to use the combination of using the same needle on a patient, and then a multi-use vial on the next patient. All of that was in the media, according to Dr. Alter. So is "I don't know" even possible after that?

Moreover, there was the mailing that you saw from the CRNA professional association which was the warning, don't engage in this practice, do not do this, this is a dangerous practice that Mr. Lakeman should have gotten. That was in 2002 that that came out. These individuals also historically lived through the identification of hepatitis C scientifically.

They certainly were around when AIDS came to light and all the precautions that were necessary in association

1 with that disease. General knowledge that everyone seems to 2 have about the dangers of blood-borne pathogens and how they 3 could be transmitted. So "I don't know" sort of becomes less 4 plausible.

On top of that, you heard from the CDC 5 representatives about the campaigns that they have done over 6 7 the years to alert healthcare providers of these dangers. And "I don't know" seems less plausible after that. 8 Under the 9 defense standard, five years from now, after all this, if a healthcare provider would say, gosh, I didn't know, I didn't 10 know that was a danger, that would be sufficient. You have to 11 look deeper. Is this plausible that they didn't know? 12

And the real distinction with Ronald Lakeman is he did know. He had the conversation with Dr. Schaefer where he explained the practice that he engaged in. He said two things about it. One, he would deny the conversation if it was ever brought up, indicating he had said something about an unsafe practice.

Secondly, he said that he used negative pressure on the syringe to make sure there was no -- there was no mix or contamination that occurred. The very act of using the negative pressure indicates that he was trying to accommodate or address a risk. He was aware of the risk; he tried to address. He just -- it just didn't work. Now, as to Dr. Desai, he would have had knowledge,

as well. He had every bit of knowledge all of the other 1 doctors had, and they certainly knew of the dangers of this. 2 And remember, Dr. Desai is a gastroenterologist. He treats 3 people with hepatitis C regularly. Surely, someone who does 4 that would be familiar with the risk factors associated with 5 hepatitis C transmission, and he certainly didn't need to ask 6 his boss, Dr. Carrcl, about any sort of facts about 7 transmission. Desai also had conversations with Keith Mathahs 8 9 and Linda Hubbard, which indicated a knowledge of the risk, 10 but he went forward anyway.

Now, the crimes themselves of -- in terms of the 11 patient crimes have an element of substantial bodily harm, 12 which is defined as bodily injury, which creates a substantial 13 risk of death, or which causes serious permanent disfigurement 14 or protracted loss or impairment of the function of any bodily 15 member or organ, prolonged physical pain. And then you also 16 have to determine whether the criminal act was the proximate 17 cause of the substantial bodily harm. 18

And let's look at our victims in this case. We know 19 that Michael Washington came into the clinic with some stomach 20 upset and diarrhea, and he left with hepatitis C. Rodolfo 21 Meana, he came in with constipation; he left with hepatitis C. 22 Stacy Hutchison came in with some bleeding, and she left with 23 hepatitis C. Sonia Orellono, whose is pictured there came in 24 with constipation, and she left with hepatitis C. Patty 25

Aspinwall came in for a diagnostic test and left with hepatitis C. Gwendolyn Martin, she came in for heartburn; left with hepatitis C. And Carole Grueskin came in with some slight bleeding and left with hepatitis C. So the all came in with minor problems, and they left unknowingly with bigger ones.

Now, Sonia Orellono Rivera may be the patient that 7 overall did the best. She's the youngest. She didn't have 8 severe acute symptoms. She felt ill, she felt tired, and she 9 says she still feels that to this day. But it was -- you 10 know, it's taken a toll that she hasn't undergone Interferon 11 treatment. So maybe she did the best, but she still had to 12 change her life, and you saw her testify. This isn't an easy 13 thing for her. She still had to take precautions. She still 14 had the stress of wondering if the disease was going to 15 surface, and she certainly suffered. 16

Now, Patty Aspinwall, maybe she did the second best of the seven we have, although she was hospitalized because of her acute systems, which certainly would constitute substantial bodily harm, and she also had to deal with the stress of wondering if the disease was going to come back or the steps that she had to take to protect her husband. She had -- she had substantial bodily harm.

Now, Stacy Hutchison and Gwendolyn Martin, they wenta different path. These women actually underwent the

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Interferon treatment. This was the treatment that lasted like
 for almost a year with the shots and the pills and feeling
 depressed and feeling crazy and tired and fatigued, all of
 which constitutes substantial bodily harm.

5 But they ended up with a good outcome relatively 6 speaking, in that they don't seem to be suffering from those 7 symptoms now and there's no indication of disease in their 8 system. But there's no requirement that hepatitis -- or that 9 substantial bodily harm be permanent. They certainly went 10 through a long phase of pain and suffering.

And maybe sadly, predictably, the three people that have done the worst since their infection are the oldest ones. You saw Michael Washington testify. He is hoping, according to his wife, for a transplant, a liver transplant. She also described him as being mentally different and physically different, and you can make your own assessment based on your recollection of his testimony.

18 Carole Grueskin didn't seem to ever recover from the stress of learning what -- learning that she actually had been 19 infected by -- infected with hepatitis C at the clinic. You 20 21 heard from Dr. Lewis that there was no sign of dementia. 22 There was no sign of her loss of competency prior to her going to the clinic and learning of the diagnosis. And now she --23 she doesn't know where she is, she doesn't know what her name 24 25 is, she doesn't know any of her history.

Rodolfo Meana, he obviously had the -- you know, the worst outcome. He -- he ultimately died from this. And before he died, he suffered the symptoms of feeling ill and feeling fatigued.

So let's talk about the crimes, the first crimes 5 that are -- that are relating to patient care, and this is 6 performance of an act and reckless disregard of persons or 7 property. And the elements of this crime, essentially, a 8 reckless act sort of disregarding the safety of another, but 9 it doesn't have to be by a healthcare provider. It's just a 10 reckless act that unreasonably risks the safety of another 11 12 individual. And this is where direct liability and conspiracy 13 liability and aiding and abetting kind of come into play.

On July the 25th it's Ronald Lakeman who is treating both the source patient and Mr. Washington. He is the direct actor. He is the one that did the injections on both of those people. So his actions, he is the direct actor for that -that act.

Now, on September the 21st Mr. Lakeman was working with Keith Mathahs, and you know Lakeman treated some of his own patients directly, and then there's kind of an interplay between the two with supplies and also Mathahs's patients. And there has been some talk in the -- in the courtroom about how these -- these patients must have been treated -- must have been treated at the same time.

If you look at the 21st, it's clear that the day 1 starts off with Clifford Carrol covering both rooms. And he's 2 clearly not in, you know, two places at once, so these --3 these room times, as we've talked about it again and again, 4 they don't -- they don't represent real time because otherwise 5 he would be in two places. But Dr. Carrol does this 6 7 procedure, this procedure, this one, this one, and he kind of goes back and forth as they testify between the rooms. 8

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We get to Kenneth Rubino, and that -- that's sort of 9 the last one he does, and then Carrol testified that Dr. Desai 10 comes in. And this is Lakota Quannah. And if you look down 11 here, Stacy Hutchison has Dr. Desai, too, as her doctor. So 12 somehow Desai is going back and forth between the two, and 13 there's no -- there's no suggestion that he's in two places at 14 once. It's just the timing is off. But there's really no 15 question that Stacy Hutchison is treated after Kenneth Rubino. 16 17There's no mystery about that.

Now, we know that there were also skips along the 18 way, some people who didn't get infected. And we heard from 19 some experts about that, that sometimes people can be exposed 20 to the virus and they might be a lucky person who doesn't --21 who is able to clear it on their own and doesn't have the 22 virus. Or Dr. Alter said that maybe they wouldn't have enough 23 of a viral load to actually contract the disease. Or, you 24 know, there's a lot of happenstance into how the -- the clinic 25

did it's practices. Maybe they actually got a prefilled
 syringe and that's why they got skipped along the way.

But the question is were the practices unreasonable? Were the practices ones where there was a risk associated -sassociated and that was disregarded by Ronald Lakeman? And obviously that was the case. Every -- every medical provider you heard from talked about how unreasonable it would be to engage in that type of administration of propofol.

9 You cannot reuse syringes and reuse vials. The 10 combination of the two spreads infection. And you can't 11 really say that it was just one bad day for Lakeman anyway, 12 because he's there on July the 25th, and he's also there on 13 the 21st. Actually, only he and Desai are there on both days.

14 Now, with regard to the patients that Lakeman didn't 15 treat, meaning Mathahs's patients on the 21st. Lakeman has what we call aider and abettor in conspiracy liability for 16 those patients. As the Judge instructed you, conspiracy 17 18 liability occurs when there's an agreement to do something illegal. And if you agree with another person to engage in an 19 illegal act, you're responsible for the foreseeable 20 21 consequences of that act.

Similarly, if you aid and abet in a legal act with the intent to -- to commit a crime, which is in this case employ dangerous practices or perform this -- this act in reckless disregard for patients, you're responsible for what

your cohort does. So the agreement, of course, between these two CRNAs was not to infect everybody with hepatitis C, but the agreement was, look, we're going to engage in these injection practices. That's a dangerous practice. We understand the risk, but we're going to take the risk and go along.

And they worked together doing it because we know 7 they shared their supplies against all their training. 8 We 9 know that propofol now went back and forth. And there really is no tie of one patient to another in terms of the care. 10 There were -- the way the infection perpetuated, it was 11 possible to infect this many people because both of them were 12 willing to engage in these dangerous practices. And once they 13 violated the standards, it was sort of up to fate as to who 14 was going to get infected and who wasn't. It wasn't tied to a 15 particular CRNA. So Ronald Lakeman has liability for Keith 16 17 Mathahs's patients, as well.

Now, Dr. Desai, although he's there on July the 25th 18 and September the 21st, he doesn't do any of the injecting, so 19 he's never the direct actor. He is what's -- he's what's 20 called an aider and abettor or in the conspiracy. And aiding 21 abetting -- aiding and abetting is simply encouraging someone 22 to commit a crime. And in this case, it's that performance of 23 an act in reckless disregard of persons or property. 24 And Dr. Desai we all know is many things, but one of 25

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those is he's very intelligent. He's had training, the same training as all the other doctors who testified in this case and knew of a risk associated with this type of injection practices. We know that from Keith Mathahs that there was a discussion with himself and Dr. Desai about the dangers of reusing syringes.

And you also know about the conversation that Linda Hubbard related to the police about Desai instructing her to do anesthesia Ron's way, which means with the reuse of syringes. That is aiding and abetting. Now, there's been some suggestion that the statement that Linda Hubbard made was coerced or that she was lying about it.

You heard from Detective Whitely that there was no coercion with that statement. He was present in the interview. And think about what the -- the statement was. I mean, Linda Hubbard in 2008 is able to recall a pretty subtle conversation that she had back in 2005 with pretty good accuracy.

Now, there was the -- the point that, well, look, you know, she started in August 2005 and they didn't order those 50 milliliter vials until October. So -- so there was like a six-week gap there. Her conversation didn't say it was the day I started. And the other thing I would point out is people are kind of, you know, bad about time. I mean, Ralph McDowell testified that in 2008 it was

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1 six months earlier that there was the discussion about using 2 saline with propofol, which would have put the time at the --3 at the end of 2007. And he was clearly wrong about that 4 because Ann Lobiondo said she was at that meeting, and she had 5 left the clinic by the spring of 2007.

And Vince Sagendorf hadn't even heard about the meeting and he was there at that time period. So just -- just because the time period is off isn't really suggestive of deception. It's just how people, when they're working in the same place every day and they have discussions, it's hard to pinpoint an amount of time.

You also saw Linda Hubbard, okay. You saw Linda 12 Hubbard testify I don't remember, I don't remember. And you 13 know Linda Hubbard is the person who never seems to have the 14 glove on, who is capping needles, who is pulling off needle 15 caps with her -- with her mouth, who is still pulling propofol 16 after the CDC comes, who is still willing to use the 50s even 17 when there is a memo or an edict that she's not supposed to do 18 that. Now, do you really think that woman is capable of 19 conjuring up this subtle conversation just -- just to benefit 20 the police, or is she actually recalling something that was 21 actually said? 22

Now, Desai, you know, he had a policy about everything. He told Vince Sagendorf, don't use more than 200 milligrams of propofol on a single patient. Don't use a lot

1 of tape to the nurses. Don't use too many gowns to the 2 doctors and the techs. Don't use too much jelly to the techs. 3 He tells Ralph McDowell, you're the most expensive CRNA, you 4 use the most propofol.

5 There was nothing that wasn't controlled by him. He 6 was focused on saving money at every turn. And it wasn't like 7 some eccentric personality that you have with like a paternal 8 relative that, well, he just doesn't like lollygagging and, 9 oh, he just doesn't like waste or people standing around. 10 That's not what this is.

This is a willingness to compromise patient care to collect a couple cents on each procedure. He was willing to do that. And what's sobering, actually, in this case is that it wasn't that hard for him to get other people to compromise, as well. The ones who didn't left quick, and that was Anne Yost, Jean Scambio, and Karen Peterson who all left like within days or weeks of being employed there.

Now, the second -- the second crime that deals with 18the care of the patients is the criminal neglect of patients. 19 This one is a little different in the sense that it -- you 20 have to be a professional caregiver for the crime to apply to 21 There's a recklessness aspect to it to where you have to 22 vou. 23 have engaged in reckless behavior and it has to be a departure from the standards of an ordinary prudent person, and the harm 24 25 has to be foreseeable.

And we know that -- that the behavior itself was certainly reckless, and we know that Ron Lakeman had an awareness of it and that it was just not a practice that people engaged in. It was a departure from what an ordinary person would do. And was the consequences, you know, was it foreseeable?

Well, they're injecting people into their blood stream. It is foreseeable that they would get a blood-borne disease if they're cross contaminating their vials of propofol. This wasn't a mistake, it wasn't misjudgment, it wasn't a misunderstanding. It was a calculated risk that something probably wouldn't happen, and they were wrong in the calculation.

In terms of the criminal neglect charges, Lakeman has, of course, liability for the patients he treated himself, meaning Mr. Washington on July the 25th, his own patients on September the 21st, and through conspiracy and aiding and abetting liability for Mathahs's patients on -- on the 21st, as well.

Now, Desai, once again, isn't the person injecting the propofol, so his liability is solely as to being an aider and abettor or in the conspiracy. And we know that Desai was aware of the risk because he had those discussions with Linda Hubbard and Keith Mathahs.

25 It's also a fair bet that the harm would be JRP TRANSCRIPTION 59

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foreseeable for him as a gastroenterologist who treats people with hepatitis C. He might be aware that if you contaminate vials that you're injecting in people's blood, that hepatitis C might be spread. And it wasn't the result of misadventure or a problem or a misunderstanding. It was a calculation made to cut costs.

Now, the -- the sort of second part of this case is 7 about financial crimes or insurance fraud, essentially. And 8 the -- the way they -- the way they committed the insurance 9 fraud was sort of via a group effort, and that's what made it 10 impossible, really. Because if you have one CRNA that is 11 actually putting in the correct times, that would have been 12 kind of something that would stick out to the insurance 13 companies as they process the claim. 14

So this certainly was a practice that all the CRNAs 15 were involved with and all, you know, could have been charged 16 for their part in committing the insurance fraud. It was a 17 group effort. I mean, remember the testimony of Rode Chaffee 18 where the CRNAs would be talking to each other that I can't 19 take another PacifiCare patient. I just had one. And so 20 they'd switch the order so the PacifiCare wouldn't have the 21 times overlapping on the insurance claims. 22

That kind of thing, that sort of behavior is evidence of a conspiracy. On the two days in question, Mr. Lakeman himself worked about ten hours. Maybe a little --

1 give or take ten hours on the -- on July the 25th and on 2 September the 21st. He actually billed a little over 14 hours 3 in his anesthesia time.

So you can go back and you can compare the tape reads versus the anesthesia time -- anesthesia time recorded and see if you see the discrepancy. And you now from Joan Syler that they're not allowed to overlap, they're not allowed to bill more hours than there are in the day, and they're not allowed to count recovery time because they're no longer caring for the patient at that point.

Now, a couple things are unusual with the insurance counts. One of them concerns Sharrieff Ziyad. His claim, when you look at his 1500 claim, it actually -- they made a mistake, the clinic made a mistake. They put eight, meaning eight units, but that insurer wanted time, like minutes. And so that insurer on his claim actually only pays for the eight units.

There was an attempt to defraud there, but it really didn't work out because they -- they submitted the information in unit form versus minute form and the insurance company paid according to the minute form. So the endoscopy center didn't really make extra money on Sharrieff Ziyad's claim.

With some of the other patients, with Carole
Grueskin, with Stacy Hutchison, and with one of Patty
Aspinwall's insurance claims there was just sort of a flat

rate pay. So although they certainly -- they -- they put in
 the false numbers and they got up to the 33 minutes, there was
 no net gain to the clinic as to those claims.

The State's perspective is, though, and you can evaluate the testimony how you see fit, is that the insurers testified that if there was false information on those claims, they wouldn't have paid them at all. And so ultimately they got money that they shouldn't have been entitled to. And you -- you can recall the testimony and -- and make your own assessment of it.

The other people where there was a clear gain, that occurred with Sonia Orellono. There was extra units paid. There were extra units paid on Patty Aspinwall's claim to United Healthcare Partners, and there was extra money paid on Gwendolyn Martin to PacifiCare. The insurance fraud is pretty clearly established in this case.

Now, Desai's participation is also established. 17 Remember that memo, the PacifiCare memo? You can lock at that 18 in the deliberation room where he is actually instructing the 19 staff not to put PacifiCare members in -- in close succession 20 with each other. And you also know that he told Ann Lobiondo, 21 hey, remember to make your time 31 minutes. And he told her 22 that more than once, and that was for the insurance claims as 23 24 well.

And you also know from his conversations with Tonya

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1 Rushing that as this is all crashing down and she's crying and 2 talking about insurance fraud and that this -- you know, she's 3 worried about what's going to happen to her, he doesn't really 4 have much of an answer for her. His involvement in that, it 5 was his design.

Now, there are other crimes sort of associated with -- with the insurance themselves. There's a count of theft which has a threshold value of \$250. And as you look at all the people that -- that are charged or that consist in that count, you may be adding up in your head like, well, is that -- you know, did they get 30 extra dollars there, did they get ten? And it's kind of a tedious process.

Just so you understand, the State's theory on the theft count is based on what the insurance representative said, none of these claims would have been paid if there -- if they had known there was false information on them and that would add up to \$250. And that same analysis applies for the obtaining money under false pretenses, as well.

The last charge that I'd like to talk about is the death of Rodolfo Meana, which is a murder count. Now, normally, we all think of murder as the intentional killing of a human being, and certainly that is the form of murder. But under the laws of Nevada there is a lesser form or a less severe form of murder, and that is second degree murder. That occurs when someone engages in an inherently dangerous

unlawful act and there's a death resulting from it. And
 there's other requirements to the crime. Or they engage in an
 inherently dangerous felony and death is what results.

In order for you to find the defendants guilty under this theory of murder, you'd have to find that the death was foreseeable. And that is -- I mean, that is what happened in this case. Is it foreseeable that Rodolfo Meana would contract this disease, and is it foreseeable that someone would ultimately die from that disease.

Now, you heard that he was in sort of a weekend 10 state, that he had a lot of health problems, and that he also 11 had problems with his kidneys and so there may be some issue 12 regarding what the ultimate cause of death was. And I'd ask 13 you to consider the testimony of Alane Olson who observed the 14 autopsy, actually saw the organs and actually made an onsite 15 assessment of the cause of death. And she said that the death 16 was caused by complications from hepatitis C. She saw 17 literally the toxin spill out of his body when he was taken to 18 19 autopsy.

The other aspect I'd like to remind you of is this. As to the element of the cause of death, it is sufficient if from the evidence it is proven beyond a reasonable doubt that Rodolfo Meana's hepatitis C was of such nature that in its natural and probable consequence it produced death or at least materially contributed and accelerated death. So you can

1 consider that instructions -- that instruction in your 2 evaluation of the murder count as well.

Now, again, because neither Lakeman or Dr. Desai was the person who administered the propofol to Rodolfo Meana, their liability is premised on conspiracy and aiding and abetting. But it was just by happenstance that Mathahs would have ended up treating Meana.

8 I mean, there was no rhyme or reason as to why 9 Mathahs got him as a patient rather than Lakeman. So Lakeman 10 has -- has responsibility. And in terms of, you know, Dr. 11 Desai, was this something that was foreseeable given his 12 knowledge and his expertise and the nature of the disease, you 13 know, it certainly was.

In the end you'll have a duty to sort through, you 14 know, literally all the facts and the evidence in this case 15 and make an assessment. And, you know, people in their 50s 16 and 60s and 70s shouldn't be going in for routine 17 colonoscopies and coming out with communicable diseases. Ιt 18 was 2007 when this happened. It was at a time when the nature 19 of this disease was understood and the precautions that needed 20 to be taken to administer medication were well known. 21

Their infection was the result of laziness, sloppiness, and arrogance. It wasn't the result of a lack of knowledge. They took -- I mean, they ended up taking chances with other people's health and well-being, not their own, and

those people dealt with the consequences. And the really ironic part, or ridiculous part, I guess, is that it was all so avoidable. I mean, none of this needed to happen. None of these people needed to get sick. None of the people at the clinic needed to have trouble finding a job. No one needed to lcse their license.

But it did happen and it did occur and it was the result of reckless behavior. And in the end, your collective verdict is going to write sort of the ending to this story. And part of -- part of that will be your -- your assessment of the evidence. You will write the end of the story.

And unlike the civil cases and civil judgments that 12 you've heard about in this case, this is in criminal court, 13 and this case, the criminal case, it's about pennies. This 14 case is about pennies because the only thing that caused those 15 people to get infected was the decision not to spend a couple 16 more dollars on supplies per procedure. It's pennies that 17 were saved on these practices. And it wasn't worth it and 18 they knew better and they should be held accountable. 19

THE COURT: All right. Thank you, Ms. Weckerly. Ladies and gentlemen, before we move into the closing arguments for the defense we're going to take a brief recess. Obviously, the case is not over so I must, again, remind you of the admonition not to discuss the case or anything relating to the case with each other or with anyone

else. You're not to read, watch, or listen to any reports of 1 or commentaries on the case, person or subject matter relating 2 to the case. And do not form or express an opinion on the 3 trial. 4 Notepads in your chairs, and please follow the 5 bailiff through the rear door. We'll take about ten minutes. 6 (Court recessed at 11:23 a.m., until 11:36 a.m.) 7 (Inside the presence of the jury.) 8 THE COURT: All right. Court is now back in 9 session. 10 And, Mr. Wright, are you ready to proceed with your 11 closing argument? 12 MR. WRIGHT: Yes. 13 THE COURT: All right. Thank you. 14 DEFENDANT DESAI'S CLOSING ARGUMENT 15 MR. WRIGHT: My name is Richard Wright, as I start 16 with every witness. You all know by now that's Margaret 17 Stanish. We represent Dr. Desai. And first of all, myself 18 and the Desai family want to thank you for your terrific 19 effort. We understand. 20 I stood here two months ago and talked to you about 21 this case and we do know the -- the individual efforts in that 22 which you have given up to be here to participate in this. It 23 is an awesome undertaking when you're talking about like ten 24 weeks of being here, all to help the State and the defense try 25 JRP TRANSCRIPTION

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to achieve justice in this case, which is what this is about. 1 I started off talking to you in my opening statement 2 about the fundamental principles that would be guiding us, you 3 all, as you decide this case. And I talked about it because 4 now you've heard it all, the civil cases, some of the civil 5 witnesses, some of the evidence about it's this is a likely 6 cause. But we're in a criminal case, so I'm going to once 7 again go over those fundamental bedrock principles which makes 8 this different than the civil litigation which has already all 9 taken place. 10

First of all, criminal case indictment. Both defendants are indicted. You have the indictment. We're not going to read it because it's so long and so confusing. But it's Instruction No. 3, and that indictment is an accusation and it's not any evidence. And as we stand here even today, the defendants are still presumed innocent.

When you go in and deliberate and review all the evidence, then you'll make a determination whether the case has been sufficiently proven. But I talked about this with you all at the inception because the presumption of innocence is almost counter intuitive that I must presume, that is I have to say the man is innocent as the trial starts and progresses.

And then the question becomes in our criminal justice system, okay, he's innocent right now, he's accused of

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very serious felonies, billing, murder, medical negligence, reckless disregard. Who has to prove it and what do we have to do? But who has to prove it? The burden of proof is solely on the State. That means they have to prove every element, everything to your satisfaction, and we don't have to bring in any evidence whatsoever.

We don't have to bring in a single witness. All --8 all we will do is cross-examine witnesses. We can bring in 9 witnesses if we want to. You saw by the end of the case we 10 brought in Dorothy Sims and we brought in Dr. Howard Worman 11 from Columbia University. Other than that, the defense 12 rested.

13 So the State has to bring all of the evidence that 14 you need to make the determination. Okay. So now making the 15 determination, how -- how certain, how conclusive do you have 16 to be before you convict a fellow citizen? And that's what we 17 call the quantum of proof, the amount of proof.

Now, you now from -- we've heard about civil cases.
In a civil case it's simply like 51 percent of the evidence is
all that matters in a civil case. Whoever makes it more
likely than not. Just push the ball over the 50 yard line,
and that's good enough for one side to win.

In a criminal case, it's proof beyond reasonable doubt. That means excluding all of the other alternatives to your satisfaction so that you have an abiding conviction,

1 that's the definition that's in your instructions, that on the 2 most important affairs in our own individual life, you would 3 act absolutely like that without hesitation because you're so 4 firmly convinced that the evidence comes only to that one 5 absolute conclusion. That's what has to be shown in a 6 criminal case.

And this testimony we've heard from Brian Labus, 7 from Miriam Alter, from various CDC representatives about the 8 causation and it's the most likely cause is this or that. 9 That's simple stuff. You didn't hear a single expert or 10 witness come into this courtroom and say I have ruled out 11 every other method of causation and I will tell you beyond 12 reasonable doubt to a certainty this is how it happened on 13 that day. 14

And a witness came in here and said that. All you heard was the civil standards about most likely. So that's the amount of evidence that has to -- or that's how convinced you have to be. And the State has to present it all.

Obviously, my client didn't testify, nor did Mr. Lakeman. And there's an instruction in there, once again, this is counterintuitive, but the instruction tells you it's their constitutional right, the same right you would have if you're ever sitting over there and I'm representing you, that's the right that you do not have to testify and you don't have to say a single word, and that the jury will absolutely

1 not hold that against you if you were the defendant or against 2 my client.

3 So once again, you have to work on that. You can't 4 think, well, gee, I'd like to know what he has to say about 5 this, or I'd like to have an explanation or answer for that. 6 If you even speculate along those lines, you're violating the 7 instructions which you've agreed to abide by.

8 You just have to accept it that they are relying 9 upon, as the instruction says, the advice of their counsel, 10 and their counsel has made the determination the case has not 11 been proven, there isn't proof beyond a reasonable doubt, so 12 we don't have to do anything other than rest and argue the 13 case based on the evidence or lack of evidence that the State 14 didn't bring into those courtroom.

So with those -- with those guidelines, I'm going to 15 first talk about the billing, theft, obtaining money under 16 false pretenses, and false medical billing counts. As -- as 17 you know, there's two components to the case, what happened on 18 the healthcare and whether that was reckless and how the 19 transmission of hepatitis C occurred, and then the second 20 part, just like a second, separate trial, is the billing fraud 21 component of the case. 22

And, of course, the billing fraud, as I just call it, I love the three different charges all into one thing, because factually it all has to do with the same thing, with

1 the anesthesia time, unlawfully, knowingly, intentionally 2 inflated. In other words, too much anesthesia time means 3 higher billings and did that get the clinic, the defendants, 4 money they weren't entitled to.

5 And it's -- even though we've talked about it 6 generically and generally, clinic practices and everything 7 else, we are dealing with discrete individual counts, crimes 8 in the indictment. There's like 27 separate crimes in there 9 and nine, ten, eleven, twelve of them, twelve deal with the 10 false billing.

And so what you've had to do and why -- why we dragged in all of these insurance company witnesses, Veterans, Blue Cross Blue Shield, Health Plan of Nevada, because every one of them had to deal with one count, one bill, and how much was paid, how much should have been paid so we can come up with a number and see if there was a loss, because that matters. Because is it over 250, under 250?

And so that's why a lot of what was boring and 18 methodical, but you have to count by count because you're 19 going to see that -- and I will -- I will put up a chart for 20 you all and you can go through the calculations. You're going 21 to see that the grand total, the grand total in the case of 22 the total false billing if we just use absolutely the doctor's 23 note times, in other words, the time when the doctor started 24 his procedure until the time he ended his procedure. 25

If we use that as the anesthesia time and ignore 1 pre-op interview and ignore taking them out to the recovery 2 room, we come up with a grand total overpayment, total of all 3 counts of \$219.40. And if we do the amount of overpayment by 4 Lawrence Preston's method, he was the witness who came in, 5 Larry Preston, I'll go through his testimony. But he was the 6 one who initially set up anesthesia billing, started the CRNA 7 program when Dr. Desai went from anesthesiologists to CRNAs. 8

And Lawrence Preston is the fellow who testified 9 that from his years of experience and him owning a billing 10 company and starting the billing practices for Dr. Desai, that 11 the anesthesiologist time is from the -- when he starts 12 history and physical, starts interviewing the patient, did you 13 -- do you drink milk, are you allergic to milk, all of the 14 questions they ask on that form, from then until they leave 15 the recovery room. Leave the recovery room. 16

Now, that's what Lawrence Preston testified. And he explained because the recovery room -- it isn't like a hospital. It's an ASC. The recovery room is right -- the CRNAs are over there, the recovery room bays are right here. They are responsible for the patients, and his words is the billing time follows the responsibility for the patient.

And until the blood pressure, that last check is taken and they are unhooked in the recovery room, Lawrence Preston says that is the anesthesia time. And so if you view

1 that as the anesthesia time, you will see that the total 2 overpayment for all counts is \$54.70.

Now, to be certain so that we focus solely on what we are talking about, which is was the amount of time overstated on the bill, and you can go through and look at all of the bills, but that was at 1500. And so a bill went in with an amount of time on it saying it's 33 minutes and that's why Margaret sat there and worked through all these different calculations which end up on my chart.

10 She would say each of them, if it was eight units, 11 if there was a base units of five for payment, and then the 12 first 15 minutes got you one unit, second 15 minutes got you a 13 second unit, five, six, seven. And then if you went over 30 14 minutes you got a third unit you add, so that's eight. And 15 Margaret would say, what if it's eight, how much do you get? 16 What if it's seven, how much do you get? What if it's six?

Because what the charge is in the indictment is the 17 accusation that they got paid too much, more than they were 18 entitled to because of the excessive time. The charge is not 19 they were entitled to nothing. You can read every single 20 insurance fraud billing count. I will just use one as an 21 example, which is Count 14, insurance fraud. And the -- the 22 theft counts and insurance counts, the theft counts, 23 fraudulent billing counts, and obtaining money under false 24 pretenses counts all use the same factual allegation of 25

1 wrongdoing.

And the factual allegation on this is that they falsely represented, in other words the bill falsely stated that Anthem Blue Cross Blue Shield, that the billed anesthesia time and/or charges for the procedure performed on Patty Aspinwall was -- were more than the actual anesthetic time and/or charges.

Said false representation resulting in the payment 8 of money to the defendants, which exceeded that which would 9 have normally been under a -- which would have normally been 10 allowed for said procedure. So what -- what we're talking 11 about as the fraudulent allegations is how much more did they 12 get? Because they're entitled to some amount, and that's what 13 I worked out on the charts, if you accept the State's version 14 of the evidence. 15

And so the sole dispute of every one of them is the billed anesthesia time was more than the actual anesthesia time. In other words, they padded it by minutes, and by how many and how much of those padded minutes were. That's ever single count.

Now, how did we get to the billing practices and where we were? Because a false bill is one half -- is one component of the criminal charge. The second component -they first have to prove, the State, that the bill is wrong. That when that says 34 minutes, it -- it truly should say 17

1 minutes.

That would be a one-unit difference, and that would translate in some counts into like 38 bucks. In some counts it made no difference. There are counts in here in this indictment that were flat fee payment whether you put down 280 minutes or 1 minute, you got 90 bucks. So there was absolutely no loss, and that's why the number comes cut so low.

But how did we get there? Dr. Desai has get his 9 clinic. He was using anesthesiologists, as you know. One of 10 them was Dr. Yee, a fellow who came in and testified. He's 11 using MD anesthesiclogists. He's got one procedure room over 12 on Shadow Lane. And then in about 2001/2002, the 13 determination was made to go to CRNAs rather than 14 anesthesiologists. And Lawrence Preston testified to this. 15

And the decision -- there were several decisions that had to be made. And he testified -- he told them contact the nursing board, contact the State, because one thing you have to figure out is can a CRNA work in Nevada withcut a MD anesthesiologist supervising him. And for the first year or two at the clinic there was confusion about this.

And they even set up, Mr. Yee testified about it and Mr. Satish Sharma came in and testified about it, entering into an oversight agreement by MD anesthesiologists, which they signed but never was implemented and never went into

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1 effect. Because it turns out in Nevada you don't need an MD 2 anesthesiologist. All you need is a CRNA working for a 3 podiatrist, a dentist, or an MD, and then that person is the 4 responsible supervisor for the CRNA.

5 So Lawrence Preston testified the question was what 6 should they have done? Dr. Desai was having problems 7 scheduling anesthesiologists to come in for all of the 8 procedures. And so should he hire anesthesiologists to work 9 for the clinic, or hire CRNAs?

And Lawrence Preston testified that if you hired 10 anesthesiologists, if you can get some that would come to work 11 there like for a salary, anesthesiologists get to bill more. 12 CRNAs have a reduced factor. I think he testified it was like 13 85 percent. So if you hired anesthesiologists, their bills 14 get paid higher. The question would be would they work 15 independently and put in their own bills and keep the money, 16 or should the clinic hire them and bill them out and just pay 17 them a salary? 18

The way they -- the determination was made, Lawrence Preston testified to, to go with the CRNAs because you can get more of them, ending up hiring five or six, including part time. So CRNAs were hired. The first CRNA was Ms. Lobiondo. And she testified that she brought some of her forms with her because CRNAs had never been used in the clinic, had not been used anywhere in this fashion. She had been working at North

Vista North Las Vegas Hospital, other places, came, brought
 her forms.

Lawrence Preston started the billing practice for it. At the time, Lawrence Preston, Tonya Rushing, the chief executive officer or whatever she was of the clinics who testified in here, for the first two years she worked at the clinic she was working for Lawrence and his company basically on contract to the clinics. And she left.

9 Lawrence Preston sold his billing business because 10 he didn't want to deal with the federal government was his 11 testimony, and the -- but he testified that at the inception 12 he started the billing, the billing method and practices. And 13 his testimony is at the inception, anesthesia time starts 14 first time you start dealing with the patient, ends when the 15 cuff comes off in the recovery room.

And this was a witness not called by the defense. 16 This is a witness called by the State and then testified for 17 the State. And he testified that that is the correct billing 18 method and practice in his judgment and he so advises his 19 clients. And the questions were asked by the State, you mean 20 to tell me someone like an anesthesiologist could be billing 21 for more than one patient at the same time? 22 And his answer was absolutely correct. You've got 23 that right. I can -- I can have like three patients I am 24

25 responsible for. I can have two in the waiting room. When

1 they stop, the clock goes off, they're not my responsibility.
2 I can be doing a procedure on one, and, yes, the answer is,
3 like any other physician or practice, there can be times where
4 I have multiple billing and it's legal.

And he testified that he has gone to conferences, he 5 has talked to insurance companies, and that is what he 6 believes and so advises clients. And so this billing practice 7 He sold his business. It went to a lady. I don't started. 8 remember her name, but went into partnership with Tonya 9 She was the -- doing the billing for Dr. Frank 10 Rushing. Nemec. 11

And so Tonya Rushing set up the billing company, taking over for Lawrence Preston. And Tonya Rushing was like 90 percent owner, and this lady did it for 18 months and then she said this is -- I'm not doing it anymore. And Tonya took it over and said I will do it all myself, and she hired individuals and the billing company continued as it had -- as it had been doing on their merry way.

And it -- and it continued on their merry way up until what we've heard was the Rexford case, and that's the testimony of Dr. Clifford Carrol. Because what happened in 2007 was there was civil litigation. A patient named Rexford sued Dr. Carrol because of whatever happened on the procedure. And during the discovery, in the fall of 2007, in January/February of 2008, and it just so happened to coincide

1 with the investigation of CDC and the notice and closure of 2 the clinics.

But Dr. Carrol explained and testified that he's got 3 this litigation going on, and all of the sudden his lawyer is 4 telling him the plaintiff's lawyers, the lawyers for the 5 patient are raising questions about our billing and anesthesia 6 times. And Clifford Carrol testified that he goes and talks 7 to my client, Dr. Desai about it. And says in the -- in this 8 Rexford litigation they were subpoenaing, the plaintiff's 9 lawyers are subpoenaing our anesthesia records, all of the 10 Is there anything records for the date of the procedure. 11 wrong? Are our records right on this? And he said Dr. Desai 12 said there is no problem. Our records and billing is correct. 13

And so at first Dr. Carrol testified he was a little 14 concerned, sloughed it off, but then additional, I can't 15 remember, someone else was deposed in this civil litigation. 16 And, again, it came up as an accusation of false billing. And 17 then Dr. Clifford Carrol testified that he has this in his 18 mind and he's concerned about it because these lawyers are 19 making accusations of false billing and he sees a CRNA, I 20 think it was Sagendorf, rely on your own memories, but Cliff 21 Carrol says he sees a CRNA putting down like 31 minutes on --22 on his timesheet on his anesthesia record. 23

And Cliff Carrol sees this and this is in January or February or 2008. And he says what is this? And Sagendorf

1 says that's the way we've been billing. And Cliff Carrol says 2 he goes to Dr. Desai and they have a conversation again and --3 and he says is there billing fraud going on here? And Cliff 4 Carrol says Dr. Desai said there is not any billing fraud 5 going on here. So we've had two conversations of Clifford 6 Carrol and Dr. Desai.

And then the third and final conversation Clifford 7 Carrol testified to with Dr. Desai was in June 2008, Summerlin 8 He goes, and this Starbucks right before his second stroke. 9 is at a time when Cliff Carrol said he was very emotional and 10 he needed help and was crying because the clinics had closed. 11 Their -- their -- their business was wiped out, their licenses 12 were suspended, and Cliff Carrol said he was almost suicidal 13 at the time. 14

And he talks to Dr. Desai and holds his hand and he 15 said is there -- on this billing, how -- how did this happen 16 and how did we get started into this? And the answer was from 17 Cliff Carrol's mouth, relating what Dr. Desai said, was this 18 all started back the way we did it when we had one room, maybe 19 one procedure room at the clinic years ago and it didn't 20 change. But, of course, it had changed in like January or 21 February 2008. 22

You can look at all the records because the second meeting of Dr. Carrol with Dr. Desai when he saw Vinnie Sagendorf, 31 minutes, that's what, I think, Tonya Rushing

1 testified about this also, all of the sudden it came to a
2 head. Wait a minute, let's get straight on this, and on the
3 billing. And that's when the edict was put out that no more
4 pre-op times, no more post-op recovery room times. Make those
5 bills precisely doctor times.

6 Because at that point Tonya Rushing said she 7 researched it and looked into it. Whether she called the 8 insurance companies or who, I don't know. But from that day 9 forward, the billings changed. And this is like in February 10 2008 is the testimony of, I think, Dr. Carrol and Tonya 11 Rushing. However you recall it, it is.

But at that point forward -- and of course one cf 12 the billers came in that worked for Tonya Rushing's company. 13 They saw that all of the sudden the times had dramatically 14 dropped on the anesthesia billings. And of course they 15 dropped. That coincided exactly with Cliff Carrol, Dr. Desai 16 saying from now on do it exactly like this. And so that's the 17 evolution of this billing and it's carrying on. And so you --18 you all make the determination. 19

I mean, if it is mistaken billing or misinterpretation because Larry -- Lawrence Preston is wrong, then it's not a crime. If -- if it is a justified billing that's arguably correct and you have your biller saying that's how it's done, then it's not a crime. That is a civil argument with the insurance company. We say it's that, you

say it's that. The insurance company will pay what they want.
 You can put in a bill for \$8,000 and they'll pay what they
 want.

But you -- you make the determination. Is it false, 4 incorrect? And then if it is, to make it a crime, I have to 5 have intentionally known it and have no basis for what I did. 6 Just like when you file your tax returns. These are specific 7 intent crimes. You file your tax returns this year and 8 there's a mistake on it. You forgot you got some dividends or 9 you got a bonus or you won the NFL prize at the sports book 10 and you didn't put it on your tax return. 11

Well, you tax return is false and that's what's 12 called a false tax return. That's not a crime. It's simply 13 an incorrect tax return. You will -- when it's found out, you 14 will owe, pay fees and interest up the gazoo, but it's not a 15 crime. If you know it, if you're sitting there and you're 16 conscience is saying to you, ha ha ha, I'm leaving off those 17 tips or I'm leaving off that parlay card I won, you're 18 committing a crime because that's -- that's the mental 19 component that criminalizes false tax returns and false 20 billing case. 21

The actual computations here were pulled together. This -- this exhibit you don't have. This is called a demonstrative exhibit. And I'll file a copy with the Court and give the State a copy. The demonstrative exhibit means I JRP TRANSCRIPTION

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1 get to use it and show it to you, but it doesn't go into the 2 jury room. The exhibit that's in evidence is Z1, and that has 3 the times I'm talking about. This was a chart that Margaret 4 put together and was introduced through, I think, Whitely or 5 by stipulation.

But it essentially pulled all of the times out of the records for the patients to figure it out. And you will have this exhibit with you. And you will see it has the patient name. And actually you can go through. We didn't do this, but you can take the exhibit and you can put the actual counts on here because each of these is alleged as a separate crime.

And you have the patient name, patient date, who the 13 physician is, who the CRNA is, time of procedure, colonoscopy 14 or endoscopy, doctor's note start time. Lord knows we've 15 heard a lot about times in here about which ones are correct, 16 which ones aren't correct. This -- the -- this doctor start 17 time, report process start time from the doctor's note. This 18 -- this, I believe -- recall your own recollection, but I 19 believe the -- the evidence has been that like the -- the 20 best, most reliable, consistent time between nurses times, 21 computer times, rhythm strip times, because all clocks are a 22 23 little different.

Let's just use one time and make it consistent. And this is the doctor's note start time. In other words,

patients enter the room, equipment scope being hooked up, patients log onto the computer. And so this -- this is like the logon start time which is designated. So that's why we did this doctor's note procedure start time.

Next we have the doctor's note procedure end time. 5 And, of course, once again you heard testimony as to that. 6 Doctor finishes the procedure, patient is being tended to by 7 CRNA, doctor goes to the computer, all the photographs have 8 9 been taken of the internal testing, and then he puts the findings, conclusions, whatever it is, all of the notes that 10 he puts on there, and then he punches the signature button and 11 that produces to the second and end time. 12

So this is the total time of the procedure that the 13 doctor was working on him. So if we were to use that 14 15 conservatively as anesthesia time, because we know the anesthesia time, the evidence has been the CRNA starts with 16 the patient interview, hooking up before the doctor comes in, 17 18 and also tends to the patient who is still presumably asleep when it's over for awhile before then moving him out to -- or 19 she out to recovery. 20

So if we use this as the conservative amount, let's say -- let's bend over backwards and call that anesthesia time, this doctor's note total time, that's -- from these, that's where we get the 10 minutes, 14 minutes, 8 minutes, 18 minutes, total minutes.

Now, if we use the last recovery room vital sign, 1 this -- this would be the procedure end time out in the end 2 room. Because you know they unhook the patient in the 3 procedure room, roll them out, hook them up again to new 4 rhythm strips, blood pressure, heart monitoring, and they're 5 out in the recovery room, and that like takes 10 to 15 to 25 6 minutes, whatever your recollection is of it, and then they 7 unhook them out there, which is at the time they're going to 8 take them over, get them dressed, see the discharge nurse. 9

10 If we use that, I would call this the Lawrence 11 Preston end time because that's what he says is the correct 12 end time for anesthesia. And so those times all come out of 13 the patients' records as to when they were -- their last 14 reading was in the recovery room.

15 If we use those times in brown, brown would be 16 Lawrence Preston, yellow would be ultra conservative billing 17 purposes, like face to face time, ignoring everything else, if 18 we use Lawrence Preston time, you can see it's 26, 29, 20, 34, 19 32, 45, 41, 39, and 36 minutes. Those are the actual times.

And so then, for my demonstrative exhibit, I took Exhibit Z1 and this -- I added -- I converted the minutes to money. And this -- this couldn't be done until we were complete and heard the last witness testify for the insurance company. And when we convert -- convert it to money, we convert it giving you alternative ways to do it on -- on what JRP TRANSCRIPTION

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1 should be the correct way.

And if we do it by using the most conservative, just 2 plain doctor's time, the first one, Rubino, 10 minutes. The 3 -- from the witness who testified or the insurance company for 4 Mr. Rubino, five units -- the -- the over -- the overpayment 5 is five plus one, so there would be -- would have been two 6 units of overpayment. That comes to \$76.60 for Mr. Rubino if 7 we use that method. If we do the overpayment by Lawrence 8 Preston, it would be one unit overpaid because it was 26 9 minutes for Rubino, and that would be \$38.30. 10

Doing the same for each of these, Mr. Meana, one, \$32.80, or \$16.40. These will be the amounts that go right to a specific count in the indictment alleging a false fraudulent overbilling.

Now, if we go to Orellono, eight minutes, \$34 if we do it most conservatively. If we do it Lawrence Preston's method, there is no overcharge at all. Going to Hutchison, 14 minutes, it's a flat fee. So either way it's irrelevant. Same with Grueskin, flat fee.

Ziyad, source patient, his -- there was none because they underpaid. The insurance -- the insurance company underpaid the clinic. There was actually a credit, so they owe the clinic on that one because it was an underpayment. Either way, underpayment.

25 So what -- what do the totals come out to? \$219.40 JRP TRANSCRIPTION 87

total of every single count, or if it's done Lawrence Preston's way, \$54.70. Now, where do these numbers matter? If you find that this was a crime, knowing intentionally they're wrong, and you -- and you just -- if you -- if you think this was incorrect billing based upon Lawrence Preston or if you have a reasonable doubt about it, if you just simply don't know, then there's no crime at all.

8 But if you're firmly convinced beyond a reasonable 9 doubt, ah-ha, they conspired to do this and they knew what 10 they were doing, then when you got through it you'd say, okay, 11 I'm firmly convinced they knew what they were doing and their 12 conscience said ha ha ha, I'm cheating, if that's your 13 finding, then you have to figure it out and plug it in.

Because in the theft count, the theft count which is simply one count of theft, it has to be either over \$250 or under \$250. And there's a verdict and you would either check -- if you think it's a crime, you either say over 250 or under 250. And, of course, it matters. Under this it makes no difference either way because both of them are under \$250.

20 When you go to the obtaining money under false 21 pretenses, it is also a dollar amount driven two charges, and 22 it has to be over \$250. I can't remember which patients are 23 under -- on the false -- obtaining money under false 24 pretenses. You'll see them in the indictment. But for each 25 of those, it has to be that the inflated time resulted in more 30 JRP TRANSCRIPTION

1 than \$250. And if it -- and if it doesn't, then all no's. 2 It's simply not guilty.

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Pardon me, it's -- it's under \$250; right? MR. STAUDAHER: That's what it would be.

MR. WRIGHT: Under 250 for those. And for no matter 5 which patient it was, none of these -- 76 bucks is the highest 6 7 one. So for obtaining money under false pretenses, it would be under \$250, whichever patient it is. It may be one of the 8 none ones. I don't remember. And then when you get to the 9 false medical billing case, the amount of money doesn't 10 Okay? It has to be a false billing and some money. 11 matter. If it's none, there isn't any because they've 12 alleged an overpayment. But if there is \$16.40 and you 13 believe that that was done intentionally and willfully, then 14 on that the answer would be guilty. On the -- there are nine 15 counts, nine different patient charges. So you go through 16 them on each and figure it out. Now, that -- that's 17 essentially the billing fraud component of the case. 18

19And if we could take a lunch break, Your Honor.20THE COURT: All right.

21 MR. WRIGHT: We're not -- I'm going to argue some 22 more. I'm done with the billing. You're going to have lunch, 23 and then I'm going to come back and talk about the other half 24 of the case.

THE COURT: Can I see counsel at the bench.

(Off-record bench conference.) 1 THE COURT: Ladies and gentlemen, we're going to go 2 ahead and take our lunch break now. We'll be in recess for 3 the lunch break until 1:30. Obviously the case has not been 4 submitted to you. The case is not over yet. So please be 5 aware and mindful of the admonition, which I am about to give 6 7 you. Do not discuss this case or anything relating to the 8 case with each other or with anyone else. Do not read, watch, 9 or listen to any reports of or commentaries on this case, any 10 person or subject matter relating to the case. Don't do any 11 independent research by way of the internet or any other 12 medium. And do not form or express an opinion on the trial. 13 Please place your notepads in your chairs and follow 14 15 the bailiff through the rear door. (Jury recessed at 12:28 p.m.) 16 THE COURT: All right. I'll see counsel at the 17 bench regarding scheduling. 18 (Off-record bench conference.) 19 (Court recessed at 12:32 p.m., until 1:40 p.m.) 20 (Outside the presence of the jury.) 21 MS. STANISH: Judge, is the jury instruction on the 22 23 petty larceny --It was wrong. 24 THE COURT: 25 MS. STANISH: Yours was changed. JRP TRANSCRIPTION

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THE COURT: So I adlibbed it, and then I had my JEA 1 type it to be correct because I caught it. And that is 2 Instruction No. 21. And so these are the originals and if you 3 want to look and make sure you're --4 5 MS. STANISH: No, I trust you did it. THE COURT: -- fine with the change. 6 7 MS. STANISH: I just wanted to make sure. THE COURT: But, right, I saw that it was wrong and 8 so then I just --9 MS. STANISH: Good cover. 10 THE COURT: -- corrected it and -- and then she's 11 changed it. And so the packets are all correct. We made 12 12 copies so that all of the jurors will have their own copies of 13 the instructions. 14 (Pause in the proceedings.) 15 (Inside the presence of the jury.) 16 THE COURT: All right. Court is now back in 17 18 session. And, Mr. Wright, you may resume your closing 19 argument. 20 MR. WRIGHT: Thank you. 21 DEFENDANT DESAI'S CLOSING ARGUMENT (Continued) 22 MR. WRIGHT: Ladies and gentlemen, now to the 23 medical criminal neglect, reckless disregard portion of the 24 case on the hepatitis C, the causation, and what the conduct 25 JRP TRANSCRIPTION

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was and whether criminal acts were committed by Mr. Lakeman,
 Mr. Mathahs, and my client Dr. Desai as an aider and abettor.

3 Now, remember, again, two months ago at the beginning of the case when I talked about negligence, auto 4 5 accidents, reckless disregard, driving the wrong way down the street, and tried to give you a little example by drawing it 6 7 on the paper. And it drew some objections, and I told you by the time we get to the end of the case I will show you the 8 elements of the crimes charged, and I will show you that it 9 has to be the equivalent of someone not just driving the wrong 10 way on the freeway, but knowing they're going the wrong way on 11 the freeway and intentionally going the wrong way, as opposed 12 to accidentally or mistakenly doing something. 13

And the example I gave you I'm going to talk about 14 because it fits right with the jury instructions. Because in 15 any ordinary negligence case, I think I gave you the example 16 of someone turns the wrong way out here on Fourth Street. 17 That's a one-way street downtown here. And all the time I 18 drive on it carefully because tourists and other people 19 invariably don't know it and turn the wrong way and are 20 driving the wrong way on a one-way street, and it can cause an 21 22 accident.

And if they do cause an accident, they're certainly liable. Their negligent act caused someone else to be harmed. But they aren't criminally prosecuted for it because it's a

negligent act. It's an accident, a mistake. I didn't know
 what I was doing when I was driving the wrong way.

The other example I gave you, which is where we get to recklessness, conscious disregard of a dangerous situation. I said what if you're out on the freeway? You're out here and you come up on a traffic jam, there's an accident up ahead and traffic is stopped dead and you're sitting there and you look over and there is an onramp that you can get off the freeway going the wrong way if you so choose.

In that situation, if you consciously think, oh, 10 well, I'm late, I'm going to be late for this important 11 12 meeting, there's no traffic coming, I can whip around real 13 fast and go the wrong way. I know what I'm doing, I know it's 14 risky, but I'm going to attempt it anyway. And I do that and 15 I get in an accident, I'm in big trouble. I knew my behavior was a substantial -- it was a risk of substantial harm. I was 16 conscious of it, and I said hell with it and threw caution to 17 18the wind and did it anyway. That's what crimes are made out of in these reckless endangerment type cases. 19

And there's also a component that's called proximate cause, which means my risky, dangerous behavior must have been because of the accident. In my little hypothetical, suppose I decide to go for it. I've got my business partner with me and I go the wrong way and I'm speeding up the off ramp. And while I'm speeding the wrong way, engaging in risky behavior,

1 I have a blowout in my tire because I didn't replace the tires 2 and they were -- they were too -- the tread was too low. And 3 I -- I was negligent.

In that situation, I'm engaging in risky behavior, but the risk I know of and I am taking is going the wrong way in traffic. Now, if I get in an accident through negligence and the accident isn't caused by my risky behavior of going the wrong way, then I didn't commit a crime.

Now, we've seen a lot of evidence in this case, 9 which I am going to show you had nothing to do with proximate 10 cause of the transmission of the hepatitis C at the clinics on 11 those two days. And we spent literally weeks hearing about 12 the lousy business practices, starting colonoscopies too soon, 13 ending them too fast, using all kinds of cutting-corner 14 cheapskate practices all intended to enflame you all, to make 15 you think this is a guy that's worthy of convicting and take 16 your eye off of the ball. Because all the evidence is clear 17 that the only accusation and the only evidence that matters in 18 this case is the accusation that unsafe injection practices by 19 the CRNAs caused the transmission of the hepatitis C. 20

If you are to think that scopes did it or biopsy snares, whatever you call them, bite blocks, those aren't charged here. All of that was simply brought in over and over again. The evidence about starting a colonoscopy or endoscopy procedure before a patient was fully sedated, now you tell me,

how does that cause the transmission of hepatitis C? 1 CDC, Melissa Schaefer, all of them testified that 2 3 bite blocks, they don't cause it. Bite blocks go in your mouth right here. There's no blood to blood. And if you take 4 5 the bite block, and even though it's single use, and you take it and put it in the Medivator and clean it and sterilize it, 6 7 there is a yuck factor, but there is absolutely no factor of transmission of any type of disease. 8

9 Then we heard days of testimony about those type of 10 things. And the -- the indictment -- well, first, the jury 11 instructions tell you that you've got to follow what the 12 indictment is and follow what the law is. And the indictment 13 and the jury instructions, and it's No. 15 -- pardon me, got 14 the wrong number. No. 17 when you get back there, reckless 15 endangerment and criminal neglect of patients.

Both the reckless endangerment and criminal neglect 16 of patient charges consist of a criminal act that is committed 17 with the requisite mental state in order for the defendant to 18 be found guilty of the reckless endangerment or criminal 19 neglect of patient charges, you must find that the defendant 20 committed the alleged acts beyond a reasonable doubt. What 21 alleged acts? We're limited to one alleged act in the 22 23 indictment and in the instructions.

24The alleged act is that Ronald Lakeman or Keith25Mathahs caused the hepatitis C transmission by using unsafe

1 injection practices in connection with the administration of 2 propofol. That is the only act alleged. Now, as -- that is 3 the sole act that must be proven beyond reasonable doubt to 4 have been the cause, and I will get into the Mendel component 5 and what they must have known.

But all this like CDC, Southern Nevada Health 6 7 District, everyone testifying, this is the most likely cause. Things like bite blocks or biopsy snares, scopes, these things 8 9 are less likely. If you all were to determine it occurred in some other method than this, what's alleged, then you find him 10 not guilty. This is the only thing. We -- we've heard the 11 cutting chucks in half. Heard that from 11 different 12 witnesses come in to testify that he's such a cheapskate he 13 14 cut chucks in half. And that he used -- admonished nurses to 15 not use so much tape.

The offenses, that I will ultimately get to the murder charge, but the offenses of criminal neglect of patients and reckless endangerment, I want to go through the elements of those, what you must find. And this is from the statute because you -- you will see nothing in the statute as we go through this.

It contains the words that I heard by Ms. Weckerly during the opening statement, that this case is about poor medical care. This case is about unreasonable practices. This case is about laziness. This case is about sloppiness.

1 This case is about arrogance. I could stipulate to all of 2 those things and would make no difference in the outcome of 3 the case. Because this case is about conscious, reckless 4 disregard of a dangerous practice that I know is dangerous and 5 say hell with it, I'm doing it anyway.

Instruction 15, a professional caretaker who fails to provide such service, care, or supervision as is reasonable and necessary to maintain the health or safety of a patient is guilty of criminal neglect of a patient if the actor or omission -- now, the act there, of course we're talking about multi-use propofol vials and reuse of syringe on same patient. I mean, that's the act we are talking about there.

The act is aggravated, reckless, or gross. The defendant must have been aware of the risk of the substantial harm presented by his act or omission. So that means I must know that what I am doing is a risk of substantial harm to the patient and I acted in conscious disregard of it.

That means mentally I just said, I know, people can 18 get hep C out of this or may get sick and die out of this, but 19 Mr. Lakeman and Mr. Mathahs supposedly just conspired with 20 each other and agreed to say I know all of that, but hell with 21 22 it, I'm going to do it and put these patients at risk anyway. That's what you have to find on the evidence in this case. 23 The act -- and then that's just the first step. 24 25 We've got four of them. The act or omission is such a

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1 departure from what would be the conduct of an ordinarily 2 prudence and careful person on the same circumstances that it 3 is contrary to a proper regard for danger to human life or 4 constitutes indifference to the resulting consequences.

5 They were using a reasonable man standard. That 6 means a reasonable practitioner standing in their shoes at the 7 same time in September and July 2007 in this community would 8 have recognized that this is absolutely dangerous,

9 life-threatening behavior. And that's why, when I get to it, 10 we brought in the evidence of what else was going on in every 11 single clinic at the same time. Because it matters what the 12 standard was, reasonably at the time, July 2007.

The third element, the substantial harm created as a result of the negligent act could have been foreseen by a reasonably person. That means I -- I know. Not only do I know I'm doing this, but I know what the consequences are going to be. And fourth, and every one of these have to be found when you go through the instruction for criminal negligence.

And the danger to human life of these patients was not the result of inattention, mistaken judgment by Lakeman and Mathahs, or misadventure, but was the natural and probable result of an aggravated, reckless, or grossly negligent act. That's the medical criminal negligence portion of the same counts, there's multiple counts, but that one covers

1 caregivers.

And there's another statute that's just called 2 reckless disregard. And this statute applies to each patient 3 or just leaves out a couple of the medical elements. This can 4 apply to anyone, whether you're a doctor or not. But as 5 you'll see, it has the same elements. A person who performs 6 7 an act in willful or wanton disregard of the safety of persons is guilty of reckless disregard of persons. 8 Willful means what? Voluntary and intentional. I'm intentionally doing the 9 10 act.

Wanton, it has to be wanton, meaning unreasonably or maliciously risking harm. I know what the act is, and I know its consequences are such that I have unreasonably and maliciously saying hell with it, I'm going to do it anyway. And then I have to be utterly indifferent to the consequences.

Lakeman and Mathahs have to be like psychopaths who don't give a crap and know they're going to spread hep C and do it anyway. That's what's required under the statute. The defendant must have been aware of the risk. He has to know what's happening and the consequences, and then just utterly, indifferently disregard it.

The proximate cause, you must determine that the criminal act was the proximate cause of the substantial bodily harm. In other words, you have to find beyond a reasonable doubt. If you found all of that, and that's what Lakeman and

Mathahs were doing, then, of course, my client, Dr. Desai is
 an aider and abettor.

I'm just saying Lakeman and Mathahs on this because 3 they are what we call the principals. They are the ones who 4 did the act, and so they must have had all of these. 5 Thev 6 must have satisfied every one of these elements that my 7 client, as an aider and abettor and conspirator, because he's 8 the owner of the joint, must have said, yes, I know you all 9 are doing that and I want you to do that and I agree with it. 10 And even though we're going to put patients at risk and we're going to get sued up the wazoo, I want you to do it anyway. 11 That's his theory. 12

So I don't want you to misunderstand when I keep 13 saying Mathahs and Lakeman as if I'm trying to shove the blame 14 over to them or something, because I'm not. That's just the 15 theory of the liability here. And so what has -- if you find 16 17 that all of that happened by Mathahs and Lakeman and that my client wanted that outcome and conspired and aided and abetted 18 to do it, then you have to determine if that -- that conduct, 19 that multi-use of propofol vial and reusing syringe for same 20 patient at the same time, you have to find if that caused the 21 hepatitis C transmission on September 21st and July 25th. So 22 those are the elements of what we're talking about. 23

Now, part of my problem with this case, as I told you at the beginning, was I don't have immunity power and I

1 can't make witnesses talk to me. And I -- I can't -- I can go 2 -- that's why I introduce myself to witnesses. That's why I 3 introduced myself to my own witness I subpoenaed, Dorothy 4 Sims. I subpoenaed her from BLC because the State didn't call 5 her.

And so I subpoenaed her and it was like pulling teeth. She doesn't have to talk to me. I don't have the power to get witnesses under my thumb by immunity grants and police investigations and interrogations. It's not simple. I subpoena her, I get to put her on the witness stand, I get to examine her, and I have to life with her answers.

12 I am at times amazed when I do have a witness that I am having to pull teeth. Now, bear in mind, this is a lady 13 14 Dorothy Sims was in charge of the BLC investigation. She was 15 the equal of Brian Labus for the State of Nevada and was there 16 for the -- for the 9th through the 17th investigating with two 17 other investigators. And -- and I'm having to show her her notes, having to show her everything she had written to try to 18 19 get her to answer a couple of questions.

And then the -- the testimony in this courtroom has been after BLC did their investigation, and immediately went out because what they learned was, holy smoke, multi-using propofol, using on multiple patients, this -- this practice is going on at Sunrise, at Southwestern Associates, 15 MD anesthesiologists working there. So they immediately start JRP TRANSCRIPTION

1 inspections.

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2	And what did they find? I'll get to that. That was
3	the BLC report I made her read about finding an MD
4	anesthesiologist on February 2008, a doctor reusing needle and
5	syringe between patients, nothing that is ever even alleged to
6	have occurred here. Those were the practices they're finding.
7	So what do they do? They call CDC, they have an Epi-Aid, CDC
8	sends people out, and they inspect all 51 ambulatory surgical
9	centers in Nevada.
10	MR. STAUDAHER: Your Honor, I'm going to object to
11	that. I don't believe that that's the state of the evidence
12	or and I'm just I don't want to interrupt his argument,
13	but
14	THE COURT: All right. Yeah.
15	MR. WRIGHT: I don't mind if you think I'm
16	THE COURT: I don't recall it that
17	MR. WRIGHT: I'll explain. I'll explain it.
18	THE COURT: And, ladies and gentlemen, as I've told
19	ycu, you know, Mr. Staudaher may object or it may go the other
20	way. I may not recall, I may recall incorrectly. So it is
21	your collective recollection of the evidence that's important.
22	And if any you know, this is argument. It's not evidence.
23	So if anyone says anything in their argument, that's different
24	than your recollection. It's your recollection that should
25	control us to what the evidence was.

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1 All right. Go on, Mr. Wright. 2 MR. WRIGHT: Melissa Schaefer from CDC testified 3 that -- because I showed her an article to refresh her recollection. Because CDC used the results of the Nevada -- I 4 5 can't remember what they call it -- investigation. The Nevada 6 investigation, Melissa Schaefer testified that they, the CDC, then used that to go to three other states and conduct an 7 8 investigation in three other states to see if the practices 9 nationwide on these pilot of three states were the same as the 10 Nevada.

I showed Melissa Schaefer and article and I had her look at it. And she testified that out of 51, in Nevada, CDC went -- 51 ASCs were investigated and 28 of them she testified had -- I don't want to misstate it -- infection control deficiencies or practices, including multi-use of propofol vials and reuse of syringes on same patient. 28 out of 51 was her testimony.

Now, the -- I got off track. How I got to Melissa Schaefer is -- is because I was comparing Dorothy Sims and what had happened here. Melissa Schaefer came in. She testified. She remembered all of this. I put Dorothy Sims on the stand and I asked her, what was the result? You participated in an investigation.

You may remember. I got out of line and got facetious and said you mean to tell me you don't remember the

1 governor of the state of Nevada saying to do this? And she 2 didn't remember five and a half years ago. And so I show her 3 the report out of her own office and walk up and say look at 4 that.

Now, I showed the same thing to Melissa Schaefer and it refreshed her recollection, 28 out of 51. I show it to a person who participated in it and she said I don't remember. I'm saying, come on. I don't have immunity. I can't do anything. How can you not remember? Was it zero? I looked at it, Mr. Wright, and my memory is not refreshed.

Hello? I'm thinking what went on here to my 11 12 witness? I subpoenaed the witness who I've never interviewed, and I said who did you talk to? Mr. Staudaher and Ms. 13 Weckerly. Anyway, I subpoena you, you come here with your 14 lawyer from the Attorney General's office. I don't talk to 15 you, and they get to talk to you, and now your memory isn't 16 17 refreshed by your own documents from the agency. This is what you deal with when you defend cases like this. 18

And I point it out because I've heard, and I'm not accusing Detective Whitely of improperly pressuring witnesses to testify. I'm just telling you the reality of the system and the way it works pressures witnesses to testify and to say things. And the reality of it is in the immunity agreements. Not -- and you've seen it. I've thrown it on the screen with a number of witnesses because it lays it out perfectly for

1 them what their choices are.

Now, you only get this -- this happens to be the one for Eladio Carrera, but they're all the same. And so anyone who gets one of these, the district attorney writes to him and says it's my understanding that your client Carrera desires to make a proffer to the State which will be useful in making an evaluation of our position in this case.

People get letters like this, and this is a letter that's saying whose team are you going to be on? We need a proffer because we're going to evaluate our position for your client in this case. So we'll have your client come in and we'll make a deal, we call it clean for a day, client gets to come in and he agrees to provide information, and the State promises they won't use it against him.

In other words, I talk, but they're not going to use it, except they get to use it if he lies to prosecute him for perjury or the information may be used to prove that your client testified untruthfully, or you can use the evidence against the person if they ever testify contrary to the information provided in the proffer. You've heard me say it. We call this a lock in clause.

In other words, whatever the client says, you're locked into it and then we'll decide whether we're going to give you a pass. And if you ever back up on this or you change your mind, we get to go after you. And the whole JRP TRANSCRIPTION

purpose of this, after the State discovers what your client has to say, bear in mind this doesn't say after we hear truthful testimony. It says after we hear what your client has to say and what he is willing to do for the State, we will make an evaluation.

6 Then you give these letters to somebody like Ann 7 Lobiondo or Linda Hubbard, and they're banging on them and 8 saying we don't believe you. And it -- this is -- this isn't 9 a rubber hose when -- when we talk about coercing people to 10 give a statement or say something. This is simply legal, 11 lawful, proper pressure that can be used because the 12 prosecutor has these tools which we don't, and he gets to do 13 it.

As I pointed out with Detective Whitely, they also get to lie to you. But if you lie to them, it's a crime. Let me get these rules straight, and who would play a game like that? I go and talk to the government. They can lie to me, but if I lie to them it's a crime. They can say to me, like with Linda Hubbard or whichever one we were talking. Linda Hubbard, I think.

They can say we've looked at all the record and we can prove this and that against you. And that can just be absolutely bluffing, lies, and is perfectly permissible, and now you've got to make a decision which team you're getting on. And so Linda Hubbard gave a statement and she testifies

1 in here contrary to her statement.

And so they have to put Detective Whitely on the stand to say what she said back then to try to get it in as for the truth of the matter. And, of course, what happens when you start compelling testimony from people or you start getting people to say something to save themselves, sometimes it'll be truthful testimony, sometimes it'll -- they'll say what you want to hear.

9 And with Linda Hubbard, she gave a statement that 10 just is factually impossible. She hoisted herself by her own 11 petard. I mean, she said okay -- and bear in mind, this was 12 after time outs, going off the record, stop, stop, talk, talk, 13 talk, and then go back on the record again. Four time outs. 14 And they're telling her all of this.

15 And so what -- what are they -- Linda Hubbard, she 16 says when I first came to work I was taught the ropes by Ron 17 Lakeman. And she's specific about it. And, of course, this 18 is something where she's going to contend that -- that she was 19 told to reuse needles and syringes by Ron Lakeman and by my 20 client because that's what they wanted her to say because 21 that's what they contend she had previously said, which she 22 denies.

And so she says, okay, after a time out, I've got it, I remember. My very first meeting I was there, I was learning how to do billing, it was the first meeting, he was

1 teaching me how to do it when I first came to work and he 2 taught me. And he really didn't say to do it, but he just 3 said watch how I do it, and then you do it the same way.

And of course her problem was she fabricated this story about 50 cc vials, and she specifically remembered and told the police that Ron Lakeman would take and fill up from a 50 cc vial with a spike and that's the way he did it. And this all took place when she went to work in August of 2005.

9 And, of course, where she got mixed up is they never 10 had 50 cc vials at the time. First 50 cc vials ever purchased 11 were October 13, 2005. But, of course, that's what happens 12 when you pressure people to say something. You push them hard 13 enough, they'll come up with a story. But she comes up with 14 one, but it just does not hold up.

The -- the inability of the defense to get witnesses 15 16 to be interviewed, to offer them immunity in exchange for 17 testimony is one of the hurdles. And that's why all -- all we 18 can end up with is our, the defendants' right of 19 confrontation, where at least the least I get to do is 20 cross-examine them and try to expose in this courtroom what we believe the truth is. And the truth is what this case is all 21 22 about.

And that's your job in the courtroom. I've told you what the law is. You all are supposed to find out who -- who is right, the State's version or the defense version? And if

1 it's you all who get to determine who has a motive to 2 fabricate, who because of pressure said this or that, who is 3 telling a lie and then pretending like they have no memory of 4 a report out of their agency.

All of those things take place and we do it, and I don't do it to embarrass Dorothy Sims. It's not my job to abuse any witness. It's my job to try to get the truth out here. And we don't engage on the defense side in deception in my judgment. I don't put up evidence with false inferences. I don't drag witnesses into this courtroom to testify to things that are not accurate.

And the State of Nevada has done all of that in this courtroom and I'll go through them because when that happens you have the right to consider all of that. Because when -when you stoop to this type of preparation and presentation, it calls into question the entire case. And we have seen circumstance after circumstance.

Now I hear from Ms. Weckerly, yeah, some witnesses may have said there were 80 patients a day or 90 patients a day, but those numbers don't really matter or anything. Well, they -- they mattered to me when they put witnesses on the stand sworn to testify and they allow those witnesses to mistakenly give false information, which is what to -- happens to be to the benefit of the State.

25 We knew -- we knew from day one, or the State did, JRP TRANSCRIPTION 109

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1 anyway -- I didn't, they seized all the evidence -- the total 2 number of patients every single day in the clinic. It's not 3 the State's job to go out and find a witness who has an ax to 4 grind or who is exaggerating or angry and say something, and 5 then say, oh, that sounds good. I'm going to put them on the 6 stand to repeat that, when they know from the evidence that 7 they have that it's false testimony.

8 Here -- here are the witnesses that have testified 9 and the number -- number of procedures per day. Every one of 10 these, you go by your recollection of these, but daily patient 11 numbers per witnesses. Jean Scambio said 65 to 70 patients 12 per day through Shadow Lane. Keith Mathahs, 65 to 80 per day. 13 Daniel Sukhdeo, 65 to 80 per day. Dr. Eladio Carrera, 70 to 14 80 per day. Marion Vandruff, 70 to 72 minimum per day. Pauline Bailey, 60 to 70. Vince Micne, 70 to 80. Ralph 15 McDowell, 60 to 70. Vince Sagendorf, 70 to 75. Johnna Irvin, 16 80 to 90. 17

18 And all of this while we're having this orchestration, this drumbeat of assembly line out of control, 19 20 tco many patients, how many can you do in an hour? And the 21 entire time they have every -- every single record book, every 22 single patient on every single day. And they have done the 23 math and they knew the numbers. And they knew for 2007 it is 24 59 patients per day average. They know that the highest 25 number that had ever been through the clinic was 76 on a day.

And when you know this and you have this evidence, it is impermissible. You exceed your license as a lawyer. You aren't playing fair. You can't say I get my witnesses as I find them, and so I'm just going to let them get up there and say something that I know is demonstrably false. It happened here with however many witnesses. Every one of those is wrong.

8 They put Marion Vandruff on and had him testify that 9 when the CDC came in, January 9, 10, and 11, 2008, the clinic 10 reduced the number of patients on the day that they were there 11 so it wouldn't look so bad when the CDC was there. Let's 12 reduce the patients. Look at January 9, 10, and 11 of 2008. 13 The highest number of patients, 60, for the first ten days of 14 January was on the 11th of January, the day of the inspection.

And of course the inference they were trying to draw through -- improperly through Marion Vandruff's testimony was that the clinic knew they were doing something wrong, so they intentionally scaled back and reduced the number of patients. You don't put witnesses on to say things like that. Every --Vince Sagendorf, Vince is almost laughable on these numbers.

And how do we get to these numbers? That's why I took Ms. Lobiondo through her -- she called it pressure and getting interrogated by five people at once. And I took her through her Metro interview, her first Grand Jury appearance, her second Grand Jury appearance, so you could see how people

1 get worn down and beat up to finally say what the prosecution 2 wants to hear. Because Marie --

Is that her name, Marie?

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MS. STANISH: Ann Marie.

MR. WRIGHT: Ann Marie, Ms. Lobiondo. Ann Marie 5 6 Lobiondo, they wanted out of her the quickness of Dr. Desai's 7 procedures. And the first time she was interviewed, and I had her read all of this, the first time she was interviewed by 8 9 Metro she said it really is unfair because every -- every 10 single procedure is different. It depends on the prep, the 11 age, everything else. You have all the records. I can't just 12 give you an average number.

And -- and they pushed her on it. And she said I really can't. It isn't fair. And she said, well, a normal colonoscopy, what's the fastest it could be? She finally says four to ten minutes. Then she gets called to the Grand Jury and the prosecutor examines her in front of the Grand Jury.

And the detectives that interviewed her are sitting there. And they ask her again, tell us, what's the -- what's the average time for Dr. Desai, as if -- as if this is really relevant, the quickness of his procedures. What's the average time of his procedures? And she said it's really not fair. You can't even say it that way.

And I said isn't it a fact you told the -- you had been interviewed and you told the police it was four to ten

1 minutes? She said, yeah, but -- she said so -- so you admit 2 it's four to ten minutes? Said, well, it's four to ten 3 minutes if that's what I said. And they called her back to a 4 second Grand Jury. And I took her through every one of these 5 because by the time we get to the second Grand Jury and she 6 said I can't tell you, I think four to ten was an average.

7 And then the prosecutor said I'm going to ask you 8 that question one more time, ma'am. Isn't it a fact that the 9 average is four minutes and it ended up being four to five 10 minutes? Things like that was the reason why these times end 11 up -- you've got one, two, three, four, five, six, seven, 12 eight, nine, ten witnesses who are allowed to come in here, 13 testify to something that I can absolutely without a doubt 14 prove is false.

Now, do the times really matter? No. But the only thing were the number of patients. Does the number of patients really matter? No. Ms. Weckerly acknowledged it isn't the number of patients. Well, then why did we have ten witnesses come in and give false testimony?

Because I -- I have to use examples to show you that I can impeach witnesses and what they say when I have the tools and the ability to do it. I can show you that the State is just going to go ahead and put on evidence that is -allows you to draw improper inferences. We saw it with the price of propofol.

If you remember in the opening statement way back two months ago, the prosecutor was telling you propofol is a very expensive drug and they go to 50s because it saves money. When did they go from 20s to 50s because it saves money? And he gave a price of something like \$15 for a 20 cc vial of propofol.

7 And then once again, they -- the State has the 8 evidence. They have all of the computers. They subpoenaed 9 all of the records. They know what every vial of propofol 10 costs. And they know from 2004 until the clinic closed in 11 2008 that the price never varied at all between 20s and 50s.

A 50 costs two and a half times a 20, right to the 13 10,000th of a cent. Well, on two occasions 50s were cheaper. 14 Sc there was absolutely none of this motive to save money by 15 going to 50s that the State said in their opening. And then 16 they affirmatively put on evidence by which you could infer 17 that.

18 When Mr. Carter was on the stand testifying, they 19 compared for him an invoice or something out of a computer for 20 one year for a 20 of something else, 11 months later for a 50, 21 and they wanted you all to believe that a 50 was cheaper than 22 a 20. Under that comparison it showed that you could 23 literally, if you bought 50s, you saved two-thirds of the 24 money under that comparison. It was an absolutely false 25 comparison.

The records, all of these were in through testimony 1 for each month, each purchase, and always absolutely the same 2 price. Once again, how -- how does that matter? Well --3 well, it matters because in this case you're always supposed 4 to look for the truth. That means we each put forth our best 5 6 effort at exacting accurate truthful testimony and leave it to 7 you all through our efforts of cross-examination to sort it 8 out.

9 And me, as an officer of the court, I'm not supposed 10 to stick something on the stand, some witness, and I'm not 11 supposed to put on evidence that I know is drawing a false 12 inference. Because when things happen like that it's called prosecutorial misconduct. And in this case the State of 13 14 Nevada had evidence stricken and an instruction that there was prosecutorial misconduct that had taken place. And when you 15 16 have to descend to those type of actions in putting on a case, 17 it calls into question the validity of your case and the 18 prosecution.

So poor old -- poor old Mr. Mione who -- who was a victim of Brian Labus's either inaccurate recollection or mixing up of Vinnie Sagendorf with Vinnie Mione or whoever it was. And as it played out you have Mr. Mione who Brian Labus in the Southern Nevada Health District claims admitted that he was told to reuse syringes.

Mr. Mione absolutely always denied that and even

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1 contended he wasn't even there on that date. And Mr. Labus 2 was adamant about it. And Mr. Mione got called before the 3 FBI, other agencies, was accused of lying because he wouldn't 4 fess up to it.

And ultimately, in the courtroom here, Detective 5 Whitely said I think I was the problem that led to that 6 7 because I -- older -- older Vinnie or new Vinnie, and I said 8 Mione and that's where it went. And so Mr. Labus got mixed 9 up. And so the problem is Mr. Labus made no reports of 10 anything. There isn't a single written document or note whatsoever in his investigation. And poor Mr. Mione --11 12 MS. WECKERLY: Your Honor, I'm going to object. I 13 think that --14 THE COURT: That's sustained. 15 MS. WECKERLY: -- misstates the evidence. MR. WRIGHT: I asked Mr. Labus --16 17 THE COURT: I'll see --18 MR. WRIGHT: -- when he was on the --19 THE COURT: -- counsel up here, please. MR. WRIGHT: Pardon? 20 THE COURT: I'll see counsel up here, please. 21 (Off-record bench conference.) 22 23 THE COURT: All right. That objection was 24 sustained. Mr. Wright, you need to be -- you need to rephrase 25 JRP TRANSCRIPTION

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1 your statement.

2 MR. WRIGHT: Okay. When I addressed Mr. Labus on 3 the stand, I asked him if he had anywhere any handwritten 4 notes or a report of an interview of Mr. Mione, and he did not 5 have any notes or any memorandum of interview of talking with 6 Mr. Mione.

7 And he simply stated that Melissa Schaefer was there 8 with him and heard the same thing. And that's when I -- of 9 course I examined Melissa Schaefer about that and she had no 10 recollection of ever having interviewed Mr. Mione in which he 11 made those admissions.

12 Now, going to the issue of transmission of the 13 hepatitis C and how it occurred. Because you know there's a few hurdles to get over. First of all, did everyone have the 14 15 hepatitis C of the source patients? If you go way back and you remember Dr. Yury, whatever his last name is, from CDC, 16 17 most convincing to me. You all make your own judgments. But 18 we lawyers in criminal cases look at these things because the 19 first thing is, okay, people got hepatitis C there on July and 20 September dates.

Now, did they have the hepatitis C when I walked in the door, or did they acquire it at the clinic? Was it risk factors or what was this or that? Well, as far as anyone in there, if you followed all of those trees that Yury put up there and his genotyping and genetic testing, it looked to me

like state of the art was that everyone's hepatitis C at the
 clinic came from the two identified source patients.

And I'm not going to stand here and argue with you about reasonable doubt or anything else. I didn't see any other conclusion myself other than this hepatitis C happened at the clinic on those two dates and the hepatitis C was acquired from the source patients. The first hurdle over as far as I'm concerned.

9 Next hurdle, how did -- how did they get the 10 hepatitis C? And we have to determine that beyond a 11 reasonable doubt before we get to the mechanism and start 12 applying did the act or know about it and was he cognizant of 13 the risk and everything else. So on that next factor, how was 14 the hepatitis C transmitted on those dates?

I'm going to leave some of this to Mr. Santacroce because he's the expert of the charts and the room jumping and who was in which room and where it was. And I don't know the answer. You -- you all have to make a determination to exclude every cause except one, and then find one beyond a reasonable doubt.

21 Southern Nevada Health District, CDC believe the 22 most likely cause was the method of injection of propofol in 23 combination of multi-dosing propofol vials and reuse syringe 24 on same patient. Those two things, if everything went right 25 with an imperfect horrible storm, this -- this could have

1 happened.

And those are their words when I say could have happened because that's what's in the CDC report and Brian Labus's interim report, the CDC trip report, and then ultimately the peer reviewed published report. This -- this is what could have happened. And so you have to decide if that satisfies you all that that's proof beyond a reasonable doubt, with certainty that's what happened on this date.

9 And, of course, there were unanswered questions that even -- even remained unanswered in June of 2010. This is 10 Exhibit 165 in evidence. This is what we called the peer 11 reviewed article of CDC. Gayle Fischer, Melissa Schaefer, our 12 two CDC inspectors, Brian Labus, Larry Sands, his boss, 13 14 Patricia Rowley, she's a Southern Nevada Health District --Brian Labus's -- another boss of Brian Labus, Ishan Assam, 15 16 state investigator, This is probably June 24, 2010.

As the two CDC witnesses, Ms. Fischer and Schaefer both testified it pretty much simply tracks their trip report. But in it they conclude transmission likely resulted from contamination of single-use medication vials used for multiple patients during the administration of anesthesia. That's their likely.

This would probably be good enough for a civil case. Where it's if they -- we can at least make it more likely than not. I mean, that's what you need for a civil, to meet a

1 preponderance of the evidence. But what they point out here 2 is still in June 2010 it remains unclear why some susceptible 3 persons became infected by your procedures while others did 4 not.

5 Persons with clinic associated hepatitis C infection 6 underwent procedures closer in time to that of the source 7 patient compared with uninfected persons. These persons may 8 have been exposed to higher viral loads which became diluted 9 over time. Alternatively, multiple propofol vials may have 10 been open at once, and the contaminated vials were only used 11 for persons who became infected.

Additionally, the order in which persons underwent their procedures may not have been completely accurately recorded. And room numbers identifying where persons underwent their procedures were not documented. These factors limited our ability to trace how transmission might have been perpetrated.

18 At this point they are still -- now, bear in mind, I dcn't want to mislead you by this June 2010. Mr. Labus made 19 20 his conclusions in December 2009, which predated this. But by then Southern Nevada Health District had figured out the 21 rooms, or Metro had with their assistance, and they did come 22 up with the correct chronology of patients. At the time this 23 article was written and submitted, I'm not sure that it 24 25 happened.

But the point is at that time of this article, the CDC, and of course the renowned Miriam Alter, and renowned she is, agreed -- she reviewed, she didn't participate in either investigation, but she reviewed their papers and said she concurred in their judgment and agreement that that's a likely cause.

Now, we know Mr. Labus, in his email exchange with CDC, is still looking for support. Mr. Labus was still looking for support for his serial contamination theory in March of 2009. Now, bear in mind, the investigation was January 2008.

He is on record and is admitted because I -- I read to him and had him admit to his testimony that he had made up his mind and reached his conclusion by Friday afternoon, January 11, 2008. I got there Wednesday afternoon. I looked at charts all day Thursday. I did observations on Friday.

And what I read to him was -- and this was a deposition of him February 24, 2009. My understanding is that you had already reached the conclusion by January 11, 2008, that the reuse of syringes on multiple times on one patient coupled with the propofol vials being reused on more than one patient was the source of contamination of hepatitis C at the clinic; is that correct? Answer, yes.

Mr. Labus had made up his mind, reached his

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1 conclusion after being there two full days and has never
2 wavered from his conclusion. He came up with the serial
3 contamination, which has never been found elsewhere in
4 published reports, ever been a case in which it has been
5 documented.

And, in fact, that's why on -- right after this deposition, because I asked Mr. Labus on the stand, at that deposition you were asked by the lawyers is there anything that supports that in writing, any prior case, any published material, any of these esoteric journals?

And he sends an email to Melissa Schaefer, March 5, 11 12 2009. I read this to him and he read it. Melissa forwards it 13 to everyone at CDC. Hi Everyone, Brian Labus called yesterday 14 and was wondering if we were aware of any article in the 15 published literature that documents serial contamination of vials, as we presume happened in Vegas. Presume. 16 А 17 presumption. Not as we found; not as we conclude. As we 18 presume happened in Las Vegas.

He wants to cite an article in his report that describes this. Melissa Schaefer forwards that to all of CDC. And she says -- and she gets -- that -- that was her letter, her email to all of CDC. She gets a response. I had Mr. Labus read this. Here's the most infamous pooling outbreak I know of not exactly the same -- done the same, but seems like there's enough information here and from your investigation to

1 show that this is clearly a plausible explanation.

That this serial contamination theory is a plausible explanation. Not proof beyond a reasonable doubt. Not that we know that's what happened, but that's what CDC said. And that's Mr. Pretty (phonetic). And this was all forwarded back to Brian on March 27, 2009.

7 And, of course, I asked Mr. Labus on the stand, 8 today in 2013 do you know of a single published article, do 9 you know of a single case anywhere where this serial 10 contamination theory of multiple vials being polluted, despite 11 dilution, and going forward in needles and/or vials exists? 12 And he said, no, the record still remains as it is.

So you -- you all determine that next term. Can you conclude beyond reasonable doubt, even though they can't figure out why it jumps room to room and why it jumps, some people don't get infected at all and some do. And the other mystery they can't figure out is with hepatitis C, one out of ten people is symptomatic. Maybe it's two out of ten, it's like 80 percent. No symptoms whatsoever.

So two out of ten people, yet somehow here, this virus on this date of September 21, all but one was symptomatic, got symptoms, got sick over it. It was some peculiar strange virus that they still don't have an answer for. So if -- going to progression, if you determine we find beyond reasonable doubt there's no other reasonable

possibility at all and we conclude hepatitis C was spread by multi-use propofol vial combined with syringe reuse on same patients, next step in your analysis. That is the act alleged.

And so the question then becomes when Mr. Mathahs and Mr. Lakeman, in July and September of 2007 were reusing needles and syringes on an individual patient, but changing the needles and were multi-dosing propofol, did they know at that time everything that's required by the instructions.

Meaning, did they realize and were cognizant of this risk of serial contamination in that they knew or could reasonably foresee and just said hell with it, I'm doing it anyway? That's your next big hurdle if you think that's how the hepatitis C was transmitted in this case.

15 And, of course, the -- the problem is that the -this practice of multi-use of propofol vials was pandemic. 16 It was everywhere. That's the evidence in this case. 17 The 18 witnesses who have testified to that, Ann Lobiondo, Vincent Mione, Rod Chaffee, Keith Mathahs, Ralph McDowell, Vincent 19 20 Sagendorf. Vincent Sagendorf not only -- Vincent Sagendorf started in November 1, 2007, came to work at the clinic after 21 the outbreaks had occurred, lucky for him or he wouldn't be --2.2 23 he's still practicing in California today at a pain clinic. And he testified he comes to work, he interviews. 24 Every practice that he engages in at the clinic was identical 25

to what he had been doing his entire career. They didn't tell 1 him to do anything differently. And they used 50s and 20s as 2 multi-dose vials. That's the way he had been doing it. 3 That's the way he had done it at the two clinics in 4 California. And he understood it all and they all give their 5 explanations and rationales for their reasonable beliefs 6 7 because there is so much labeling problem and misinformation with it. 8

9 Because it was Mr. Sagendorf who was the same as Mr. 10 Mione who talked about there is a shelf life with it. And so 11 as long as once I open it, as long as I use it within six 12 hours, that's the only reason it's called single dose, and so 13 I am using it appropriately. And Mr. Sagendorf testified that 14 to this day, he's working at the pain clinic in California, 15 and they continue to multi-dose with propofol.

16 Linda Hubbard, Dr. Satish Sharma, Dr. Carmelo Herrero, Dr. Arnold Friedman -- and, in fact, on Mr. 17 18 Sagendorf, he testified that he -- he went out and was 19 interviewed at Southwest Associates trying to get a job, and 20 that's where 15 anesthesiologist MDs work, and he tried to get hired there, same time, August to September, October 2007 and 21 22 that they were all multi-using propofol, using the vials as multi-dose. 23

And they all gave their explanations for it. It comes with a spike. A spike only comes with a -- for a

multi-dosing. There's no other use for it. All of this is to
 show you the lack of consciousness of wrongdoing by Mr.
 Lakeman and Mr. Mathahs, that they are engaging in practices
 that are the standard of practice that was going on.

5 That doesn't mean it's right, and that doesn't mean 6 -- I don't want any of you getting off into thinking that I'm 7 like saying, well, if everyone is committing a crime, then my guy is not committing a crime. Are you following me? Because 8 9 it isn't like speeding. It isn't like going through a school 10 zone where ignorance of the law is no defense. You all heard 11 that. I didn't know I was in a school zone. Tough luck. 12 Ignorance of the law is no defense. You were, and that's what 13 the speed limit is.

This is a case with a specific intent, a mental 14 component. That's all of those elements I went through. 15 They 16 must have been cognizant of it and know they can't do it and 17 know that it is a risk of substantial harm to be caused. Yet 18 Dr. -- all of these -- all of these are the State's witnesses. 19 Dr. Frank Nemec came in here and testified. Dr. Nemec 20 testified that until this incident, the 50s were being 21 multi-dosed, until this incident in 2007.

And when I examined the CDC, Melissa Schaefer, I asked her about the testing and what is still going on with multi-use vials and who is it? Why do you keep having these health bulletins and all of this go out, and there just still

1 ends up being confusion on the part of the practitioners. And 2 she said that's why we keep educating and keep trying to do 3 it.

And I asked her if it had anything to do with -- and 4 she said that's what -- this is a current dangerous 5 misperceptions that they put up because there's still the 6 7 common belief by Mr. Sagendorf, obviously, and the pain 8 clinics he works at, single dose vials with large volumes that appear to contain multiple doses can be used for more than one 9 10 patient. That's under myths and dangerous misperceptions. 11 That's the myth.

And it's called the myth because it persists. And myths happen to be actually believed by people. Mr. Sagendorf is a myth believer. And what's the answer? Single-dose vials should not be used on more than one patient regardless of the vial size.

And when I asked Miriam Alter about it and the confusion, and says isn't part of the confusion what's the difference between single-patient use, single-dose vial? I said they're -- they're contradictory. When I get that 20 milliliter, 20 cc vial, is that a single dose vial, meaning I can take out one dose only, I can never re-enter it, or is that a single-patient vial?

And she said well they -- they use the terms interchangeably, single-does, single-patient, single-use all

means the same thing. I printed out for the -- I don't want to say her website, but her -- her CDC currently right off the website. I said I -- I can't even tell today in 2013 when it talks about use and dose, a single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. That one I get.

7 Single-use vials contain only one dose of medication 8 and should only be used once for one patient using a clean 9 needle and syringe. So I asked her, I said does a single-use 10 vial only contain one dose? Because that means I can only use 11 it once and toss it, or can I use it all on the same patient 12 aseptically?

13 She said, well, dose should mean use. And if they 14 mean the same thing, I don't know what that means. And I 15 said, well, what's a multi-dose vial according to CDC? I 16 printed this on June 19, 2013. A multi-dose vial is a bottle 17 of liquid medication that contains one -- more than one dose 18 of medication. So if -- so if a vial contains more than one 19 dose of medication, it's a multi-dose vial according to CDC?

Well, I -- I asked Miriam Alter, I said can I use the 20 on the same patient if she needs another dose? The answer is yes. I said then it's a multi-dose vial. She said, Mr. Wright, if I had my laptop here I'd get on the website and go to FDA and see what they have to say because there's confusion on what the CDC says and what the FDA says.

And, of course, that goes without the confusion of what Medicaid says. What does Medicaid -- it's Exhibit N1. Single -- wasting of drugs in single-use vial, March 30, 2006. Medicare's definition of single-use vial is a vial that has a volume suitable for administration to one or more patients. A single-use vial is a vial that has a volume suitable for more than one patient.

If, for example, the medication contains enough for 8 9 three patients, and all three patients are scheduled to come in for administration on the same day, likely for the same 10 reason, the manufacturer states that after opening, the vial 11 12 is only good for 12 hours, at which time any remaining 13 medication must be discarded. Administering this medication 14 that all three patients within 12 hours of opening the container fits the definition of single-use. 15

So if you're billing this for Medicaid purposes, 16 you're required to use the 50 on multiple patients as long as 17 18 it's within the time frame. And so that's -- that is a 19 permissible correct use. I asked the witnesses, isn't there 20 confusion here about that? She didn't have her laptop up to explain it. But that must be why things like that persist. 21 22 Because even Miriam Alter said if you use aspetic techniques and you used a brand new needle and syringe every time you 23 went into it, there is no chance of transmission of hepatitis 24 25 C by multi-using that vial.

And so when -- when Ms. Weckerly talks about Mr. Mathahs and Mr. Lakeman saying I didn't know, that -- that was her -- she had the words up there, recklessness, and she said the defense to the case is I didn't know. They didn't know what? Exactly what are we talking about? When Mr. Mathahs was interviewed and Mr. Lakeman was interviewed and they didn't know, what was it they didn't know?

They knew exactly what they were doing because they 8 9 explained it. And Mr. Mathahs did it right in front of CDC. 10 What was it they didn't know? And which the State says the "I 11 didn't know" is a lie, they really did know? Well, what the 12 -- what the State is saying is that Mr. Lakeman and Mr. 13 Mathahs really did know the serial contamination theory, 14 really did know you shouldn't be multi-using propofol even 15 though everyone else is doing it, and didn't know you shouldn't reuse needles and syringe for the same patient after 16 17 changing the needle.

So what she's saying is they were both lying, they really know that's risky and dangercus. Why would they know that? Who -- who would know? Who interviewed Mr. Mathahs? I mean, the one witness who actually talked to Mr. Mathahs, interviewed him right at the time, that was Melissa Schaefer and she testified she talked to him for 20 minutes. And I asked her, was he genuine and do you believe

25 he actually thought he was engaging in safe practices? And

she said yes. And she said, when I took her on recross, that was corroborated by the fact that he did it right in my presence. Because when people are doing something consciously wrong, I know I've engaged in wrong doing, I do what Miriam Alter testified about on her first or second New York examination.

That's where they examined a guy and he lied about 7 He denied reuse of syringes. That's what someone does 8 it. 9 when they know they can't do something. They deny it. And 10 what does Mr. Mathahs do? He is there. In comes CDC, in comes Brian Labus, BLC, they're all there, and right in front 11 12 of them he is multi-using propofol just like they admitted 13 doing at the clinic the moment all the investigators walked They admitted it. And so he does it. 14 in.

15 And what does he do right in front of her? Needle and syringe, need to re-dose, take cff the needle, put on a 16 clean one, and then she interviewed him about that. And he 17 18 said that is safe. I would never use a dirty needle on the same patient. I always do that. She said, no, Mr. Mathahs, 19 20 that -- that's one of the myths, changing a needle makes the 21 syringe safe for reuse. Why is it a myth? Because these are 22 misperceptions that continue.

And if -- and if you believe Mr. Mathahs and Mr. Lakeman were honest with Ms. Fischer and Ms. Schaefer, because each of them were interviewed when they said I do this, I

1 think it's safe, I change the needle, and I use negative 2 pressure. That's what they believed. And Melissa Schaefer 3 said she believed Mathahs, that he was sincere. And she said 4 he did it right in front of me.

And Miriam Alter, she said the guy back there in New 5 York, he lied about it. And only when they caught him because 6 7 of supplies did he ultimately fess up to it. And if you take that -- I mean, this is like deciding to go the wrong way on 8 9 the freeway, you're going to take that shortcut, and you do it right in front of the highway patrolman. I see him sitting 10 there and I do it anyway. That just doesn't add up in this 11 12 case.

If you think Mr. Mathahs and Mr. Lakeman were part 13 14 of the -- I can't say majority, a large group of practitioner 15 that were all believing the same and doing it the same and that's what they thought and it was mistaken, inadvertent, and 16 17 that they didn't recognize the grave risk of what they were 18 doing, then the State doesn't win the case. If you have a 19 doubt about it, if you can't say I don't know whether Mr. 20 Mathahs knew it or didn't know it, then you have a reasonable 21 doubt.

You have to find beyond a reasonable doubt he knew exactly the risk and danger that he -- he -- he essentially had, when we get to the murder count, he has to -- he has to admit it was foreseeable, the harm he was going to cause was

foreseeable, and that he was doing this right in front of them
 and then lied to them about it and said I didn't know.

THE COURT: This might be a good time, Mr. Wright, to interrupt you, so we can take a brief recess. We've been in session for awhile now and I think some people need a break.

7 Ladies and gentlemen, we're going to take a brief recess, about ten minutes. During the recess you're reminded 8 that you're not to discuss the case or anything relating to 9 the case with each other or with anyone else. You are not to 10 read, watch, or listen to any reports of or commentaries on 11 this case, any person or subject matter relating to the case, 12 and please don't form or express an opinion on the trial. 13 If you'd please place your notepads in your chairs 14 and follow the bailiff through the rear door. 15 (Court recessed at 3:21 p.m., until 3:39 p.m.) 16 (Inside the presence of the jury.) 17 THE COURT: All right. Court is now back in 18

19 session.

And, Mr. Wright, you may resume your closingargument.

22 DEFENDANT DESAI'S CLOSING ARGUMENT (Continued) 23 MR. WRIGHT: We've been talking about the propofol 24 multi-use, the syringe reuse. Because, as you know, it's 25 those two things that should have put them on this absolute JRP TRANSCRIPTION

notice that they disregarded. I went through the witnesses on
 propofol reuse, the witnesses on syringe reuse.

Of course, we're talking this -- I hate to keep 3 repeating myself. I only get to talk once. The State gets to 4 talk again. They opened. I'm done. I can't get up and say, 5 oh, I forgot, I hope you understood this, because they get to 6 7 close and argue again. So bear with me the -- I want to be certain when I'm talking about the syringe reuse what we're 8 9 talking about is reusing the syringe on the same patient, 10 which is -- which is what was acknowledged happened here by 11 Mr. Mathahs and Mr. Lakeman.

This isn't like the incident over at the Maryland Parkway clinic between patients. This is the belief that changing the needle and using negative pressure is a safe aseptic technique, two of the myths that CDC keeps writing about that practitioners keep doing.

And so when I'm talking about needle reuse, I'm 17 talking about witnesses who testified that's what they do and 18 they do it aseptically. Ann Lobiondo, Vincent Mione, Linda 19 20 Hubbard, Keith Mathahs, Dr. Thomas Yee, Dr. Satish Sharma -both of those are anesthesiologists that testified about it --21 Carmelo Herrero, Dr. Eladio Carrera. Dr. Miriam Alter, she 22 23 said you can use the same needle, same syringe, same patient, same needle -- needle and syringe, same unit. I didn't go 24 through needle change with her or anything. 25

Dr. Arnold Friedman, an expert called by the State testified that in 2007, at the time he testified about the evolution of changed practices, best practices, how in the -one time in the '90s like 40 percent of the practitioners were using same needle and syringe in between patients by changing the needle, and how that's down to like 1 percent now, and how it evolved 2002 up until the present time.

8 And with Dr. Friedman, he testified -- you recall 9 Dr. Friedman. He's the fellow that I read him his deposition 10 after I asked him in 2007 was it within the standard of care 11 to reuse same needle, same syringe, same patient? In 2007 is 12 that within the standard of care? He answered no.

And I said remember what you testified in one of the civil cases, Mr. Washington's case in 2009? I read him the deposition and then I had to hand it to him and he read it to himself over and over and over again. This is what he read. Question -- and there was -- there was confusion at the beginning.

19 "Question, Were there instances in July of 2007 where it was within the standard of care to reuse a 20 syringe? 21 syringe? 22 "Answer, No. 23 "Question, And let's see if -- we're not connecting 24 here. I think I asked you in July of 2007 whether 25 it was within the standard of care to reuse a single 26 DEPENDENCE.

syringe on a single patient as long as the syringe 1 and the vial were thrown away? 2 "Answer, Under those circumstances, yes. 3 "Question, Okay. So in July of 2007 were there 4 circumstances where the reuse of a syringe was 5 within the standard of care; right? 6 "Answer, with the vial being thrown away, that's 7 correct. 8 "Question, And today -" 9 2009 is when this deposition is being taken. 10 "Question, And today are there circumstances where 11 reuse of syringes is within the standard of care? 12 Answer, Again, I think practices changed because of 13 the recent several cases that have occurred because 14 of the transmissions of the hepatitis virus. And I 15 think the standard of practice now is to go to a 16 17 single-use vial, defined as one draw, and throw the 18 vial away, and one syringe and one needle. 19 Question, So the standard of care has evolved from 20 July of 2007 to the present with respect to reuse of syringes? 21 "Answer, I think it's hard to put a year on it. 22 I think this has been an evolution between, you know, 23 to saying exact 2007 or a certain date. 24 25 "Question, What I was trying to say is that JRP TRANSCRIPTION

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somewhere between the year 2002 and where we are 1 2 presently if changes in JCAHO in terms of what they -- they're coming up with, and, again, some of those 3 things happened in 2004 and 2005, we are seeing a 4 5 much stricter interpretation of reusing of a syringe a second time on the patient. 6 7 "Answer, I can't tell you an exact date. I can't 8 tell you an exact year. This is an evolution of 9 what has occurred. 10 "Question, All right. Just to make it clear, 11 though, as of today do you believe it would be a 12 violation of the standard of care to reuse a syringe 13 in any circumstance even if it was only on the same 14 patient? 15 "Answer, With a single-use vial, yes." And he read all of that and then ended up concurring 16 that in July 2007 the standard of care was using a vial -- a 17 18 needle more than one time, with the caveat of throwing away 19 the vial, throwing away the needle. At the end all of that is 20 understood. What we're trying to get at is what were Mr. 21 Lakeman and Mr. Mathahs thinking at that time. 22 Dorothy Sims, one of the two witnesses we called. 23 Why did I call her? I called her because the BLC inspected the clinic and it -- it wasn't until after March of 2008 that 24 25 the BLC, all three inspectors, all three nurses, Nadine JRP TRANSCRIPTION

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Howard, Leslee Kosloy, Dorothy Sims, it took until after March
 2008 for them to recognize and put together the reuse of
 syringe problem with the multi-use of propofol as being a
 dangerous practice.

And so why did I bring her and have her put -- put in her BLC findings and reports? Because she testified that moment they walked in there, Jeffrey Krueger, Mr. Carrol, Dr. Carrol, Tonya Rushing explained on that Wednesday afternoon, Katie Maley, here's our practices, we multi-dose lidocaine propofol. That's what we're doing and it's right in the reports Wednesday afternoon. Multi-dose propofol.

No light bulb went off. I asked her, did anyone there in the meeting, CDC, Mr. Labus, did anyone say, wait a minute, that's dangerous, you can't do that? No. She didn't know at the time. BLC didn't know at the time. She came back the next day, Dorothy Sims, and she observed Dorothy Hubbard and did an observation of it and saw Linda Hubbard multi-dosing the propofol vials.

This -- this supposed conduct that is supposed to be so shocking that everyone in their right mind would say, whoa, risk, danger occurring. It is being done right in front of BLC, three inspectors, registered nurse inspectors for the State. I said did you say to Linda Hubbard you can't do that, what are you doing? And she said no.

25 Later they looked up on the Internet, talked to JRP TRANSCRIPTION

Brian Labus, figured out, nope, it's single-use and it shouldn't be used as multi-use even though there's the shelf life issue. It did not dawn on them. They weren't cognizant of this risk that Mr. Labus and Mr. Mathahs were supposed to be so aware of.

And so then what else did Dorothy and Leslee find out as they investigated going forward? That's why I had her go through the interviews. She interviewed Linda Hubbard and she kept notes of it very nicely which Mr. Labus didn't and doesn't. And she interviewed Sagendorf, she interviewed Mione, and she interviewed Linda Hubbard.

And Mr. Sagendorf was the only one on -- and this was on January 16, 2008. It was doing it the BLC best -- BLC, CDC best practices way of brand new needle, brand new syringe, never reenter. Just every time I use it throw it away. Linda Hubbard, Mione, both stated they were reusing same needle, same syringes, same patient.

18 Still, no light bulb went off with BLC and the three 19 nurse inspectors. They did not connect. They didn't say --20 that's why I said did you say to Linda Hubbard or Mr. Mione, you can't reuse a needle and syringe like that? No, we 21 didn't. Because they didn't recognize, they weren't cognizant 22 of this deadly -- if -- if it is -- if this horrible storm is 23 what actually caused the transmission of hepatitis C, they 24 didn't even connect the dots. 25

That's why I had her read through the three findings of the BLC as to what the clinic did wrong at Shadow Lane and the three findings were multi-use of propofol vial. Number two, they weren't changing the detergent in the first cleaning for every single scope. They were doing two scopes rather than one scope.

7 And the third one was their policy for forceps was 8 outdated. The written policy manual still said reusable 9 forceps and they were using disposable forceps, so they had to 10 rewrite the policy. Those were the three findings of 11 transgressions by BLC that jumped out when they were fully 12 cognizant of syringe reuse and multi-use of propofol vial.

13 And then I asked her, were you interviewed, all 14 three of you on March 5, 2008, by Metropolitan Police 15 Department? And at that time on March 5th didn't you, all three of you together, tell them that the reuse of syringes in 16 17 that fashion was absolutely permissible and okay? She said 18 yes. And I said and sometime after March 5th you learned that 19 this combination could have theoretically very bad 20 consequences on serial contamination of vials. And she said 21 yes.

So that's why we called them. Because if this is so readily apparent and horrible that Mr. Lakeman and Mr. Mathahs are liars when they say they didn't recognize the harm that flowed from it, why didn't Dorothy Sims, Kosloy, and the other

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1 one, can't even think of her name, why didn't they bring it up 2 and stop it? Because it simply was not apparent and known 3 even to these practicing nurses.

Before I move on to the murder -- murder part of the case, I just want to be positive. I'm not -- and of course, after -- after March was when -- well, I did forget one. Another reason I had Dorothy Sims come, Exhibit CC1. Just -just to -- so we didn't just have the testimony of Dr. Nemec and the other witnesses that this was going on at all of the other facilities, this investigation took place.

MR. STAUDAHER: Your Honor, I'm going to object to that. I don't think that was the testimony, all of the other facilities. What facilities are we talking about?

14 THE COURT: All right. Well, that -- that's -- I'm 15 not sure that was the testimony.

MR. WRIGHT: Okay.

16

THE COURT: So that's sustained. But, again, ladies and gentlemen, I'll remind you that it's your recollection that's important.

20 MR. WRIGHT: Well, their objection is well taken. I 21 don't mean all of the other facilities. I mean, the 22 facilities that the witnesses testified to, Sunrise, Southwest 23 Medical Associates, Gastrointestinal Diagnostic Center on 24 Maryland Parkway. It was where the witnesses said -- and Dr. 25 Frank Nemec at the hospitals that he practiced at -- that this 30 JRP TRANSCRIPTION

1 was a common practice until all of this happened and everyone
2 woke up to it.

Now, this inspection on February 15th, Exhibit CC1, this fits in the time frame when it is not yet public what had occurred at Shadow Lane. As you recall, the investigation, January, the public announcement, February 27, 2008. So before the public announcement they go out and do some surprise inspections.

9 And they go in on a surprise inspection to a 10 gastrointestinal center where they're doing endoscopies, and 11 you can look at page -- there's the date, 2/15/2008. It was 12 accepted. In other words, the plan of correction accepted by 13 BLC on March 12, 2010.

They inspect and this is exactly what I went through with Lawrence Sims -- Dorothy Sims. 2/14/08. At this point cold inspection. Just walk in the door. We're here to see what's going on and there's been no notification. No bulletins went out yet. Don't reuse propofol multi-patient. So what did I find? You can read it all, Patient 1, Patient 2, and to Patient 3.

Patient 3 was brought into the procedure room at 8:35 a.m. The anesthesiologist injected the patient with propofol through the patient's intravenous IV tubing. The anesthesiologist opened a new vial of propofol. They anesthesiologist used an opened needle and syringe to draw up

additional propofol from the vial. The anesthesiologist was
 observed putting the used vial with the remaining propofol
 back on the counter.

After the case, this was the only used propofol vial observed. The other vials on the countertop were new, unopened vials. Patient 4 rolls in, brought into the procedure room at 9:15. Anesthesiologist was observed drawing up propofol from the same vial that he had used on Patient 3 to inject Patient 4. 2, 3, and 4 were transferred out of here into recovery.

During the observation time frame the anesthesiologist was never observed opening new syringes. 9:45, interviewed the anesthesiologist. This is a doctor, not a CRNA. He stated it was okay to use single patient use propofol vial on multiple patients because the purpose of the single patient use label on the vial was to prevent bacterial growth in cases that required a long period of time.

An anesthesiologist stated that because these cases were of short duration, there was not enough time for bacterial growth to occur. Therefore, it was safe to reuse the propofol vials on multiple patients. The anesthesiologist was asked what the process was when he went from a used propofol vial to a new patient.

The anesthesiologist stated he would change the needle and reuse the -- reuse the same syringe. The

anesthesiologist explained that because a high port was used on the IV line it was safe to change the needle and reuse the same syringe on multiple patients. The -- another myth, syringes can be reused as long as the injection is administered through an intervening link of IV tubing. Truth, can't do that.

Another myth -- well, this myth doesn't even work. On this case they actually saw, the inspectors saw blood going in the IV line. It says an observation was made that one of the patients, the patient's blood flowed back into the IV tubing. One of the myths is if you don't see blood in the IV tubing or syringe, it means those lines are safe to be used.

It doesn't mean the conduct was right, safe. 13 What the purpose of all of this is, and for this clinic, was that's 14 what they thought was safe. Just like Mr. Mathahs and Mr. 15 Lakeman gave their explanation. This anesthesiologist gave 16 his explanation as to why he thought he was safely engaging in 17 good practice. The State would have you believe that he was 18 19 consciously trying to knowingly put patients at risk and harm 20 them because his conduct is more egregious than what's accused of these fellows. 21

The plan of correction was filed and approved by the State. The plan of correction. All patients -- let me see. I'll get to the part where they're dealing with in-services have been done with MDs, anesthesiologists, and staff to avoid

1 further deficit practice.

Acknowledgement form signed, RN and MD, 2 anesthesiologist signed off on procedure at the GI clinic on 3 propofol. Emergency plan of action was implemented on 2/14/08 4 of the use of propofol. All anesthesiologists who were 5 in-service signed an acknowledgement on patient safety on 6 propofol, all signed the policy of IV safety and nursing staff 7 will continue to be observed. They've all been observed by 8 the RNs, anesthesiologists have been using sterile syringes 9 and needles on each patient. Propofol is being used as 10 single-dose vial. All unused propofol is discarded after each 11 12 patient.

And, of course, after this inspection there's another exhibit in evidence, R1. This went out from the State of Nevada essentially saying what's been found in these clinics. And you can read R1. It's giving the best practices, safe techniques that should be used.

18 Thereafter notice has been given to every clinic. 19 It's broken in the newspaper on February 27th. And after news 20 reporting and it being sent to every provider in the state, they did their inspection of the 51 ASCs in the state, and 21 found 28 of them still hanging out there, all showing they 22 simply were not cognizant in recognizing the risk. 23 The -- I'm going to go to the murder charge, which 24 essentially tags on because essentially the allegation is this 25

1 is a second degree murder case because Mr. Meana died. And 2 there's no dispute Mr. Meana died, and there's no dispute -- I 3 think one of the elements in this case is substantial bodily 4 harm. And you've heard no argument from us, nor will you, 5 that this -- this horrible virus that these patients have is 6 not substantial bodily harm. That -- that is not an issue in 7 the case.

8 Every -- I mean a couple of them took the Interferon 9 treatment and have, according to Dr. Frank Nemec, he treated 10 Ms. Martin, she has eradicated, the virus is totally gone. 11 They -- it -- the -- the virus, no one wants hep C. I hope 12 that none of you have it. Who knows? I keep hearing these 13 statistics on how many of us might have it and don't know it.

But this -- that issue, substantial bodily harm, that element is not in dispute. All we're disputing is don't know how it happened. And secondly, if it happened the way the State theorizes is most likely, that's not proof beyond a reasonable doubt.

Now, Mr. Meana, he died. And so the question becomes did he die as a direct, foreseeable result of that act on July -- September 21, 2007. And was there no intervening act whatsoever that precipitated his death? And that's why we called Dr. Howard Worman who is an equivalent if you want to call Miriam Alter a dean of hepatitis C epidemiological studies.

Dr. Worman, who you saw from Columbia University, is an outstanding, renowned hepatitis C expert and does nothing but write, teach, and treat hepatitis C patients. And so he looked at all of the records of Mr. Meana to make the determination did he die of this hepatitis C infection. And you heard his testimony. Unfortunately, it was right at the end so it's most recent.

8 He cannot say beyond a reasonable doubt. He cannot 9 conclude that hepatitis C did or did not, with the medical 10 problems Mr. Meana had, both preexisting his treatment because 11 of the kidney failure. And when asked, well, did it -- did it 12 contribute? I can't answer that question. I mean, the 13 ultimate questions you'd like to ask to be clear for proof 14 beyond a reasonable doubt he couldn't answer.

What I'd like to ask, and it was one of the juror questions that was given to him, was can you say that if he didn't have hepatitis C and got it on September 21, 2007, wculd his death have occurred on the same date from those other causes? I mean, that would be nice if we could look and answer questions like that, but Dr. Worman said I cannot answer that question.

I'm just saying I cannot say with any degree of medical certainty. He died of hepatitis C, as opposed to died from the chronic kidney failure and the other problems that he had. So with the murder component of the case it's the

1 proximate cause issue.

Now, to get to all of that, I'm just jumping over. You have to have found how he got the hepatitis C and if Mr. Lakeman and Mr. Mathahs were in the wrong, and that my client aided and abetted and conspired to make it happen. And then you have to get to at the time it happened. As Ms. Weckerly said, the instruction for the murder requires that it have been directly [inaudible].

9 And, additionally, Instruction 27, the conduct 10 constituting the crime of criminal neglect of patients and/or 11 performance of reckless disregard. So it's the conduct we're 12 looking at, the conduct alleged propofol use. The conduct is 13 inherently dangerous where death or injury is a directly 14 foreseeable consequence of that act.

And that even if you found that death was on the 15 doorstep and on their minds when they were engaging on this 16 anesthesia on Mr. Meana, you then have to say -- and where 17 18 there is an immediate and direct causal relationship without 19 the intervention of some other source or agency between the 20 actions of the defendant and the victim's death, you have to find beyond reasonable doubt immediate, direct, causal 21 relationship without any intervention. 22

And, of course, that's why we asked, well, did -and read in portions of the deposition. Did he take Interferon? And he opted not to. And Dr. Sood's -- it was

1 read, his -- Mr. Meana's being deposed and explained that he 2 understood the risks that were involved and that he didn't 3 want the Interferon treatment and he knew there could be 4 cirrhosis and he opted to not go forward with it and take his 5 chances. And that's what's called an intervening cause in 6 between if someone opts to do that.

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And so on the murder count as to Mr. Meana, we don't see it directly foreseeable and we see intervening causes. And the interesting part about criminal cases is that State puts on their case and that we get to put on a defense. And then if we put on anything that is -- that can be rebutted, the State gets to put on more evidence again.

And, of course, we give them notice of our experts 13 and where we're going, just like they give us notice of their 14 witnesses. So like when we put on Mr. Howard Worman as an 15 expert, if there was a single expert in existence who 16 contradicted his testimony, the State brings him into the 17 18 courtroom. And it -- on the other side, the State -- all -all they have presented you other than Mr. Meana and his 19 20 family, they didn't call Dr. Jurani, his personal physician. They didn't call Dr. Sood who treated him, nor did 21

they call any expert. They called Alane Olson, medical examiner from Clark County who went over and watched the autopsy, took samples, brought them back, they deteriorated and she couldn't test them. And so she said she agreed with

1 what the --MR. STAUDAHER: Objection, Your Honor. That's not 2 3 what she testified, and she is an expert. And the blood deteriorated. 4 THE COURT: Well, he's not -- he's not disputing. 5 6 He's --MR. WRIGHT: Okay. 7 THE COURT: It's partially sustained. It was the 8 blood that deteriorated. 9 MR. WRIGHT: Okay. The blood was deteriorated and 10 she had brought back the tissue believing that the tissue 11 could be tested for hepatitis C, but when she got back the 12 tissue was fine, but she found out they could not test the 13 tissue because that type of testing is no longer in existence 14 in the United States, apparently. 15 So the tissue was good. She got it so she could 16 test for hepatitis C, but she didn't or couldn't or wouldn't 17 test it. And the blood, which they normally rely on here for 18 toxicology testing was deteriorated and she didn't have any to 19 be tested. And so she simply deferred to the autopsy in the 20 Philippines. 21 22 And, of course, the autopsy in the Philippines was stricken from the record. It was an exhibit initially 23 admitted, but then stricken. And so all we have from the 24 Philippines is the death certificate which shows exactly what 25 JRP TRANSCRIPTION

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1 Mr. Worman was -- Howard -- Dr. Howard Worman was talking 2 about, hepatic and uremic encephalopathy, kidney failure 3 hepatitis.

And the State brought in no witness or expert to 4 contradict those findings of Dr. Worman. And so it -- without 5 any question, there is at the least a reasonable doubt as to 6 the cause of Mr. Meana's demise, and the effect of the 7 intervening causation, meaning declining to be treated for the 8 hepatitis C. And secondly, the independent kidney disease 9 which resulted in his chronic kidney failure and him being on 10 dialysis and taking him into the hospital. 11

One other -- before I close, one other matter I want to touch on. A couple of things that the evidence came in regarding the -- some of the risks seen by employees that worked at the clinic. And it comes to mind Geraldine Whitaker, Maggie Murphy.

When you go back and look at your notes, these are two of the nurses, I think they were, two of the nurses who thought that because of the speed in the clinic, because of the patient load and turnover, they thought there was patient risk which would lead to a perforation, both of them independently. And I think there was one other witness that said that.

And I point that out to you because I don't want you to get sidetracked on taking evidence or beliefs that there

1 was just patient risk in the air, or foreseeable consequences 2 that would flow from the way the clinic was operating. 3 Because we're not here simply to decide was the clinic too 4 busy. Was it run like an assembly line with profits over 5 patients?

What you have -- if -- if they want to charge that, 6 7 we'll go to trial on that. If they want to charge other things, you're here to make the one determination. And that 8 9 -- and this matter is transmission of the hepatitis C by the method alleged by the State. And the fact that someone saw a 10 risk of a perforation because Dr. Desai quickly did his 11 colonoscopies is not any cognition of risk of hepatitis C 12 infection from infusion practices. 13

And so they just don't mix together. Because as you saw from the instructions, for each of those you have to have that specific known risk, I know this conduct is bad, Mathahs and Lakeman have to be saying, boy, this can spread hep C, but hell with it, I'm doing it anyway.

Now, you've heard all of the evidence demonizing Dr.
Desai. And the -- I -- I'd like you to take into
consideration of a lot of the witnesses and why they -- what
-- what their motives were and whether they had axes to grind.
And I'd like you to recall one of the specific testimony of
some of the nurses whose testimony simply didn't match with
some of the other people who claimed this was the dirtiest,

filthiest, horriblest place on earth to work in. If you look
 at the testimony of Nurse Yost from Texas who worked there and
 testified.

If you go back and look at your notes and memory of 4 the Gestapo of the procedure room, Janine Drury who complained 5 about Sagendorf eating. And she's the one who ran a tight 6 ship and who would go toe to toe with Dr. Desai. And who Dr. 7 Desai had hired at the end of 2007 to take over as charge 8 nurse to run the place, and --- and look at her testimony and 9 description of that clinic and the practices that were going 10 on, and you will see there is another side of the clinic and 11 12 of Dr. Desai the way he was there.

I'm not going to argue. He was a cheapskate, a skinflint. One witness called him anal about his obsessiveness on costs and not liking employees sitting around. He isn't on trial for that and that didn't contribute or lead to whether Mr. Mathahs and Mr. Lakeman believed their practices were correct. Because speed had nothing to do with their practices.

They weren't rushing. Mr. Mathahs wasn't rushing in front of Linda Hubbard. Whether Mr. Mathahs and Mr. Lakeman were doing 10 procedures a day or were doing 59 procedures a day, it wasn't that they were going so fast they mixed something up. They believed their practice was aseptic and safe. So take into consideration all of the concern about him

1 being so cheap and everything else and how that allegedly led 2 to this.

People are peculiar. People are cheap. My parents were the cheapest people on earth. And it -- my mom, cutting coupons even when they didn't have to. They continued. And people are weird that way. And if you thought like to his family, cheap, cheap, cheap. Don't -- don't waste even when you don't have to.

The -- my dad used to take -- excuse me. He ran the 9 Review Journal. He'd bring home paper that had been written 10 on one side. One side is still good. He'd put together, my 11 brother and two sisters, staple it, and I was supposed to take 12 it to school. All used on one side, and I've got a new pad on 13 this side. And absurdly I was ashamed of it at the time. I'm 14 ashamed now that I was ashamed then. 15

But it was how goofy it was and people can be. And 16 even when my dad didn't have to do that, he persisted in these 17 ridiculous, cost cutting, stupid things. And my mom did, too. 18 Cutting those damn coupons when she didn't have to later in 19 life. And so don't -- don't just jump, he's the cheapest guy, 20 he's a skinflint, he cuts corners, patient care gets thrown 21 out the window like all of these damn partners there that all 22 just supposedly turned a blind eye? 23

They were buying into it. They wanted the practice, other than the one guy, Carrera or something that got cut down

to 6.4 percent. But they all testified they'd roll their eyes at his ways and antics. But every one of them said they didn't perceive any putting patients at risk in any of this ridiculous frugal behavior. That isn't what criminalizes somebody. He worked, built a practice. Built it up until it was big. He's a capitalist. He wanted to make money. He tried to sell it in 2004 and 2007.

And he works, builds it, and then all hell breaks 8 lcose and all of this comes down. And then all of the other 9 doctors -- I mean, I think Ms. Weckerly said all the other 10 doctors, they all knew this was risk dangerous behavior or 11 something. But why didn't they say something or do something? 12 These doctors all pretend like they didn't see or know a darn 13 14 thing, all of his partners. And they were all there happily 15 working along. And as far as every one of the other partners, 16 they didn't end up through bankruptcy.

They -- Ms. Weckerly says cases are strange. They take unique twists and turns or whatever. Circumstances require that Dr. Carrera and Dr. Carrol not be prosecuted for their conduct. Well, those are decisions -- those aren't just unique twists and turns. Those are decisions made right there.

Mr. -- Dr. Carrera was so callous about it. He -he gets sued. He doesn't go through bankruptcy. He doesn't pay a penny out of his pocket. His insurance pays it. He

1 couldn't even remember the three names of the patients that he 2 treated that got hepatitis C. That's how much he cares as he 3 rolls on through his practice. So all this about demonizing 4 him as if he is evil incarnate and the worst person to ever 5 run a business and practice in this community, it just doesn't 6 hold up.

7 So we ask, Margaret, Dr. Desai, and his family, that 8 you analyze this fairly and correctly and look at it as we 9 believe the law dictates and you will find that there was not 10 criminal misconduct which took place in this case and you 11 should return verdicts of not guilty. Thank you.

THE COURT: All right. Thank you, Mr. Wright. 12 Mr. Santacroce, are you ready to proceed now or --13 MR. SANTACROCE: If you'd like. 14 THE COURT: All right. You don't need a break? 15 16 MR. SANTACROCE: Maybe the jury does. THE COURT: Everyone all right? 17 18 All right. Mr. Santacroce, you may proceed. 19 MR. SANTACROCE: Thank you. DEFENDANT LAKEMAN'S CLOSING ARGUMENT 20 MR. SANTACROCE: We're not going to break any new 21 ground here today. You've heard everything that I've had to 22 say, and I'm going to say it again. Only this time I'm going 23 to tell you how I view the evidence as it applies to my 24 25 client.

And you have a jury instruction that tells you that 1 you're to view the evidence against each of the defendants 2 individually. There's two men sitting here that deserve the 3 attention that you give them to the evidence as it applies to 4 each of them. And so I want to talk to you for a few minutes 5 about how the evidence unraveled in this case as it applies to 6 Mr. Lakeman. And do to that, we need to go back in time to 7 the beginning of this investigation to show you how we got to 8 9 the point that we got to.

And we go back in time to the beginning of 2008 in January when the CDC gets a telephone call from the Southern Nevada Health District that there's a problem in Nevada, that hepatitis is popping up and they need some help. So the CDC is invited to come to Las Vegas and conduct an investigation. And they assign Dr. Langley, Dr. Fischer, and Dr. Schaefer to come to Las Vegas and take a look as to what's going on.

But before Dr. Fischer and Langley get here, they have a meeting with the higher ups at the CDC and they finally laid some preliminary opinions as to how the infection may have happened. And they come to a preliminary, even before getting here, that we're going to look at the injection practices at the clinic and see if that's the potential for the transmission of the disease.

24 So they come out to Las Vegas. They conduct first a 25 records review. Before that they meet with the Southern

Nevada Health District. They advise them. They talk about what they're going to do. They go to the clinic, they review the records, and they do some observations. And then they come up with a trip report, a preliminary finding. And coincidentally, that preliminary finding mirrors or matches exactly the opinion they had when they came out here.

Now, they're telling you that, well, we ruled out 7 all the other mechanisms of transmission. But they will also 8 tell you they were not conducting a criminal investigation. 9 Their interest was a public health issue. And so they weren't 10 looking for the scrutiny that would be applied in a criminal 11 case. And so they come up with a preliminary finding that the 12 mechanism of transmission of the disease is through unsafe 13 injection practices and they issue their trip report. 14

Now, remember, there's some important things that 15 were uncovered after the CDC left. For example, the CDC 16 didn't know which patient was in which room. They didn't know 17 basically which CRNAs or -- or what types of procedures were 18 initially. All this information came up after the fact, after 19 20 the report. And Dr. Fischer, when she was on the stand, testified when we showed the charts -- and we're going to look 21 at those briefly -- when we showed the charts and information. 22 Now we have all the segregated rooms. We know which 23 patients were in which room. We know the sequence of the 24 patients. And what was her opinion? She said, well, in order 25

1 for their theory to be valid, the infected propofol would have 2 to go from room to room. And when Dr. Schaefer was presented 3 the evidence that they didn't have at the time of their 4 investigation, her conclusion was that she would have to --5 she would have to reconsider her opinion.

Now, Ms. Weckerly made a comment in her closing that we know that propofol went from room to room. We don't know that. What we know and what the evidence suggested was that at the end of the day the propofol would be taken and collected and the half used or partially used bottles would be thrown out and the full bottles would be returned to the locker.

So when she made the statement that we know that propofol went from room to room to room, she wasn't talking about July 25, 2007, and she wasn't talking about September 21, 2007. Because we know on those particular days Dr. Carrol -- let me get this easel. We might as well go to this thing. I dread it, but we're going to have to do it.

We know that on September 21st Dr. Carrol was the dcctor for the source patient Kenneth Rubino. And we know that Dr. Carrol testified that he never saw propofol go from room to room. And we also know that Dr. Carrol testified that he never saw a CRNA leave a procedure room in the middle of a procedure.

What evidence and testimony do you have, ladies and

25

gentlemen, to show that on September 21, 2007, or July 25, 2007, that the propofol went from room to room? You have no evidence of that. And as Dr. Fischer told you, in order for the State's theory to be valid, there'd have to be a showing that the propofol went from room to room. They don't have that.

The CDC issued their trip report and their 7 preliminary findings and they said this was the likely 8 mechanism of transmission. We're not dealing with likelys or 9 maybes or probablys. Two men sit here and their life is at 10 stake on probablys and maybes and likelys? Our system doesn't 11 work that way. There has to be proof beyond a reasonable 12 doubt. We can't speculate as to how the transmission 13 There has to be proof beyond a reasonable doubt. occurred. 14

And I submit to you, ladies and gentlemen, the State has failed miserably in that regard. But how did the State get to this position? Well, let's go back in time again. March 2008, Detective Whitely, as he testified -- where is he? He left? I wanted to point to him. I've got nobody to point to.

Detective Whitely -- Detective Whitely said he was told he was getting this case and he's assigned to investigate. So what does he do? He looks at what is out there. What did the CDC say? What did the BLC concur? What did -- what did Brian Labus subscribe to? It was all that it

was through these unsafe injection practices and contamination
 of propofol.

Now, Detective Whitely told you that, you know, they eliminated all these other things. Well, did they really eliminate all the other things? They conducted a search warrant of the clinic. They identified the scopes. They were smart enough to take a picture of the scopes, but they didn't impound the scopes.

9 Now, why is that important? Because you have heard 10 testimony over and over in this case that a possible mechanism 11 of transmission was the scopes, the dirty scopes. We had 12 testimony as to how to clean the scopes. Dr. Nemec told you 13 his practice is to clean them for 55 minutes. Why? Because 14 that is a potential mechanism for transmission.

The scopes weren't impounded and the detective told you, well, you know, we probably couldn't have found anything. It was four months later. Well, maybe you couldn't have found the hepatitis, but you may have been able to find if there was fecal matter in the scopes and in the -- in the grooves of the scopes. Maybe you would have been able to find if there was blood in the scopes.

But that wasn't done in this particular case. Why? Because there was a preconceived notion and idea that the mechanism of transmission was the contaminated propofol. So now the -- the search warrant reveals all of

1 these patient records. And Metropolitan Police Department 2 decides, well, we're going to put all this information in a 3 nice little chart and we're going to present this to the jury. 4 So they do that.

5 Only, there's a problem because the nice little 6 chart that they've prepared doesn't substantiate the theory of 7 the transmission. So now the State tries to distance 8 themselves. They say, well, all the times are wrong. You 9 can't go by the times. And so, you know, it doesn't -- it 10 doesn't work.

Well, okay, let's get rid of the times. Right away this testified that the sequence of patients was accurate. And what do we find when we look at the sequence of patients? And, believe me, contrary to Mr. Wright's representation, I am no expert in charts. I'm no expert in any of this stuff. But the fact of the matter is you can use common sense and logic to come to the proper conclusion.

When you walk in the courthouse door, we don't ask you to check your common sense at the door. You have a jury instruction that says bring your life experience, bring your common sense with you and apply that to the evidence. What does common sense and logic tell you here?

The source patient, Kenneth Rubino in Room 1, is followed by another patient who we know as Lakota Quannah who is not genetically linked, and then we have Rodolfo Meana.

And then what happens after that? One, two, three, four, five 1 people who aren't reported as having hepatitis C. And then 2 all of the sudden it appears again in Sonia Orellono. And 3 then it skips over the next patient. And then it hits 4 5 Gwendolyn Martin. And then we don't see it again in Room 1. Somehow, during the same time period, it jumps over 6 7 to Room 2. And Stacy Hutchison is infected by a genetically matched link of Kenneth Rubino. And then it skips somebody, 8 9 and then Patty Aspinwall. And then it skips one, two, three, fcur, five people, and then Carole Grueskin gets it. 10 What does common sense tell you? How does the 11 disease skip over all of these people and just land 12 sporadically? It tells me that there has to be some other 13 14 mechanism of transmission. Now, remember, the State is committed to this 15 They have to prove to you it was the propofol. Thev 16 theorv. can't lay all these theories out in front of you and say pick 17 whatever you want and convict. That doesn't work that way. 18 And the defense is under no obligation to show to you or prove 19 to you what the mechanism of transmission is. All we can tell 20 you is that there were other possibilities for your 21 22 consideration. And as Detective Whitely said, we may never be able 23 to prove this case. And as another witness said, we may never 24 know the cause of the hepatitis C. And that may be very well 25

true. But you must know if you are to convict these two gentlemen. You must have a deep, abiding, moral conviction that the mechanism of transmission was the propofol. If you don't have that, if you have any doubt, you must acquit them. Because everything flows from the transmission of the disease of hepatitis C.

Now, let's look at the chart a little closer. And 7 they tell you you can't go by any of the times. And yet they 8 9 have chart -- procedure start times, end times, they have nurse log times, they have machine log times, they have 10 monitor log times. They have all of these times. And when 11 you get this chart back there I want you to look at something. 12 I want you to look at any one of the times. You pick whatever 13 time you want to pick. You pick the time that you believe was 14 most reliable from what you heard. 15

And I want you to look at Kenneth Rubino. And then I want you to compare that to Stacy Hutchison any time you want. And you will see that both of them were undergoing a procedure at the same time. How does Stacy Hutchison get a disease from Kenneth Rubino when they are both anesthetized in different rooms by different CRNAs at the same time? I don't know.

23 So what do we do? We look for commonalities. Not 24 to prove another alternative method or mechanism, but there 25 are other commonalities. We talked about the saline in the

1 pre-op room. You've seen this chart a hundred times. You've 2 seen the infected people in Room 1, the infected people in 3 Room 2, and we know that Lynette Campbell and Jeff Krueger 4 started those IVs. We know, too, that they shared saline. We 5 also know that it was all in the same pre-op area.

6 There was no room changing of the saline. There was 7 no isolation of the saline bottles as was suggested by the BLC 8 to put it in a central medicine area. That wasn't the case. 9 The saline was here for both of them to dip into. Lynette 10 Campbell was a new nurse. I'm not suggesting that Lynette 11 Campbell did anything intentionally, but I'm suggesting she 12 was a new nurse.

And what was the testimony regarding IVs? If IVs 13 14 couldn't be started, who did them? The CRNAs. Well, why 15 couldn't an IV be started? It's because they had multiple pricks, couldn't find a vein. And the State wants you to 16 believe, well, they never went back into the bottle. There's 17 no testimony to that fact. But the circumstantial evidence 18 and testimony is that there were times when the nurses 19 couldn't start an IV, so they would go to the CRNA. That 20 suggests to you that there were times when there was a 21 possibility or potential that the saline bottles were 22 23 infected.

We don't know what Jeff Krueger did. We don't know what Lynette Campbell did. All we know is that they shared

saline bottles. They shared a procedure room. And we don't
 even know if they shared needles or not. But it is a
 mechanism for transmission.

It's interesting to note that in the State's
presentation Ms. Weckerly told you we could rule out biopsy
forceps for the contamination on the 25th of July. And -- and
she told you that because I have been arguing or bringing out
throughout this trial that both the source patient and Michael
Washington on the 25th both had biopsies.

And we know that some of the biopsies were reused. 10 And we also know that there was improper cleaning practices at 11 the clinic for scopes and biopsy equipment based on the BLC's 12 inspection and the CDC. And what did -- what did Ms. Weckerly 13 tell you was the reason that we could rule out the biopsy 14 forceps in this particular case? Do you remember? Because 15 other people had procedures, biopsies on that day, and nobody 16 17 else got it.

Isn't that the same defense that we have been 18 talking about for the last two and a half months? If you can 19 rule out biopsy forceps because other people had procedures 20 and didn't get the disease, why can't you rule out the 21 propofol for the same reason? It's simply common sense and 22 logic. You don't have to be an epidemiologist to reach these 23 conclusions. You don't have to be a specialist in hep C to 24 reach these conclusions. It's right there for you to look at. 25

We also know from the testimony in the case that in the beginning of the day, what did the CRNAs do at the beginning of the day? We know that they checked out flats of propofol and we know that that propofol was stocked into one room, and propofol was stocked in another room at the beginning of the day. There was no reason way propofol would have had to go from room to room.

8 We also know from testimony that in the beginning of 9 the day the CRNAs would preload a bunch of syringes because of 10 the time factor. People were being rolled in and out. So 11 syringes were preloaded. You'll notice on the 25th of July 12 that Mr. Sharrieff was the first patient of the day in Room 2.

How could a bottle be infected if there were preloaded syringes and he was the first patient of the day? How could the disease have skipped over three people, landed in Mr. Washington and nobody else got it the rest of the day or reported having it?

Ladies and gentlemen, I suggest to you that the cause of the hepatitis C outbreak cannot be proved beyond a reasonable doubt. It is unfortunate that we don't have an answer because the public is clamoring for an answer. That's why you see all the television cameras and the news reporters because the public wants to know.

And so the State and the District Attorney's office was forced into the position of taking this approach and

prosecuting two individuals, Dr. Desai and Mr. Lakeman, to the exclusion of all the other CRNAs, to the exclusion of all the other doctors. They had to come up with a sacrificial lamb because the public wants to know. And they got a sacrificial lamb. They got Mr. Lakeman. But I'm imploring you not to allow that to happen.

And it's going to take courage on your part. You're going to have to put blinders on. You're going to have to jignore the public outcry. You're going to have to ignore the television. You're going to have to ignore the pressure that you may get from the decision you make here in the next few days.

But when we queried you in the beginning of this 13 process, we believed that each and every one of you was strong 14 enough to handle the pressure. We believed that each and 15 every one of you was fair and unbiased. We believed that each 16 and every one of you would do the right thing, that you would 17 hold the State to their burden of proving each and every 18 element of the crime beyond a reasonable doubt. That's why 19 you're sitting here. 20

And we call upon you to honor that oath and that promise you made to us in jury voir dire. And we call upon you to be strong because this is an important case. The State, the public has vilified this man. If we had a big oak tree out in front of the courthouse, in days gone by they

1 would have strung them up. There would have been no
2 questions, no trial. But we've evolved. We're better than
3 that. We give people a fair hearing and make a fair decision,
4 and that's all either one of us are asking is that you do
5 that.

Now, we have to talk about this theory that the 6 State has that somehow Mr. Lakeman is involved in Mr. Meana's 7 death. And after sitting here for two and a half months, I'm 8 still unclear as to their theory. But I believe that their 9 theory has to do with something called conspiracy. Because 10 remember, Mr. Lakeman had nothing to do with Mr. Meana. 11 Didn't treat him, didn't see him, was in a different room. 12 Didn't know Mr. Meana from anybody, and yet he sits here 13 charged with murder of somebody he never even saw. 14

How do we get to that point? Well, the State wants you to believe that somehow Mr. Lakeman was involved in a conspiracy with Mr. Mathahs and Dr. Desai. And because of that conspiracy he is liable for everything that flows after that. But let's look at the conspiracy instructions. A conspiracy is an agreement between two or more persons for an unlawful purpose.

And then it goes on to say that a person who knowingly -- knowingly, there's that element of knowledge again, does any act to further the object of a conspiracy. Well, let's stop there. Has there been any proof, evidence,

anything, that Mr. Lakeman knowingly did something to Mr.
 Meana? I didn't see any. But, again, you need to rely on
 your own notes and memory.

A person who knowingly does any act to further the 4 object of the conspiracy. What acts did Mr. Lakeman do to 5 further conspiracy which resulted in the death of Mr. Meana? 6 Has there been any evidence of that? No. Or otherwise 7 participates therein as criminally liable as a conspirator. 8 Now, note this, however, mere knowledge or approval of or 9 acquiescence in the object and purpose of the conspiracy 10 without an agreement to cooperate in achieving such object or 11 purpose does not make one a party to conspiracy. 12

The fact that Mr. Lakeman worked at the clinic, 13 worked at the same time, on the same day, in a different room, 14 does not make him a party to a conspiracy. There had to be an 15 agreement between the coconspirators, Mr. Lakeman and whoever 16 else the State suggests, there had to be an agreement between 17 those individuals. And that agreement would have to be 18 furthered by an act which was the object of the conspiracy. 19 There has been no evidence whatsoever to meet any of those 20 elements of this crime. And yet this man stands here accused 21 of murder. 22

The Supreme Court, when it talked about the duty of a District Attorney's office said it is not the duty of the District Attorney's office to obtain a conviction. It is the

1 object of the District Attorney's office to do justice. Does 2 that sound like justice to you? Charging a man with murder of 3 someone he never had contact with, someone he didn't know, 4 someone he never treated? Is that justice to you?

Now, the district attorney will stand up in a few 5 minutes and say, well, what about justice to the victims? And 6 believe me, we are not unsympathetic to the plight of the 7 victims. We feel terrible that this happened. We feel 8 9 terrible for them that it happened. But you just can't set aside the burdens of proof from the State to convict somebody 10 just to achieve what's perceived to be justice to the victims. 11 12 There has to be equal justice.

And that's why when you walk in the courtroom the Lady Justice has scales in her hand, because she balances the justice and the equalities of people. She's blindfolded because she doesn't see that race, gender, social economic status have anything to do with a decision when it comes to meting out justice. And you have to look at it the same way.

Now, let's continue with the conspiracy. In order to be -- have a conspiracy -- note this line here -- both conspirators must have the specific intent to commit the crime. First of all, what is the crime? Secondly, what was the intent that Mr. Lakeman had in the death of Mr. Meana? Did Mr. Lakeman have some kind of criminal intent for somebody he never knew, never met? It's illogical and it doesn't hold

1 | water.

The next instruction, No. 9 on conspiracy, evidence that a person was in the company or associated with one or more other persons alleged or proven that have been members of a conspiracy is not in itself sufficient to prove that such a person was a member of alleged conspiracy.

7 So the fact that these two individuals worked 8 together, that they worked in the same place, at the same 9 address, did the same job, that in and of itself is not proof 10 of a conspiracy. It says, however, you are instructed that 11 the presence, companionship, conduct before, during, and after 12 the offence are circumstances from which one's participation 13 in the company, conspiracy may be inferred.

So let's look at that. Was there a relationship by -- between Mr. Lakeman and Mr. Mathahs outside of the workplace? Was there a relationship either before, after, or during other than a professional work relationship? Was there any evidence presented to you of those facts? The answer is no.

Now, the State is going to say, well, there was a conspiracy between Mr. Lakeman and Mr. Mathahs and Dr. Desai because Rod Chaffee heard a conversation at the nurse's station where Mr. Lakeman was talking about PacifiCare patients.

25 First of all, let's talk for a minute about

witnesses. There's an instruction in your packet here which talks about the credibility that you give to witnesses. That's strictly up to you. You can give them whatever credibility you want. But if the -- the instruction tells you that if you believe they have lied, that you can either choose what portion of the testimony you want, or you can discard it all together.

And I wanted to talk about this conversation that 8 Mr. Chaffee had. And it also goes to another instruction that 9 we have on statements that are alleged -- allegedly given in 10 this case. So let's look at that Instruction 37. You have 11 heard testimony that the defendants made certain statements. 12 It is for you to decide whether the defendant made the 13 statement, and if so, how much weight to give to it. In 14 making those decisions you should consider all the evidence 15 about the statements, including the circumstances under which 16 the defendants may have made the statements. 17

Now, we were talking about Mr. Chaffee. And you 18 remember Mr. Chaffee? He's the one that gave evidence or 19 testimony that needles and syringes were being reused and he 20 saw that, and then he went home and he read the newspapers and 21 he saw that his statements were inconsistent to what he had 22 testified previously, and he comes into court and he recants 23 everything he said about the reuse of needles and syringes. 24 This is the same individual who tells you now that there was a 25

conversation that he overheard that Mr. Lakeman was talking to
 other CRNAs about scheduling PacifiCare patients.

Now, first of all, it's up to you to decide whether that conversation ever happened. But, secondly, if it did happen, so what? So what? Does that show a conspiracy? Between whom? He couldn't identify who was there. He only identified Mr. Lakeman. He didn't identify Dr. Desai. He didn't identify anybody else.

9 And what does that suggest to you? That there was a 10 conspiracy to move PacifiCare patients around? What does that 11 have to do with murder? What does that have to do with the 12 object, to further the object of the conspiracy? It has 13 nothing to do with it whatsoever.

So the State is going to pull out all of these little things and try to infer to you that there was a conspiracy. They're going to suggest to you, well, all the CRNAs bill at 31 minutes. Was there an agreement between Dr. Besai and the other CRNAs to bill at 31 minutes?

19 If you recall the testimony, Ann Lobiondo is the 20 first CRNA. She brought her own billing stuff. She then told 21 Keith Mathahs. Keith Mathahs presumably told Mr. Lakeman this 22 is how we do it here, you bill 31 minutes. Did anybody ever, 23 any of the CRNAs ever testify to you that they knew the reason 24 for that? Did any of the CRNAs tell you they were involved in 25 the billing process? Did any of the CRNAs even know the

billing process? Could we know the billing process? 1 You heard from insurance carriers. You heard from 2 people that talked about CPT codes and modifiers and all of 3 these other things that went into the equation of paying a 4 claim for insurance. Do you think that these CRNAs knew all 5 of that stuff? Do you think they had any idea about billing? 6 What they did was they put 31 minutes, they put the paper in 7 the bin, somebody from the billing department would pick it 8 up, put in the information, press the send button, and that 9 was the end of it. 10

Did any of the CRNAs get any of the money from the 11 insurance companies? Remember, there was a CRNA account.... Who 12 got the money from the CRNA accounts? The doctors. The CRNAs 13 didn't get any money from the CRNA account. They didn't get 14 any additional benefit from the payment of the insurance 15 companies. They get a salary. They didn't receive any 16 additional funds. And so that goes to all of the insurance 17 fraud and all of the billing issues raised by the State. 18

And I just want to go over some of those with you 19 real quick, if we can. And just to point out where they're 20 found in the indictment. With regard to Count 1 -- you can't 21 see that, can you? Can you see it now? Count 1, can you read 22 who that is, Ziyad Sharrieff? Somebody talk to me. 23 JURY PANEL: Yes. 24 MR. SANTACROCE: Okay. Ziyad Sharrieff, there's one

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count of insurance fraud. Again, it's alleged as a 1 conspiracy. But you'll remember that Ziyad Sharrieff, if you 2 look at his EOB form, this was the one where it was base plus 3 one unit. They had put eight minutes. And so the insurance 4 company considered that one unit. And so his claim was paid 5 at \$206.82, base plus one unit. 6 And you remember that everybody got the base for 7 anesthesia time. Everybody. And then it was just added by 8 the minutes. There was no fraud for that because that's 9 exactly what it was. It was base plus one unit, eight 10 minutes. It could go from zero to -- what she say, 15 11 minutes, right, for one unit? So there was no insurance fraud 12 there. What about -- let's look at another one. 13 MS. WECKERLY: It's Michael Washington. 14 MR. SANTACROCE: Okay. What are we doing about 15 I thought it was omitted. 16 that? THE COURT: Are you looking at the jury 17 instructions? 18 MR. SANTACROCE: I'm looking at just the indictment. 19 THE COURT: From the jury instructions? 20 MR. SANTACROCE: Yes. 21 THE COURT: That -- I don't think that's the right 22 23 count. MS. WECKERLY: It's 4. 24 THE COURT: It's Count 4 that was omitted. 25 JRP TRANSCRIPTION

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MR. SANTACROCE: Oh, okay. Count 4 is -- oh, this 2 is performance.

THE COURT: Right.

3

4

MR. SANTACROCE: I'm sorry.

5 Okay. Here. Count 4 is omitted, so you don't need 6 to consider that one.

Kenneth Rubino. And I want to talk to you about 7 people that Mr. Lakeman didn't bill. You're going to see 8 9 insurance fraud claims for all of these people up here in Room 1. Mr. Lakeman didn't bill for any of these people. So he 10 didn't submit any kind of insurance form regarding Kenneth 11 Rubino, Rodolfo Meana, Sonia Orellono, and Gwendolyn Martin. 12 And so, therefore, I'm going to ask you to acquit him on every 13 single insurance fraud charge related to those people he 14 didn't submit forms for. 15

Now, the State is going to argue the same kind of 16 conspiracy, that there was this conspiracy. But remember, 17 they have to prove to you the agreement, the furtherance of 18 the act, the intent. All of those things have to be proved 19 beyond a reasonable doubt. So with regard to all of those 20 people, I'm going to ask you to acquit Mr. Lakeman on all of 21 those people that he didn't submit an insurance form for. 22 Because you'll see in the -- in the language of the fraud 23 there has to be some material of misrepresentation on the 24 And since he didn't submit a form, there can be no 25 form.

1 material misrepresentation.

Now, with regard to the other patients, Carole 2 Grueskin, that's in Count 21. I'm not going to go through all 3 of this. You can do it in the back, but I'm going to just 4 highlight some of these counts. Count 21, Carole Grueskin, 5 that was a Mr. Lakeman patient. You remember she received a 6 That was it. So it didn't matter how 7 flat fee of 90 bucks. much time you billed. If you billed, you know, an hour, two 8 hours, five minutes, it didn't matter. They were getting 90 9 10 bucks and that's it.

And you need to look at, too, how the indictment is 11 pled because that's very important on the insurance fraud 12 counts. It talks about -- it says -- let me go up here a 13 little bit. False representation resulting in the payment of 14 money to the defendants and Keith Mathahs and/or their medical 15 practice which exceeded that which would have normally been 16 allowed for said procedures. That's important language 17 because the 90 bucks, that's all the insurance company paid 18 anybody. It didn't exceed that which would normally have been 19 allowed for said procedure. You can't convict on that. 20

Now, let's talk about -- who else did he treat?
Stacy Hutchison, 90 bucks, flat fee. Patty Aspinwall, \$249.92
was paid. And then she had another insurer, a secondary paid
\$78.20. She was out of pocket nothing. Did they provide any
information to you, any evidence as to what normally would

have been allowed by that company for that procedure? No. 1 So those are the insurance claims. And the theft 2 claims Mr. Wright went through. I'm not going to go through 3 all that math with you. the substantial risk, those -- those 4 claims, Mr. Wright went through those with you, as well, so 5 I'm not going to go through those again. But be advised that 6 7 there has to be -- and Mr. Wright went through this meticulously with you, so I'm not going to try to pretend to 8 9 embellish upon that.

There were elements in each one of those crimes that 10 needed to be proved beyond a reasonable doubt. There needed 11 to be some intent. There needed to be some deviation from 12 what was standard and customary practice. And he went through 13 all of that evidence with you as to what was standard and 14 customary. They wculd have had to have known. There would 15 have to be foreseeability that what they were doing was going 16 to cause this harm. None of that has been proven. None of 17 that was present. Therefore, you need to look at that very 18 closely. 19

Ladies and gentlemen, again, on behalf of Mr. Lakeman, his family, and myself, I want to appreciate and thank you very much for the service that you rendered here. We know that all of you underwent hardships to be here. And without you, our system of justice wouldn't be what it is. And we truly appreciate, and I can only hope that when you

1 look back at this experience in retrospect it will have 2 enriched your life just a little, if not a lot. And we -- for 3 that -- for that we thank you very much.

As I said before, these are hard decisions. But when you look at all the evidence, and it all flows from here, the infection. If you don't prove the infection happened here, you don't have any of the other medical claims and the medical counts. It all flows from that.

9 And I beg and implore you to look at it closely. 10 Look at it carefully. Bring your common sense to your 11 decision. And when you've done that, I hope that you will 12 agree with me that all of the counts against Mr. Lakeman, he 13 should be found not guilty. Thank you.

14 THE COURT: All right. Thank you, Mr. Santacroce. 15 Ladies and gentlemen, we're going to take a really 16 quick break while we switch over some of the equipment, and 17 then we'll move into the State's rebuttal argument.

Before we take our quick break I must remind you 18 that you're not to discuss the case or anything relating to 19 the case with each other or with anyone else. You're not to 20 read, watch, or listen to any report of or commentaries on the 21 case, person or subject matter relating to the case, and 22 you're not to form or express an opinion on the trial. 23 Notepads on your chairs, and follow the bailiff 24 25 through the rear door.

(Court recessed at 5:13 p.m., until 5:24 p.m.) 1 (Inside the presence of the jury.) 2 THE COURT: All right. Court is now back in 3 session. 4 And the State may begin its rebuttal argument. 5 MR. STAUDAHER: Thank you. 6 STATE'S REBUTTAL CLOSING ARGUMENT 7 MR. STAUDAHER: Ladies and gentlemen, I know you're 8 getting hungry. I know you're tired. And I have a number of 9 things to go through with you. I will try to do it as quickly 10 as I can. This is important, though, to the defense, the 11 defendants, plural, and the State of Nevada. Because of that, 12 I'm going to try to do my best to move through it as quickly 13 14 as we can. A couple things. At the beginning of this trial I 15 told you that this case was about a breach of a fundamental 16 trust. A breach of a fundamental trust between one of the 17 most intimate relationships you can have. And I'm not talking 18 about a sexual relationship. 19 I'm talking about a trust relationship, that between 20 your caregiver, your doctor, and yourself. Someone you have 21 to turn over your -- your essential life to at some point in 22 your life, if not multiple times. And during the times that 23 you have to do that, you have to rely on those people to do 24 the right thing with the right motivations. The right thing 25 JRP TRANSCRIPTION

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1 with the right motivations.

Now, you've heard the evidence and you've heard the witnesses. And I had to go back in my -- my notes just to make sure that when counsel was -- was talking about, gosh, that we were trying to put somebody on the stand to perjure themselves and mislead you.

7 In the beginning, if -- if I'm not mistaken -- and, 8 again, what's very important, and I'm going to illustrate that 9 in a moment, too, as to why what I say right now, what counsel 10 has said, what I said in opening, none of that is evidence. 11 It's my view, the State's view, or the defense view of what 12 the evidence that's been presented in this case shows. It is 13 up to you.

And as Mr. Santacroce said, there is a jury 14 instructions, specifically I believe it's the Instruction 41 15 on common sense. You as a collective group, you as a 16 collective group have more knowledge, experience, training, 17 life experience, period, than myself or anybody else. That 18 collective knowledge, that collective experience, whether 19 you're highly educated or have a high school diploma or never 20 even finished school does not matter. 21

What matters is that you bring that life experience with you. You don't leave it in the jury box. You don't stay here as robots just going back and crunching numbers. If that was the case, we wouldn't need you. You have to filter all of

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1 the evidence that's come before you through your life view as 2 well as -- then apply that to the law given to you by the 3 judge.

Now, in this particular case, at the outset I told 4 you that there were issues with some of the witnesses, a 5 number of them. They were uncooperative, a number of them had 6 to be granted immunity to even give information. They had --7 all had lawyers or most of them did. Some of them had 8 incomplete memory. Oh, and one of the other points was, gosh, 9 things were bad, but I didn't do anything wrong. A recurrent 10 theme. I tried to give you a heads up that that's what you 11 were going to be experiencing. 12

Now, what that means is you take the other instructions and the common sense instruction and you have to take the evidence as it comes in through the testimony, as well as all of the evidence that you have in this case, and you have to filter that through that sort of prism of whether it's something you need to believe, what portion of it you need to believe, if any, you can disregard it.

You can take a witness, if you think they've lied, misrepresented in some way, and disregard the entirety of their testimony, the entirety of their statements. Or you can take it for what it is and use it in whatever way you want. Meaning, that if it's corroborated by other evidence, if you hear other witnesses saying the same thing, if you see

documentary evidence that supports that, then maybe you can
 take and consider it. It is up to you and you alone. There
 is nothing here that the State is trying to hide from you.

Now, I will -- I will acknowledge one error. It was
an error on my part. It was a gotcha moment. Kind of like
Mr. -- or Dr. Worman on the stand when he was talking about
these journals that are third rate journals, Chinese journals
that aren't worth anything, and you can't publish anything.
And it came out that he was on the board of editors for one of
those journals.

Now, for me, that was a piece of evidence that I 11 misinterpreted. Now, it's in evidence. You can look at it 12 vourself. It's not like it's misrepresented. But my 13 interpretation of that evidence was that there was a 14 difference in cost of the propofol at least at one point. Ms. 15 Stanish pointed out, and correctly so, that it was not 16 appropriate or not -- it wasn't reasonable to compare those 17 two for the cost of the actual propofol. 18

The original reason to bring that forward is to show you that the cost of that item was far and above the cost of all of the other items. But in doing so, I misinterpreted a piece of evidence. That's why you're here, ladies and gentlemen, because it's your interpretation that matters. The rest of it that we put up witnesses to perjure themselves and that you were supposed to -- to use that information, ladies

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and gentlemen, these are representative of the charts. These
 are representative of the charts of the evidence that's
 sitting right over there.

You can all go through the books. We're not hiding them. You can go through the books and look at all the numbers. And Mr. Wright said, gosh, you heard these witnesses come in and they talked about 75, 80 patients a day, 65 patients a day, whatever. Is that what it was every single day? No. An average of 59. And he's correct.

And you know how you get that? By a piece of evidence that you have that you can just easily take a calculator a piece of pencil and paper, and you take that number right there which is the number of syringes and you take that number of patients, and by gosh, that's the number of patients. The number of patients in the year of 2007.

You know that the work days in 2007 are 254. You make a division and you come up with an average of 59 patients per day. Now on the two days in question, these two days, you know exactly how many patients there were, 63 and 65. That's more than the 59. But, of course, an average is just that. There are extremes on either end.

Now, ladies and gentlemen, the evidence that you have, you can sift through that in any way you want. The witness testimony you have, you can sift through that in any way you want. It is up to you to apply it to the law given to

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you by the Judge to come up with your verdicts in these -- in
 these cases, or in this case.

The issue of the propofol that I told you about earlier, which was -- the primary reason was to show that it was more expensive than any other item, and maybe that's a motivation or a reason why it would want to be conserved, at least by Dr. Desai, the, as the defense said, admitted penny pincher.

9 The tape that he -- and you've got these -- all of 10 these invoices in evidence over here. The tape that he would 11 use, that he would restrict was 78 cents a roll for an entire 12 roll. The K-Y jelly was 29 cents a tube. The chucks were 13 less than a penny a piece. The alcohol pads were less than a 14 penny a piece.

And probably the most important item beside the propofol, we know the propofol was in the range of anywhere from two and a half bucks to fifteen bucks. So it -- it varied. The syringe, the 10 cc syringe, 10 cc syringe, 7.4 cents a piece.

So when Ms. Weckerly told you that this was a case of pennies, that's exactly what it is. A case of pennies of a person, an individual who had either such power or influence over his employees to create such a work environment to where people checked their morals, their ethics, their training at the door and engaged in practices which were known risks to

1 patients for what? A dollar. A penny. Money. He had to 2 maximize the profits of that business.

And what were the examples? You heard Tonya Rushing say that one of the things that he did was he ran -- he ran the costs of the -- one of the most expensive costs related to the clinic would have been salaries, CRNA salaries. He ran that through the gastro center so that it wouldn't appear on the books so he could officially raise the value.

9 That's why when these -- these insurance people --10 excuse me, the insurance people came in and they had to 11 provide their contracts. Remember, we had to wait and do some 12 out of -- or out of context. We had to take them because we 13 had to get some of those contracts.

There was some difficulty doing that because they had contracts with the gastro center and they had contracts with the endoscopy center and they were being asked specifically about CRNA anesthesia type billing. Well, that's run through a different entity. It wasn't readily apparent in the contract they had with the endoscopy center.

An example, ladies and gentlemen, of what we're talking about. Every possible way to inflate the value of that clinic was going to happen. And if it meant running patients through at a perceived rate of every person coming in here that told you about that, 70, 80 patients a day, that's what they told you. That's their perception. You've got the JRP TRANSCRIPTION

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1 records. You know the number. It's not like we're hiding the 2 number. You've got this chart. You've got this chart back in 3 the -- in the room when you go back to deliberate. All of the 4 numbers are representative of what happened at the clinic.

The -- all of the argument about propofol, about 5 propofol reuse, no question it's being reused. These are the 6 This is how two days, ladies and gentlemen, that are charged. 7 many vials of propofol were used. This is how many patients 8 they had. There is no possibility on those two days that if 9 every patient got propofol, that if every patient got 10 propofol, that there wasn't reuse of the propofol bottle from 11 patient to patient. 12

You've heard the CDC come in. You heard other 13 people come in and say, okay, grudgingly on CDC that, you 14 know, if you -- if you reuse the syringe on the same patient 15 and you use the same bottle of propofol, you know, it's not 16 the best practices, but as long as everything gets tossed at 17 the end it's okay. Because there's no risk of contamination 18 that is going to be spread to another patient regardless of 19 what your practices are. There's no risk of you use the same 20 syringe on the same bottle. 21

I mean, everybody pretty much agrees that -- agrees with that as long as that bottle, that syringe is not used on another patient. The problem comes, and there's not a single person that came in here and said it was okay to do this. The

coupling of the two, the reuse of the bottle from patient to
 patient and the reuse of the syringe on the same patient.

Now, when you go back and look at those records on 3 -- on what the cost of things were, look at the cost of a 60 4 cc syringe. It's more money than a 10. A 20, they didn't buy 5 any so we don't know. I'm making an inference here. I would 6 make the inference reasonably based on the evidence that's in 7 question, and I get to do that in argument, that a 20 is more 8 money. Maybe a penny, maybe two pennies, maybe even ten 9 pennies. I don't know. But it's more. And because of that, 10 that's why they use the 10s. 11

If they had used a 20 and the 20s were such that you drew those up and that was the majority of the patients that actually went through and used about that much, 180, 150 milligrams. Remember, we talked about milligrams. It's ten to one. So it's 10 to 15 ccs or so. Then every 20 cc syringe would have been done with the patient. They could have tossed it.

But what would that have meant? What would that have meant? That would have meant propofol wasted unless you used the propofol in the syringe you just used on a patient for the next patient, or put it into a bottle and you used that in some way on the next patient. Even as bad as things were in the clinic, that practice wasn't followed. Now, we get to the -- the whole thing about speed.

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You heard ad nauseam, and I -- and I -- maybe you were nauseated about it, I don't know. The GI techs, the nurses, everybody coming through talking about fecal material splattering, about speed of procedures, procedures starting too quickly, all of those kinds of things, just brought in to muddy up Desai? Muddy up Lakeman? No.

First of all, defense, at least for Lakeman, the 7 whole issue is making the transmission something other than 8 the propofol, other than what the CDC saw, other than what the 9 CDC observed and heard from and people admitted to, making it 10 That was coming out. We brought it out something else. 11 primarily to you because we know it's coming out. And for the 12 primary purpose, which was to show the level of the 13 environmental stress that these people were under, to give you 14 an idea of how fast things were running in that clinic, how 15 many patients were put at risk on a day to day basis. 16

And when you have people coming in here and saying 17 that they worked in the clinic a day, they worked in the 18 clinic three days, they worked in the clinic a week and 19 they're out of there because of what's going on, and the GI 20 techs aren't getting trained properly because there's so much 21 turnover they're having to pull in people from the clerical 22 staff to cover because they can't get people there. They 23 24 can't keep people.

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It is such a high stress environment, the pumping up JRP TRANSCRIPTION 190

of the numbers, the running of the patients through, what 1 happens when people are run to their maximum capacity? They 2 make mistakes. If you push people knowing that's going to 3 happen, you are -- knowing that there is a risk and 4 disregarding it consciously. We have people that have come 5 forward in this trial and told you that they thought something 6 was going to happen. They confront Desai about it. And what 7 does he do? Disregards it. He disregards it. 8

9 Now, ladies and gentlemen, Gayle Langley at the CDC 10 observed Keith Mathahs reusing syringes. This was an 11 observation of a practice that was occurring. When they 12 talked to him, he admits to doing the combination of the reuse 13 of the syringes and the bottles moving from one patient to 14 another. They stop him.

Now, he said at the time -- we're going to get to some of the things he said in a moment. But what he says at the time, I didn't know it was a problem. Now, you'll hear that theme over and over again. They were told it was standard practice, standard practice in the clinic to do that, to reuse bottles of propofol on more than one patient.

Now, we know that that's the case because of this. We know it has to be, physically. And we're talking about on the 25th of July of 2007, 65 patients, 22 bottles of propofol. If you give propofol to every patient, you've got to reuse them. 21, 63 patients, 24 bottles of propofol. They had to JRP TRANSCRIPTION

1 be reused.

This is another part. Talking about the skips that 2 you see over here and why they might -- you know, you heard 3 that the CDC saw not just with -- or, excuse me, with Hubbard, 4 that there were open bottles of propofol. One would be used, 5 and it would be set up on the -- on the table. Then others 6 would be used. And then all five of them are up there, four 7 of them were up there, they would be collectively pooled and 8 then used on new patients. 9

Ladies and gentlemen, if there's a contaminated bottle that gets set up on the table and doesn't get used for two or three patients until they pool them to use on another patient, you get holes regardless of whether the viral load is so high or not so high.

This chart here is up here from Mr. Santacroce and Mr. Lakeman. Because you notice he had the other chart. Yeah, they had -- well, this is the one. A little bit different color on the one that you have. It's a little yellow, but this is green. This is the 25th. He didn't show you this chart. He didn't show you this chart in his closing because he can't explain this.

If it's the saline, if it's the scopes, he can't explain that. Because he's -- this guy is right down here. Mr. Lakeman is down here in this room. The first patient of the day is Ziyad Sharrieff. Ziyad Sharrieff bypasses the

1 procedure room where they put in the IVs. He bypasses that 2 and goes right into the clinic. Excuse me, into the procedure 3 room. He gets his IV put in by whom? By Ronald Lakeman.

Ronald Lakeman deals with the source patient on that day. Now, there's no dispute that these are all genetically matched patients. Not even disputing that. In order for that patient to have contaminated the next patient via unsafe injection practices, which is what he admits to, Ronald Lakeman would have had to have been the one to contaminate that patient with practices that he admitted to doing.

The reason the biopsy forceps issue isn't an even --11 even remotely here is because there are patients in between 12 who had a biopsy. So we have individuals who are having --13 unless we take the biopsy -- if we're reusing at that time and 14 that's another thing we'll get to, but the biopsy forceps come 15 out and they immediately go into the next patient without 16 cleaning? I guess that could happen. Of course, how does it 17 happen in here where you've got one in between an infected 18 patient? He can't explain this without giving liability to 19 Lakeman, so he doesn't show it to you. 20

21 MR. SANTACROCE: I object, Your Honor. I did show 22 that chart in my closing.

THE COURT: All right. Sustained.

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24 MR. STAUDAHER: There was a biopsy on a patient 25 between Ziyad and Washington.

Now, Marion Vandruff. I'm not -- and because I don't want to be accused of telling you things that are just my interpretation, I'm going to go through some of these witnesses and some of the things they said. Desai -- saw Desai snap scopes cut of patients, cracking the whip. He said that in court.

Now, what is the purpose of that? What is -- what 7 is that kind of thing? It shows that he, Desai, is moving 8 patients through so fast that he really doesn't care. He's 9 putting patients at risk. The procedure is not the issue. 10 The speed is the issue. The speed, speed, speed is the issue. 11 Not just forcing the patients through, but forcing his staff 12 through, putting people at risk just because of the 13 environment. 14

If patients are moving through at breakneck pace -and, ladies and gentlemen, one of the things that I want to point out here on this, this chart, and both charts had the same thing happen to them. You're going to actually have to go back and look at this just to make sure. And all the numbers are there so you can add them all up yourself.

But on the 25th, this chart right here, I want you to notice something. Room 1, Room 2, Dr. Desai is the doctor. Dr. Desai is the doctor. He is the doctor in the morning until about 11:00. From 7:00 until about 11:00. Four hours. In a four-hour window, a four-hour window, we're talking about JRP TRANSCRIPTION

1 whether we can tell whether or not the times are correct and 2 what times are right, you already know you can't go back in 3 time. I think that's pretty well known for most people. 4 Look at these times. These times are the times on 5 the records. They're unreliable. They're here to show you 6 that and to show you how unreliable they are. Because you can

7 just start looking at them and see that they don't match up. 8 You certainly can't compare room to room to exact minutes. 9 But we can look at the doctor, the personnel, the doctor who 10 was here, going back and forth, room to room, room to room, 11 four hours. 29 patients in four hours.

12 29 patients in four hours for one man, that guy over 13 there. That is 8.9 minutes per patient. That's turnover, 14 cleaning, everything that goes along with it. So an average 15 of 8.9 minutes for 29 patients on that day alone, I submit to 16 you that there is no way that these are all over 10 minutes, 17 even the procedures.

When we go to the next chart, different doctor, same 18 result. We've got Dr. Carrol in there. Dr. Carrol in the 19 morning goes from room to room to room. Dr. Carrol in 20 the same time period -- well, actually, it's a shorter time 21 It's three hours, 19 patients in three hours. His 22 period. time averages 9.47 minutes per patient. That's how fast these 23 guys were doing it. That's how fast they were stressing the 24 25 staff.

The staff was moving, as they all came in and told 1 They all perceived that there were you, at a break neck pace. 2 that many patients, whether there were or not. You've got the 3 records. Look at them. They're all in evidence for you. 4 Now, Marion Vandruff, this whole thing about 5 starting procedures, why would -- why would Desai not stop? 6 Two reasons. You know what, the medication that we give, this 7 propofol -- and this is not propofol. It's just a 8 representation of propofol. Propofol, you head that it had 9 what's called an amnestic effect, at least that it has some 10 amnestic effect. That means you don't remember. 11

So, you know what, if you're not going to remember, 12 what does it matter? That's the attitude. That's the 13 attitude that is pervasive that invades every portion of this 14 practice. The guy -- the only one who is in charge of 15 anything in that practice of any importance is Desai, and 16 that's why he doesn't do this. He will not stop. The 17 patients are bucking around. 18

And -- and how does that enter into patient care? Nct just the fact that the patients are under anesthesia or nct yet under anesthesia, but the fact that when he doesn't stop he puts the patients at risk. Because when you have something inside of you and you are moving around, there is a chance that something bad is going to happen. Even staff thought that the speed of procedures, how he was whipping them

1 in and whipping them out put people at risk. At risk. Risk
2 is the issue here.

When they tell him that they want to stop and the 3 patients want to stop and he doesn't -- he disregards that, he 4 is consciously disregarding a known risk, a risk that has been 5 made known to him by the staff, by the people he works with. 6 Now, the CDC, he also said, didn't see how things truly were. 7 You know that when the CDC came over, they came over, they 8 went to the administrative offices, they didn't do any 9 inspection that day. 10

They came over the next day and they started doing the chart review. It wasn't until the third day that they actually did the procedures. Whether the numbers truly dropped or not drop, they were, as he said, tightening up procedures, that they didn't really get a good feel for what was going on at the clinic.

Now, they all felt pressure, or he did, felt 17 pressure because of the patient load. He also says this 18 tackle box. Now, whether it was a box or a tray or something, 19 some physical object was -- was used to have those items in 20 it, the anesthesia items, and it moved room to room. We not 21 only have the tackle box, but we have the -- that he witnessed 22 this move room to room and had another person do the same 23 24 thing.

He also saw open bottles of propofol go room to

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room, and Ann Marie Lobiondo, as you'll see in a minute, also 1 admitted that she carried her own open bottles of propofol 2 from room to room. A regular occurrence. This is the other 3 thing. CRNAs would follow the doctors from room to room. 4 This chart, the 21st, the 21st, we're talking about -- you 5 need to look at -- make sure you look at the doctor to see if 6 the doctor could be in two physical places at the same time. 7 Because the first patient of the day up here, the first 8 patient of the day down here supposedly start at the same 9 10 time.

And Dr. Clifford Carrol is the doctor in both rooms. 11 Look at the times. They don't even remotely match up anywhere 12 along the line. But the one thing that happens on the 21st, 13 and Dr. Carrol said that he actually remembered this day for 14 some reason. He remembered that Desai came and relieved him. 15 Well, that shows up on the record. Dipak Desai shows up here, 16 and he's there for the second patient. Clifford Carrol is for 17 the source patient, then we have Dipak Desai, and then look 18 down here. We have Dipak Desai. 19

You heard that the CRNAs would follow the doctors from room to room. When Dipak Desai is up here and he goes to this room or however it was, we've got Keith Mathahs who is in this room all of the sudden appearing in the record down here as if he followed from room to room, followed the doctor with his propofol, with his syringe, whatever container it had - he

had.

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Whether he brought a syringe with him or an open bottle of propofol, he brought something because there is only one way -- actually, a couple of ways, I guess, to actually get transmission. And the one that they saw, the one that everybody admitted to, the one that is the one that's in all of these studies is unsafe injection practices. CRNAs who use the supplies of other CRNAs. He saw that. He's not a CRNA.

Now, Vince Mione, you've heard a lot about him. 9 He told you that there was a lot of pressure to cut costs. There 10 was -- Desai wanted to use less propofol, less propofol to put 11 patients to sleep. He came up with that bizarre thing about 12 pushing saline in and maybe it'd make it work better, 13 following it along, getting the last bit out of the little 14 needle or making it -- force it into the patient's body. It's 15 not completely clear. 16

He was the one that told you that this is how -- how much time they had to go out and take care of patients beforehand and take care of patients afterward. As soon as he finishes one patient, by the time he's turning around, the next one is being wheeled in.

At 8.9 or 9.4 minutes per patient, believe me, if you're including a procedure, the turnover, the putting on of the -- of the sort of the monitoring leads, all of the things that have to happen, that is not a lot of time. So how long

1 do you think the procedure actually takes place on those? And 2 those are all mixtures of EGDs, the upper endoscopies, and the 3 colonoscopies. So it's not like you just have one of the 4 shorter procedure.

5 Desai, he got so impatient. He's not an 6 anesthesiologist, ladies and gentlemen. He's reaching around 7 and he would push the propofol in himself. How safe is that? 8 Known risk, consciously disregards the risk, putting a patient 9 secondary to his desire to go faster.

He also saw the yanking out of the scopes. He would tell Desai the patients are moving around. He's concerned about the scope being well -- and we're not talking about the very end. We're talking about the scope being well into the patient. The patient is moving around. Desai knows the risk. He's a gosh darn gastroenterologist. He knows the risk and he's consciously disregarding it.

And not only is he consciously disregarding it, but he's ordering somebody who is informing him again of the risk at the very time it's happening to not do something about it. He would start procedures before anesthesia was given. The speed issue, he's not going to wait. You're not going to remember. It's okay to perform an operation.

Who is going to submit? What reasonable person would submit to an operation of any kind knowing that they were going to, at least during the time of the operation, feel

1 every bit of it, the cutting, the sawing, the drilling, 2 whatever, only to know that at least at the end a drug would 3 be given that you wouldn't remember? Who would ever submit to 4 that?

5 He admitted to using open bottles of propofol from 6 other CRNAS. He said it was like an assembly line. He said 7 the start time is when the patient enters the room and the 8 stop time is when the patient leaves the room. That's what it 9 is. And you've got a piece of evidence in there that came 10 from the clinic.

There is no question about this Lawrence Preston 11 issue. It's the policy of the clinic, ladies and gentlemen, 12 that matches the CNS and the ASA quidelines which is that very 13 14 thing. Start time is when they come in contact with a patient, and stop time is when they leave. The base unit that 15 they get -- the reason that they get that base unit, you heard 16 on the witness stand from the insurance people, is because the 17 18 pre-op evaluation, if there is one, is included in that.

He, Mione, said Desai specifically said 31 minutes.
And he said it was because PacifiCare -- this isn't just
something that he said Desai said. He gave an explanation.
Desai said it was because PacifiCare would not pay unless they
were 31 minutes.

24 Well, you know that that's false. You know that on 25 the PacifiCare record, on all of them, that they require the

1 start and the stop time because they wanted to make sure that 2 they knew what the actual time was. That created some 3 problems at the clinic. But that's what Desai uses as his 4 reason. Conscious knowledge.

He's going to have to disregard it for the insurance 5 issue or the theft issue. He was told to bill for 31 minutes. 6 Desai told him to do that. That's where the information came 7 from. He said all of the records were in that range, all of 8 them, the ones that are back and forth, eight minutes or less, 9 This is -- this is key, 10 the patient nine minutes or less. too, about everybody's knowledge, acquiescence, the 11 conspiracy, the aiding and abetting. 12

Desai had whatever influence or power over these 13 people to get them to do this. You heard that every one of 14 these people who came in had never done this stuff before. 15 They leave the clinic. And if they got a job in medicine, 16 they have not done it since, including Ronald Lakeman. And in 17 between while they're at the clinic, they check everything at 18 the door, all their morals, ethics, everything, and they do 19 20 this.

And what do they do? The blood pressure and heart rate were key here because they're not just putting down false times because the times don't matter. They're doing something else falsify a medical record that another professional may rely on in the future, a medical record that would have vital

signs like blood pressure, heart rate. They put that on
 there. Why would they do that? So the record would look good
 if anybody ever looked at it.

What does that tell you? If you're fabricating information on a record so that if anybody ever looked at it would look good, that means you must have knowledge that there is going to be a problem if somebody looks at this and I don't do this. Desai wanted to do as many patients as he possibly could. That comes from Vince Mione. At the VA they would use real times. Desai is not at the VA.

Vince Sagendorf. This is the other Vince. We've 11 got two Vinces here. A little confusion on the witnesses, but 12 a Vince gave some information. At the end of the day he said 13 that the staff would bring him partially used bottles. At 14 lunch he would see open bottles in the other room. Open 15 bottles means what? You've got a CRNA that's left. He hasn't 16 taken his set and -- and tossed it. There's an open bottle 17 That person knows they're going to come in. 18 there.

Vince Mione would use the open bottles of other people. This was something that went on on a regular basis at the clinic. Mathahs told him not to waste any propofol. He was told to do 31 -- add 31 minutes. He was clear that this was about insurance billing and he says everyone knew it. These are anesthesia people.

25 They fill out very few records in the chart. One of JRP TRANSCRIPTION 203

1 those records is an anesthesia record and it has time on it.
2 The time is how it's billed. This is not rocket science.
3 It's not some cloak and dagger thing that you have this guy
4 that's been working for 30 years or 25 years that doesn't know
5 that. They know the purpose of the record. You don't falsify
6 records, first of all, on a medical chart.

Hubbard would try and give him half-used bottles of propofol. Now, she got on the stand here. She got on the stand here and she had no memory of anything. We, as a matter of fact, had to bring, as counsel said, a detective up on the witness stand with her statements to get those statements in. Because I don't remember, I don't do that, never did that practice.

This is another one of Vince Sagendorf, though. He calls -- Desai called him into his office. Now, remember Sagendorf is not one that worked with Desai much. But Desai knows how much propofol he's using. That's how micromanaging he is in the practice. He knows everything that's going on.

He calls Sagendorf into his office and he says, guess what, you're only going to use this much propofol on a patient. Now, what does that tell you? Patients are different weights, they're different ages, they have different medical conditions, they need different amounts of medication to do the same thing. You heard that even on an upper -upper endoscopy, even though it's a shorter procedure, you

might have to actually use more because you have to get
 through the vocal cords. That's a very sensitive area.

But he's restricting staff on what they can use before they even get to see a patient, before they've made their evaluation of a patient. It's -- he knows, knows that that can be risky because of the other issues, other medical issues. But yet in advance he's telling these people to disregard this.

9 Jeff Krueger, Desai wanted to know the exact cost of 10 the endoscopy, colonoscopy. Now, this was the one thing, you 11 heard about the syringes. You heard about that whole thing 12 with the -- what they found with the propofol bottles.

And also the chart that you have back there about the 2007 propofol includes Ms. Stanish's one record for 2007 on the propofol. The propofol is not the issue. The syringes are the issue. We know that the propofol was being reused. There's no question. It's whether the syringes were being reused on the same patient with the same propofol bottle.

If, in fact, you're going to do this, reuse propofol patient to patient, then you have to have enough syringes for at least, in most cases, two syringes per patient. We're going to get to this in a bit, but the numbers here, we've got 17,100 syringes ordered. No -- no lost records on the syringes.

Remember, that was McKesson, it was in town, easy to

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1 get, they would get them the next day. Nothing like the 2 supply issues that sometimes happened with propofol when they 3 had to get other vendors or so forth. There's been nothing 4 that has come out in evidence that shows that there was a 5 missing record regarding syringes.

6 If you have that many patients, multiply 17,100 7 times two. If you're going to give two syringes per patient 8 for most patients. Some take more, some take less, but on 9 average about two. You'll see the averages. You're going to 10 need over 30,000, 34,000 syringes.

So you've got a situation here where, yes, this up 11 here, and I want to make sure it's clear, this is 2007 12 comparison of syringes ordered, not taking into account any 13 preexisting inventory. They kept their inventories lean. You 14 hard Jeff Krueger say that they didn't keep more than about 15 three or four boxes on hand at a time. And how do we know 16 that? Because right at the beginning of the year -- you've 17 got those charts. Look at them. 18

At the beginning of the year of 2007 within a few days of the year they're ordering more -- more supply. So they didn't have a whole room full of syringes at the clinic and then you just ordered some more. Also, what that doesn't take into account is any preexisting inventory going over into 24 2008 from this year.

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I would submit to you that it's reasonable that JRP TRANSCRIPTION 206

that's likely to have balanced. And it doesn't take into 1 consideration any sort of syringes going from clinic to 2 clinic. This does because this -- these are the combined 3 numbers. These are the combined numbers over here for the 4 total number of syringes and the total number of patients. 5 And as you can see, even if you combined all the inventory at 6 both clinics for the entire year, there's not enough for two 7 8 syringes per patient.

With Maggie Murphy, Desai bragged about how fast he 9 could do procedures. What would be the purpose of bragging 10about that? How does the speed of a procedure on an endoscopy 11 12 or colonoscopy going to benefit the patient? What is the 13 purpose of doing those procedures? It's to look for pathology, for something wrong. The faster you look, the 14 faster you do the procedure that you're looking around nooks 15 and crannies and maybe the preps aren't well -- well done by 16 the patients, you're compromising the patients by the speed. 17 18 But he brags about it.

Again, she's another one. All of these people -and, again, why do we have these people all come in and they're all saying the same thing? Ladies and gentlemen, each -- each person had a different little piece, but most of the people saw common things.

The common things are to show you with patient after -- or, excuse me, witness after witness that this wasn't

1 something in isolation or some, as counsel said, disgruntled 2 employee with an ax to grind. This is everybody that came 3 forward was saying these same kind of things if they had 4 exposure to those areas of the clinic.

5 Desai would not stop again. She saw the double 6 dipping. The double dipping is the bottle, syringe, patient, 7 going back in the bottle, the double dipping, contaminating 8 potentially that bottle if that bottle is used on the next 9 patient. So she saw it, said it was fairly common.

10 She was worried about the volume of patients because 11 she thought something was going to happen. Something was 12 going to happen. She thought it would probably be a 13 perforation, but she said something. You couldn't run the 14 patients at this load without thinking that something was 15 going to happen.

She complained to Desai multiple times. This is where we had the conscious disregard. Known risk, she's telling him about a risk. What is his response? Nothing. He didn't do anything. He's consciously disregarding that risk.

Waiting room was so crowded that patients would cheer when somebody got called in. What does that tell you? The volume of patients and the number of procedures being done is taxing everybody, including the patients waiting in the room.

She also saw the tackle boxes and she described

25

1 them. Used a formula for putting times on the record. And 2 you heard that over and over and over again. And you've got 3 the records and you know that they follow that exact formula. 4 Why would a person do that? None of the staff had done that 5 before and none of the staff did it afterward. It's coping.

People who are stressed and have so much that they 6 have to do and they have limited time to get it done do what? 7 They start cutting corners. They start doing what 8 They cope. they can to minimize extra effort so that they can get things 9 That's why procedure charts are filled out beforehand. 10 done. That's why things are done so that they can move the patients 11 through at a breakneck pace. 12

13 Saw Desai take sheets off and reuse them. That's 14 how down in the trenches he is. Take a patients sheet off and 15 reuse it. What does that show you? It's not just to show you 16 that he's, you know, not a nice guy. It's to show you the 17 level that he is willing to go to to save money. Why money is 18 so important to him and what he's willing to do as far as 19 patient care to save money, fractions of pennies, even.

The pre-charting. The patient load would not allow them to do it correctly. To even look at a clock and put the correct times down. They didn't have time. See that? The pre-charting was done not only for speed, but because the times wouldn't match up in case something happened, meaning somebody looked at -- looked at the records. The times all JRP TRANSCRIPTION

had to match. If they follow the formula every time. It's
 all going to match up. You're not going to have a time wrong
 here and there.

Anne Yost, you were told about that. She was told to do it. She wouldn't do it. And she's told specifically make sure those times don't overlap. They're focused on this overlapping in times. She's encouraged to pre-chart for other nurses, a time saving effort, the speed, the time, the pressure.

Can you see a pattern? It's the same thing over and 10 over again. Worried about her license, there's no cleaning in 11 between the patients, 8.9 minutes per patient or 9.4 or 12 whatever it ends up being. Rolling them in, rolling them out. 13 There's not enough time. They don't -- they're not cleaning. 14 They're not doing anything except for rolling the patients 15 through. The volume was so high she couldn't keep up and she 16 was brand new. It burned her out in a day. 17

Janine Drury. Now, she was the pre-op nurse that 18 trained and watched Lynette Campbell. And you heard some 19 things about Lynette Campbell. Lynette Campbell was the new 20 nurse, but Janine Drury, the -- excuse me, the Gestapo of the 21 pre-op area, what does she do? She watches over her like a 22 hawk. You have not one shred of evidence, not one witness, 23 not one piece of evidence that says that Lynette Campbell ever 24 deviated from safe injection practices. 25

1 Mr. Santacroce brought up in his closing, he said, 2 well, you know, Lynette Campbell, ycu know, sometimes they 3 would make a mistake out there in the -- in the room and they 4 would put an IV in and they had to have somebody else put the 5 IV in. I fail to see how that's possible that that has 6 anything to do with a flush. Because if the IV never gets put 7 in properly in the first place, it doesn't get a flush.

8 And if it does need a flush, there's no reason to go 9 back into a saline bottle. There was no reason to do that. 10 They flushed once, the patient was gone. You think those 11 patients were really sitting in the pre-op room for very long? 12 They were getting their IVs in and they were moving out.

Campbell said she never did anything that was a problem, and Janine Drury never saw anything on her that would cause any concern. The CRNAs would follow the doctors into the room and back again. She saw that. So when you've got this right here about the fight, what's the fight about? The fight is about Desai reusing biopsy forceps. Now, that's a mechanism, potentially.

But what happened with the biopsy forceps? 20 Remember, she, Janine Drury, had medical problems and she had 21 to leave. You heard Jeff Krueger come in and talk about when 22 he came over, and we'll get to that in just a second. But 23 The biopsy reuse Jeff Krueger also talked to Desai about it. 24 had stopped prior to the infections at the clinic. The biopsy 25 JRP TRANSCRIPTION

1 reuse had stopped prior to the infections at the clinic. 2 Ruta Russom, the GI tech, saw Lakeman double dip. 3 Lakeman admitted to it. Here's somebody else in case the CDC 4 person got it wrong on the phone. Here's somebody that 5 actually saw him, said it was standard practice and all the --6 all the CRNAs do it.

Described an incident with Desai again. This one 7 was a bad one. It really stuck out in her mind. This 8 incident was an incident that she saw with Desai where Desai 9 is starting on a procedure on a patient. The patient is 10 awake. It's -- it's hell be damned, he goes forward, the 11 patient was awake, remembered it, it upset Russom, it upset 12 the patient. This isn't one where the patient forgot, 13 unfortunately for her. 14

Now, Peter Maanao, and I don't know how that's 15 pronounced. This is an important one because he overhears a 16 conversation between two people, Desai and Carrol, about what? 17 About syringes, the price of them, and that they had to get 18 the staff to reduce or minimize the things that were used. 19 That is corroborative of Vandruff, of Rod Chaffee, saying 20 about the syringe reuse. Linda Hubbard's statement that she 21 was instructed to do that. Desai and Carrol are discussing 22 syringes and minimizing the use of those supplies. This is 23 before the CDC comes in. 24

25 Now, Peggy Tagle saw CRNAs go back and forth from JRP TRANSCRIPTION 212

room to room, so we know it's happening. We know that the
 nurses sometimes, according to her, relieved another CRNA
 before the procedure was done. Actually, that's nursing, not
 CRNAs. I misspoke.

5 So the nurses in the rooms would leave. And the 6 part that's significant about that is if you've got -- if 7 you've got a nurse leaving a room before the procedure and 8 they're filling out charts in advance, the next CRNA may not 9 even be the right person on the record, hence the reason over 10 here where it's even possible where it says Ron Lakeman, he's 11 gone for the period of time in this room.

It's very possible that he could have been there, I 12 mean, with Keith Mathahs, that he follows Desai over for this 13 procedure because who's doing that -- that person? Desai is. 14 Desai was over here, and then he comes across there. Does it 15 seem reasonable or logical that somebody who says that they 16 follow the -- follow the doctor that he would stay in his room 17 if there's another CRNA down there, Lakeman, and that he would 18 then come across to that room when he's got to be back up here 19 again with Desai? 20

You heard about Chaffee. Chaffee has got his issues, no question about it. But Chaffee told you some things that are corroborated by other people. Didn't see any patient care issues with Chaffee. He's not even in the clinic. He's gone in April. He's gone. He never comes back. JRP TRANSCRIPTION

1 He's not any roque employee. He's not there.

Sukhdeo, another one that I have trouble with. He 2 saw Mathahs with a tackle box go back and forth. Another 3 person who saw something like that. Desai said that the CRNAs 4 were using too many supplies. The CRNAs, what supplies do the 5 CRNAs use? Propofol, needles, syringes. That's what they 6 use. They don't use the other stuff. That's what they put 7 people to sleep with. Desai showed them how to squeeze out 8 even the last drops out of K-Y out of a tube. That tells you 9 how down in the trenches Desai is with saving money. 10

11 Clifford Carrol, the first thing he did -- now, this 12 is the doctor. This is the doctor who is, according to this 13 record here, going room to room to room doing patients, 19 14 patients, less than 10 minutes a patient. He feels that the 15 patients are so -- I mean, the patient load is so high that 16 the first act he does when Desai is not there and he gets a 17 chance to do it is to reduce the patient loads.

The Rexford lawsuit, though, the 30-minute issue, 18 now counsel talked about that. The 30-minute issue. He 19 talked to Desai when that came up, and Desai's first statement 20 to him is that there was no billing issue. Second time that 21 he talks to Desai about this is not when he sees that 22 anesthesia record. It's -- it's when there is about a week 23 later that still the deposition thing going on. That issue 24 has come up again. He goes back and talks to Desai. And not 25

Carrol's words, because I asked him about this specifically,
 no Carrol's words, but Desai's words. There is no billing
 fraud. He, Desai, used the word fraud.

Clifford Carrol noticed the anesthesia record filled
out before he starts the procedure. Now, this isn't something
where it's just a little filled out. He said it was
completely filled out before he even walked in the door.
That's vital signs, that's the time, that's everything.
That's when he goes -- he gave up. He got very upset.

He goes upstairs and talks to Tonya Rushing, then 10 they go down and talk to Desai. He confronts Desai about it, 11 and he agrees begrudgingly that the end time had to be the end 12 time. He doesn't justify, well, that's not what the end time 13 is even though our own policy says that, even though that's 14 what everybody else knows. He wasn't surprised by it. He 15 later reviews the anesthesia records and he finds out that 16 17 they all say 30 or 31.

Now, this was important because he remembered the 18 call to PacifiCare. That call that came in from Keith 19 Mathahs, the PacifiCare issue, he remembered it. And Desai 20 took it. Carrol was terrified about the implications of the 21 falsified records because he had done that, and he also saw 22 that all these records are 31 minutes. And he knows how fast 23 he's doing them, and he knows how fast Desai is doing them, 24 and he knows how many procedures are getting done in a single 25

day.

1

Now, Ralph McDowell, he works with Desai only a few 2 Only a few days, ladies and gentlemen, but during that 3 days. time Desai tells him too much propofol. He's the most 4 expensive CRNA. Vince Mione frequently offered him open 5 bottles of propofol. This is a regular occurrence. We've got 6 7 open bottles of propofol being offered to people, going room to room, being in rooms, there's clear mechanisms, vectors for 8 9 this contamination to take place in the way that the CDC saw 10 it.

Desai met with Desai -- or with McDowell right after the outbreak and said, if you are asked if you use multi-use vials, you say to him, what's that? You make your own interpretation of what that means.

Rod Chaffee, he too -- and the reason I put Rod 15 Chaffee here was because the other people saw exactly the same 16 thing. Open bottle in the hand. Who said that they carried 17 an open bottle in their hand from room to room? Ann Marie 18 Lobiondo. Saw Lakeman carrying half-filled bottles of 19 propofol from room to room. He left in April before the 20 infections. Stopped reusing biopsy forceps and snares in 21 Again, that stuff which would have been a potential 22 2006. mechanism wasn't even being reused at the time, even though it 23 had been before. 24

25 Lakeman, these are things attributed to Lakeman.

Again, you'd have a -- this is not to be used against Desai directly. Against Lakeman. Lakeman complained about having to put the 30 minutes on the records. Conscious knowledge of that issue.

Issue about PacifiCare. He's aware of it. Not only is he aware of it -- now, he didn't want to do too many of them because you're going to have to take the next patient because I've done - I've done too many PacifiCare patients. Conscious knowledge of that issue.

I can't make the times work. Does that -- does that 10 scund like somebody that just doesn't know? Just has no clue 11 12 as to what's going on? Lakeman would say that if someone asked they would justify the 30 minutes by what? You heard 13 this a couple of times. By saying that PacifiCare would not 14 pay unless the record said greater than 30 minutes. That's 15 what he said is what the answer would be if anybody asked 16 17 about it.

This was a gem. If the shit hits the fan, I'm not 18 covering for him. Does that sound like somebody that doesn't 19 know what's going on? He knows exactly what's going on. The 20 pressure of that clinic, it shows the conspiracy, it's shows 21 the aiding and abetting because he's coming up with ways of 22 explaining it away if he needs to. He's involved at all 23 levels. When he's the direct actor, when he aids and abets in 24 the process, and when he conspired with these individuals 25

because clearly we're showing an agreement between two or more
 persons to commit a crime. That's a conspiracy.

3 She mentioned, Ann Marie Lobiondo, had open vials of 4 propofol brought to her. She said she would carry them room 5 to room, saw open bottles in other rooms when she relieved 6 other CRNAS. Saline flush was short lived. That's not an 7 issue in the case. That's something that you're considering. 8 May of 2007 that was done. So that was before the clinics.

9 Desai -- this is attributed directly to Desai. 10 Remember 31 minutes anesthesia billing time. Desai would say 11 that it was -- say that in the endoscopy suite that the time 12 had to be over 30 minutes. Desai's direct knowledge 13 encouraging, counseling, advising. It goes to the aiding and 14 abetting. He's using others to perform the tasks that he's 15 directing them to do.

Testified that the anesthesia time is -- well, she knows what it is. It's when you have contact with that patient, when you first see them, when you leave them. That's the anesthesia time. She said that you cannot count the time in between when a -- or when you are working on another patient. You can't do that.

This is another one. Also shows a lack of concern for patients. The conscious disregard of risk to patients, which blends itself into the actual harm that occurred in this particular case to the victims in this. Desai tried to get

her to do something to a patient that she thought was 1 medically not proper for the patient. She argued with him. 2 3 You heard that they were going to get the lawyers, all that. She leaves the clinic. Desai wanted her to do it anyway, even 4 though she expressed to him what her -- what her concerns 5 were, what the risk was. Now, that's important because she 6 7 came in and testified here and you're going to hear that Keith Mathahs had the same thing happen to him except with the 8 9 syringe reuse.

These are statements that Lakeman made to the CDC. Again, this is offered for Lakeman. Lakeman asked Schaefer if she was recording their conversation. She said no, but she was taking notes. Lakeman said he would deny the conversation if it ever came out. Again, does that sound like somebody who thought what they were doing was proper and reasonable?

Even Mr. Wright said, boy, people that deny 16 17 something they've done with the taxes or whatever shows what 18 their mental state is. That's what we have to prove. The 19 difference between civil and criminal in some cases is your 20 knowledge, your intent, and all the stuff that we brought in is to show the knowledge and intent. It's called 21 22 circumstantial evidence of what his knowledge and intent was. 23 Lakeman said if he walked into a room to give a break he would use partially used bottles of propofol drawn on 24 25 another patient. Now, you heard from Ann Marie Lobiendo. You

1 heard from Vince Sagfendorf. You heard those people tell you 2 that there is a risk, pretty clear risk. You don't know who 3 did what to that vial, but you're going to take that risk for 4 the patient. You're going to take that risk for the patient.

5 That's the key here with Ronald Lakeman. He believed he could do that. The chances were low. He didn't 6 7 go out and ask the patient, you know what, I don't know where 8 this has been. I don't know who's done what to it, but I'm 9 going to use it on you and I'm going to put it in your body, 10 in your blood system. And if, gosh, it's got a contamination 11 like a virus or a bacteria, it could cause some problems, but 12 a pretty low risk. He didn't ask the patients.

He admitted, admitted to the practice which the CDC said caused this infection outbreak. Admitted to double dipping, same syringe to draw up more. He would use -- he would even -- here's -- here's another thing. The fact that he would use some technique to minimize the risk indicates that he knows there is a risk.

He's aware of the risk, he did things to minimize it. Now, this is another telling part. He leaves the clinic. He goes to Georgia. He's working there. Does he continue this practice that this is okay? No, he does not. He doesn't do that. They use dedicated vials of propofol there for the patients.

25 Linda Hubbard, she told Schaefer -- she told JRP TRANSCRIPTION



Schaefer that she did not reuse syringes, but she was told to
 do so. Now, that's corroborative. That's Schaefer, the CDC
 person. That's corroborative of the statement that she gave
 that we had to bring our here with Detective Whitely.

5 She was told to reuse syringes even though she didn't do it because it was unsafe. Saw Lakeman reuse 6 7 syringes, changing the needles. So she's actually seen him. Not only does he admit it, but she sees him do it. Lakeman 8 9 told her that that was the way to do it. That was the way it 10 was done at the clinic. She told Lakeman she couldn't do it. But what happens after she tells Lakeman that? She gets a 11 visit from Desai. She gets a visit from Desai who approaches 12 her and tells her that he wants her to do it the way Ron does 13 14 it, to reuse the syringes. He doesn't use those words. He 15 uses these. But it's immediately after she tells Ron that she 16 refuses to do it.

17 Keith Mathahs, he thought the number of procedures 18 -- this is just a reference to a place in the transcript. 19 Mathahs thought that the number of procedures per day were 20 unmanageable. He's in the trenches doing it. He thought it compromised patient care, developed foot rot in 2003 because 21 22 he couldn't leave the darn room. That tells you how much he's 23 getting up and seeing patients before and afterward. He would relieve others for breaks and lunch and 24 25 bathroom breaks. Went to the pre-op area to deal with

patients rarely. It was a rare occurrence for any CRNA to go out to the patient room, the recovery room. Patients going in and out, no cleaning, only a minute or two between patients, Desai was the one that pushed him to move faster, Desai regularly ordered additional medication or ordered that no additional medication be given, contrary to patient care needs.

He bragged about the number of times he -- or about 8 9 how fast he can do procedures. Desai would push Mathahs to start procedures before he was ready. That means that he's 10 trying to fill out -- he's trying to get this anesthesia bill, 11 12 he's trying to get the information that's appropriate or 13 important for him to be able to use this information for a 14 patient. And Desai wants him to disregard that. Desai was 15 emphatic that the times had to be 30 minutes. You've heard 16 that over again. Procedures did not last very long.

17 He knows -- he knew that this time related to 18 billing. He fabricated vital signs on the record so it would 19 look proper. Have you heard that before? Knew it was going 20 to the insurance company. The pre-charting was going on all 21 the time. Why? Because of how fast they were moving. The 22 environment was very stressful. His words. I mean, it was 23 just speed, speed, speed. Come on, let's go faster and 24 It gave him concern that it might cause trouble, and faster. 25 it did.

After 2004 PacifiCare patients were treated 1 2 differently, and that's the whole thing about Desai getting a call, or him getting the call, Desai going in, and afterward 3 he comes back, Desai comes back and tells him from new on 4 5 we're not going to do PacifiCare patients back to back. Conscious knowledge of them, all of them agreeing, a memo 6 brought out so that everybody follows that procedure so that 7 8 nobody makes a mistake on it. It's all about overlapping 9 times. That's what Desai told him.

10 Couldn't waste the propofol. Desai would start procedures before the anesthetic. Desai would know the 11 12 patients were awake and proceed anyway. The sharps container. 13 He would come into the rooms and look in the sharps container 14 to see if there were open bottles of propofol or syringes to 15 see if they were wasting it or not. He paid attention to it. He saw if there was a syringe on the counter. He would get 16 upset by that because if there was any propofol in it, what 17 18 would happen? It would probably get discarded.

19 It is common practice to use the bottles for more 20 than one. Desai instructed the CRNAs to reuse syringes on the 21 same patient. This is Mathahs telling you this. This is 22 direct action of Desai ordering the reuse, the forbidden 23 thing. They're reusing the propofol. You can't reuse the 24 syringes and the propofol together. This is Desai ordering 25 that practice. This was common practice according to him.

He expressed his concerns about it. And this is 1 2 where you have to make sure that we have proven the issue 3 about Desai's knowledge. Not only his knowledge and training 4 and so forth, but Mathahs even confronts him about this and 5 expresses the risk to Desai. And what -- what is Desai's response to that? Desai's response is just go ahead and do 6 7 That's what his response is to that. Hey, if we reuse it. the syringes and we reusing the bottles of propofol, this 8 9 could cause a problem. Just do it. And if you then do it and you have the knowledge whether you're the direct actor or 10 Desai, you're both equally guilty. 11

Now, this is important, and this is where these 12 bottles come in. July 25, 2007. And all this is in evidence. 13 14 You can make the calculations yourself. Room 1, Ms. Hubbard. 15 If you go through and add up all of these milligram amounts, 16 you come up with, for Room 1, 5400 milligrams. There are 66 17 -- if you add up, if you go through this on each one of these 18 things and you see where the times are, the first one, for 19 example, has 350 cc -- or, excuse me, three 50 milligram 20 injections. That's 5 ccs a piece, one 10 cc syringe.

That means if you weren't reusing syringes, you'd have to use two syringes. Go through that process on every one of these, and you come up with, in Room 1, that they would have -- if they were not reusing, they would have needed 66 syringes for that room alone that day. They did 34 patients, JRP TRANSCRIPTION

1 15 EGDs, 19 colons, if you can see that.

2 Room 2, Lakeman. This is how much was used. 4102
3 milligrams of propofol, 49 syringes if no reuse, 31 patients.
4 Again, a mix of -- of the procedures. A total of 115 syringes
5 if no reuse, 65 patients, that's 1.77 syringes per patient if
6 nc reuse.

7 Now, the propofol, same thing, the 25th. 20 -these are 20 ml bottles. There were two used that day. 8 That's 400 milligrams, 1 milliliter per 10 milligrams. 50 ml 9 bottles, 20 were used. 10,000 milligrams. According to 10 injection amounts, that number, the 5400 from the previous and 11 12 the 4100 from the previous slide gives you 9,502 milligrams. You subtract -- or the checkout amount was this amount, the 13 14 10,400. If you subtract that, you end up with 8 -- cr 898 15 milligrams which is 8.98 mls. That's how much was wasted.

That is a representation of how much propofol was administered to 65 patients. That's how much was given, that's how much was wasted. They weren't wasting a drop. If you start thinking about the amount of waste from just residue inside a bottle that doesn't get out and in that many bottles, that's how much, ladies and gentlemen.

Now, on the 21st, Room 1, Mathahs, same -- same deal. This is Mathahs now. 5970 milligrams. If no reuse, going through that same process, it would have been 71 to 73. Depending on how you do it. There was a way to make it less,

so I made it less because I didn't want to misrepresent. So
 71 to 73 syringes if no reuse.

Room 2, Lakeman, he used this much. 57 syringes if no reuse. He had 31 patients. So there was either 129 or 131 syringes that would have needed to be used that day if they had not reused the syringes. 2.05 or 2.08 syringes per patient. You know from this chart here, the number of patients, that they didn't have enough for two syringes per patient. With all inventory combined at both clinics.

10 The propofol, same thing. There were no 20s used that day. There were 24 50s used that day for a total of 11 12 12,000 milligrams. Reported injection amounts were this, the 13 amount checked out was that, and you subtract those, and it's 14 1260 milligrams for a total of 12.6 milliliters. That's the 15 waste. That's a representation of how much was actually given to patients that day. This is how much was wasted between two 16 rooms, two CRNAs, 63 patients I think it was that day. 17

They did not waste a drop and there weren't enough syringes to give that medication the way it was supposed to be given. They had to do both. The cardinal sin from everybody that's testified here. They had to reuse syringes and reuse propofol on the same patient.

That -- and how did the CDC, how did -- when Miriam Alter came in and said in New York, remember, that they couldn't figure it out, the person hadn't disclosed that they

1 had done this stuff. They had to go back to this, the supply 2 issue. They found out that there weren't enough supplies to 3 do what the person said they were doing. It is exactly the 4 same situation here. There were not enough supplies.

5 Now, the scopes, this is a possibility. Langley 6 said very low likelihood. Alter said it has never been the 7 scopes. In all of those studies, it's never been them. No 8 evidence that she saw here that implicated the scopes. And 9 she went back and looked at all the data that they had done. 10 And not only did she concur, but she said it's not the scopes.

The defense expert, Mr. Worman even, low, low, low, low probability that the scopes would be the mechanism. And he's testified previously in another case where three patients, it wasn't the scopes.

15 The infected patients were done back to back, and I'm talking about these right here. If it's the scopes, for 16 these patients to get infected, ladies and gentlemen, from the 17 18 scope, because there's no way that you're going to go in two minutes cleaning. You'd have to literally take the infected 19 scope out and take it and put it right back in the next 20 21 patient and take that one out and put it right back in the 22 next patient, three in a row. It's not the scopes.

None of the infected patients had any common scopes.
If you look at your chart here, there is a place, and let me
see if I can find it. Where is it? Oh, here it is, scope

number. That column, none of the scope numbers are the same.
 It's not the scopes. The biopsy forceps had been
 discontinued. They didn't reuse them anymore.

There's only so many ways you can get a blood-borne transmission. They saw the practice. It was admitted to, it was observed. The CDC looked into the cleaning and found the Medivators at that time were functional. You head about the stuff that happened before, but they were functional at this time. Another reason why it's not the scopes.

10 The saline flush issue. Different nurses on -- on 11 9/21. There were two different nurses that worked on 9/21. 12 No evidence at all that there was any issue between -- and you 13 heard that from Janine Drury, Jeff Krueger, and Lynette 14 Campbell.

15 Now, the saline flush issue. They had no reason to No one observed any reuse or anything by any person. 16 reuse. 17 And Stacy Hutchison, what about Stacy Hutchison? She came in 18 and testified to what? She came in and told you that she was 19 the one person out of the whole group who actually remembered her flush. She remembered it because she was curious. 20 She watched it. 21

What did she tell you? When the person came out to do the flush, they popped the top off of a brand new saline bottle. A brand new saline bottle was used for her flush. There is no way that Stacy Hutchison down here who gets a

brand new saline bottle could be infected from this patient if
 it was through that mechanism.

And we know that on the 25th it was Ziyad Sharrieff was the source and that the contamination started with him and moved to Michael Washington, both of which were Lakeman's patients, and no nurse or saline flush was implicated there. It's not the saline flushing.

B Disregard for the patient, Sagendorf. Started 9 procedures and would not stop despite knowing. Desai's 10 knowledge of risk, Krueger. This is -- this is one related to 11 Krueger where we know absolutely that Desai knew the risk. 12 And why? It's not a stretch to see how he disregards it when 13 he's disregarded it here.

You've got Krueger. Desai was ordering staff to reuse the biopsy forceps. Krueger goes to Desai and the tells him, he says, look, you can't do this. He presents him with a paper, a scientific paper that says this is risk behavior. You cannot do it. Desai acknowledges, Krueger goes away because, remember, he was at Burnham.

Later, Krueger hears from the staff that, hey, look, he's pressuring us to do this again even though I've just had the conversation and I've given him the paper and he knows the risk and he's agreed to not do it because of the risk. What happens? He had to go back over to Desai.

25 And the only reason that that ever happened, why the

1 reuse stopped, was because the manufacturer found out about it 2 and they started brining in the scopes -- or, not the scopes, 3 but the biopsy forceps on a par rate or a par thing where they 4 just kept replacing them so the staff never could run out and 5 they didn't cost Desai anything additionally. So because they 6 didn't cost Desai anything additionally, he didn't care. So 7 it's not the biopsy forceps.

8 Ziyad Sharrieff, the source patient. That man did 9 not want to be part of the infection. That man certainly, 10 Kenneth Rubino, didn't want to. Michael Washington was 11 infected. You saw him. Who among you would want to have a 12 liver transplant regardless of how much money you got? Stacy 13 Hutchison, Patty Aspinwall, Gwendolyn Martin, Sonia Orellono, 14 Carole Grueskin.

Dr. Worman on the stand, absolutely no evidence in the literature of any infiltration of the hepatitis C virus into the brain. Three out of the four papers I provided to him show just that. Invasion of -- hepatitis C viral RNA into astrocytes within the brain.

Lewis came in and told you that she was mentally okay, he was her patient -- excuse me, she was his patient -until she had the colonoscopy. And even until later when she started getting the anxiety and everything related to the fact that there was an outbreak and she was infected and she didn't know what that meant. She's never recovered.

Rodolfo Meana. You know, this is the -- the murder charge. Ronald Lakeman is -- is partly -- I mean, his -- his role here is not a direct actor. It's through an aiding and abetting, the conspiracy. You are liable for the foreseeable results of those actions which you had specific intent to engage in.

7 It's not that you wanted to engage in -- this is not 8 first degree murder. This is second degree murder. It's 9 engaging in an unlawful act, the acts that he was talking 10 about, which are putting people at risk. Putting people at 11 risk, a conscious disregard for that risk. A conscious 12 disregard for the risk, a known risk, consciously disregarding 13 it, and somebody gets death as a result of it.

14 Now, Rodolfo Meana, this is where he is later. Look at his abdomen. That's that ascites fluid that we talked 15 16 about, that buildup of fluid. That's what he was at the end. 17 And when we look at -- remember Worman was saying, gcsh, if I 18 had any evidence that said that there was this hepatcrenal 19 syndrome onboard with this patient, yeah, I might revisit my 20 opinion. But I didn't see any. Oh, I saw some sort of thing about mention of it somewhere, but I didn't see any evidence 21 22 of that.

Did you review the medical records? Yes. The hospital in the Philippines, the records that are sitting right over there, this is the record that I was trying to find

1 the other day. And that part right there is a note on the 2 first section of the record. And you've got the real record 3 to look at, but that says assessment, hepatorenal syndrome. 4 It's in the medical record that is in evidence sitting right 5 over there.

Now, that's not all. In the same medical record
there is a chart, a piece of paper that has his past medical
history, past medical history. July 21st to 26th of 2011,
edema ascites cirrhosis issues. The beginnings of kidney
insufficiency. The beginning. So he's got cirrhosis, he's
got liver problems onboard, and now he's getting the
beginnings of kidney problems. Not the other way around.

We move forward in time to August 24th and 27th of 2011. We've got hepatorenal syndrome of kidneys. 2012. He has now -- has a diagnosis of this, which began up here, progressed down here, in his past medical records. This is not the other way around.

Hepatorenal syndrome, as you were told by the defense expert, was that the failure of the liver causes damage to the kidneys, and then results in - as a cascade multi-system organ failure, which the encephalopathy up in the brain because the toxins that are building up causes the brain to eventually shut down and you eventually die.

This is in the medical record, not the -- not the certificate of death, the medical record in this. And you'll

1 have it. It's talking about CP arrest, cardiopulmonary 2 arrest, secondary to hepatitis and uremia, and over here it's 3 talking about secondary, again, to hepatitis C. The hepatitis 4 C caused these conditions. The autopsy in the Philippines 5 confirmed that fact.

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And Dr. Olson, who was present, who did her own 6 7 evaluation, saw her own thing there, brought tissues back and looked at the tissues, concurred with that very thing. So the 8 9 actual death certificate, which mirrors what was in the 10 hospital record, remember, the autopsy report follows the 11 hcspital record and is more complete than the hospital record 12 because now they've cut the body open, they can do things, and 13 lcok inside of it, intestines and the like.

This matches up with the hospital record. This 14 whole issue about why there were some wording differences, 15 it's the same exact kind of thing. But even in the hospital 16 record, even in the death certificate, the underlying cause is 17 18 hepatitis C. If he had driven down the road with his condition and been hit by a car and was killed, that would be 19 supervening intervening cause of death. Desai and Lakeman 20 would not be on the hook. 21

The fact that none of that stuff happened means that although you see the word immediate, that means that it has to have been the focal point of the cause of death. That had to have occurred in unbroken chain to the death. The fact that

because of these things you can -- other organ systems failing
 at the time does not mean that you are not responsible.

Alane Olson, her decision, what she testified to is that he ultimately died as a result of chronic active hepatitis cause be hepatitis C. Now, Ronald Lakeman and Dipak Desai sit in two different positions. Ronald Lakeman is only brought into this because it is aiding and abetting his -- and conspiring -- his agreeing to that process.

9 In the scheme of things, the more culpable person is 10 clearly Desai because he's the one that directed this, he ran 11 the clinic, he set the -- the policy, he set the -- not only 12 the policy, but the atmosphere in that clinic which caused the 13 conditions for these people, Ronald Lakeman being one of them, 14 to engage in unsafe injection practices which you know from 15 the evidence caused the death, ultimately, of Rodolfo Meana.

Ladies and gentlemen, that -- that's all I have. At 16 the end of the day the State believes we have proved to you 17 18 beyond any reasonable doubt that the crimes of criminal 19 neglect of patients and performance of an act in reckless 20 disregard and second degree murder have been proved beyond any 21 reasonable doubt, that the mechanism in this case of the 22 transmission is through the unsafe injection practices, the 23 propofol being it. There is not another alternative that is 24 plausible.

Ladies and gentlemen, one of the last things you --

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I want to say to you is that you have two instructions. And I
I use an example to illustrate this, the direct and
circumstantial evidence instruction, which is 35, and the
reasonable doubt instruction, which is 32.

5 Imagine if you would that you are not in Las Vegas 6 at this particular time. You are someplace where it is cold, 7 really cold. And you're at work and you're coming home, and 8 you hear on the radio as you're coming home that there is a 9 snow storm coming in.

A snow storm coming in that night, and you drive home, and as you're driving home you get out of your car and snowflakes start to fall. That's direct evidence that it's snow or snowing. You see it. You can feel it. You can taste it. You go into your house and everything is all snowy.

Now, same situation except for you hear that, you go home, you don't see any snow, you get inside the house, you are sitting around the table, you heard the wind rustling outside. The leaves that are still available, if there are any, are rustling around. You go to bed.

You wake up the next morning, you come out to get your paper, and lo and behold, directly in your field of vision outside your front door there is snow covering the cars and the trees and the houses and so forth. That is circumstantial evidence that it snowed last night. Now, is it possible that it didn't snow last night? JRP TRANSCRIPTION

Is it possible that while you slept a legion of noiseless snow blowers blew through the area blowing snow everywhere that you were going to come out and look at that morning? Is it possible that Steven Spielberg or somebody came in and put stuff out there that looked like snow? Is it possible?

I submit to you, ladies and gentlemen, that anything is possible. But is it reasonable? I submit to you that in that case no. In this case is it reasonable for there to be any other mechanism of transmission in this particular case other than unsafe injection practices and the mechanism of that through the use of propofol with the -- with the CRNAs. That is what you have to determine.

The very last thing, then I'm done. The theft counts, the insurance fraud counts, you put knowingly false information into an insurance record that you're submitting for the purposes of billing, that's material, to get more money than you should, you're done. That's insurance fraud.

18 The actual amount that you get back if you represent 19 to the company that you're putting in a legitimate claim, you 20 heard every single one of these witnesses that came in and said we rely upon good faith claims. We believe the people 21 22 are doing it. If we have any reason to not believe it, we 23 don't pay the claim. If they don't pay the claim, they're not entitled to any of the money regardless of how legitimate or 24 25 not legitimate that is.

They're not entitled to any of the money. That is 1 2 the theory by which the State goes for. You can parse this out. If you parse it out like counsel has mentioned, then 3 there are -- then most of the thefts are misdemeanor theft 4 counts. Some of them none at all, if that would be the case. 5 But even on the flat rate ones, if you're submitting a claim 6 7 for a -- a false claim, and the insurance company will not honor it if there is false information there, then you're 8 9 getting every dollar more than you would ever get back 10 normally.

And in this case, Sonia with Culinary, Sonia 11 12 Orellono with Culinary was \$306 was the charge. Stacy Hutchison with HPN, the flat rate was \$90. Kenneth Rubino 13 14 with Blue Cross Blue Shield was \$245.12. Patty Aspinwall, 15 United Healthcare, was \$249.92, and Blue Cross Blue Shield, 16 the secondary, was \$56.48. Ziyad Sharrieff with Blue Cross 17 Blue Shield was \$206.82. Michael Washington, the VA was flat 18 rate, that was \$100. Carole Grueskin was with HPN. That was 19 a flat rate, that was \$90. Gwendolyn Martin, PacifiCare, was 20 \$304. Rodolfo Meana with Secure Horizons, also PacifiCare, was a hundred and thirty, I believe one or nine, dollars and 21 22 20 cents.

The two that were separate counts of obtaining money under false pretenses individually were Sonia Orellono at Culinary of 306, above the \$250, and Gwendolyn Martin of

PacifiCare of 304, above the \$250. The rest of them are 1 aggregated. You add up the dollar amounts. The State submits 2 3 to you that we get to count the entire dollar amount because they weren't entitled to any of it because they were filing 4 false insurance claims and there is not a shred of evidence 5 that --6 7 Objection, Your Honor. That's a MR. WRIGHT: misstatement of what's charged. That's a very --8 9 THE COURT: I'm sorry. The bailiff was speaking to 10 me. I'll see counsel at the bench. And there's some ringing 11 going on up here. (Off-record bench conference.) 12 THE COURT: Sustained. Mr. Staudaher will rephrase. 13 14 MR. STAUDAHER: The insurance -- excuse me. The anesthesia times were inflated, which would have resulted in 15 16 paying them money which would have been in excess of what was 17 allowed. That's what it says in the indictment. 18 The State's theory is that any money would have been 19 in excess of what was allowed because of the falsity of the 20 record on those claims where it was a flat rate. The rest of them where there were dollar amounts involved where they got 21 specific amounts of reimbursement because of the time that was 22 23 given that was false, they weren't entitled any of it because 24 they would have never been paid. 25 Ladies and gentlemen --

1 MR. WRIGHT: Mischaracterizes the evidence, Your 2 Honor. The evidence and the testimony was that they would 3 resubmit it correctly.

THE COURT: All right. And, ladies and gentlemen, again, it's your recollection of what the witnesses said regarding that that should control. Whether the witnesses said to resubmit or they wouldn't pay or they would pay anyway, that's entirely up to your recollection. All right.

9 MR. STAUDAHER: It all comes down to trust and 10 whether or not you consider that those things that we've 11 mentioned, that the patients -- I mean, that there wasn't a 12 known conscious risk that was disregarded by these people for 13 the purpose of getting money, more money, that every single 14 person that was involved in that clinic did what they did.

These two individuals, meaning Desai and Lakeman, Desai running the show and directing and encouraging and the like, and Ronald Lakeman agreeing to do that and doing it, and instructing others to do it. He's involved. They're intimately involved, both of them. We ask you to come back with verdicts of guilty on all charges. Thank you.

21THE COURT: All right. Thank you. And, Mr.22Staudaher, would you take --

Okay. Kenny, take that down so I can see the jury.
And the clerk will, in a moment, swear the officer
to take charge of the jury.

1 (Officer sworn to take charge of the jury.) 2 THE COURT: All right. Ladies and gentlemen, in a 3 moment I'm going to have all 17 of you follow the bailiff 4 through the rear door. Because of the late hour, you will not 5 be deliberating tonight. We will have you return tomorrow to 6 deliberate.

As some cr all of you may know, a criminal jury is composed of 12 members. Five of you are the alternates who were designated prior to jury selection so that the selection of the alternates is somewhat random. Those are Jurors No. 14, Ms. Harsonyee (phonetic), Juror No. 15, Mr. Nadonga (phonetic), Juror No. 16, Ms. Conti, Juror No. 17, Ms. Stevens, and Juror No. 18, Mr. Keller.

Now, the role of the alternates is very important and it is not over. So before you leave, please leave phone numbers where you can be reached. Because if, God forbid, prior to the time a verdict is reached, one or more of the other jurors cannot fulfill their obligations, you will be called in.

For that reason, until you hear from someone from my chambers, the bailiff or the judicial executive assistant, that the jury has reached a verdict, you must be mindful of the prohibition on discussing the case, reading, watching, listening to any reports of or commentaries on the case, doing any independent research relating to the case, and forming or



1 expressing an opinion on the case.

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For the rest of you who will be deliberating tomorrow, obviously tonight you also must be mindful of that prohibition. You're not to do anything relating to this case, discuss it anything like that, until you return tomorrow and begin your deliberations with one another.

In a moment I'm going to have all of you get your belongings and your notepads, which you will be turning over to the bailiff before you leave. He will be distributing parking tickets, vouchers, whatever, to all of the jury so you can get your cars tonight.

And then the bailiff will give you further directions on when to return and make sure that the alternates all have good numbers so that if, God forbid, somebody becomes sick or something like that we can be able to contact you.

So having said that, if you'd all get your things and bailiff through the rear door.

THE COURT: We probably already have all of the lawyer's cell phone numbers, but just make sure that Denise has good numbers for all of you. As I said, they'll be going home tonight and then probably 9:00 or 9:30 tomorrow coming back.

(Jury recessed at 6:58 p.m.)

24 MR. SANTACROCE: I wanted to put an objection on the 25 record. During Mr. Staudaher's closing he asked the jury

improperly if -- how would they feel if they --1 THE COURT: Yes. Put --2 MR. SANTACROCE: -- had to have a --3 THE COURT: -- themselves in the --4 5 MR. SANTACROCE: -- liver transplant. THE COURT: -- shoes of the victims by having a 6 7 liver transplant. 8 MR. SANTACROCE: Improper prosecutorial misconduct. 9 THE COURT: I caught it as well, but I didn't sua 10 sponte do anything because then he moved on and I figured that 11 might be worse and nobody objected. 12 But I did -- I did catch it as well when he said how 13 would you like to have a liver transplant. And that's kind of 14 asking them to put themselves in the shoes of the victims. 15 And he moved on and that's why I didn't call him to the bench and nobody asked. 16 17 But you're right, Mr. Santacroce, I caught it, too. 18 All right. Well, like I said, leave numbers and --19 MS. WECKERLY: Just for the record, from the State's 20 perspective, that certainly wasn't the only improper argument 21 that was made during the closing. 22 THE COURT: Yes, Ms. Weckerly. As you know, I 23 cautioned -- believed, and I mentioned at the bench, that I thought Mr. Wright was crossing the line when he suggested, 24 25 when he was disparaging opposing counsel by making the JRP TRANSCRIPTION

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1 suggestion --

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MS. WECKERLY: Yeah.

3 THE COURT: -- that there should be some kind of 4 disciplinary bar action taken against opposing counsel. I 5 felt like that was crossing the line to disparaging opposing 6 counsel.

> Is that what you were talking about, Ms. Weckerly? MS. WECKERLY: That was one of them.

9 MR. WRIGHT: I -- I dispute it. I did not suggest 10 any disciplinary act against counsel. I said the State of 11 Nevada. And I said counsel, as officers of the court. I 12 don't buy this distinction that I can put up someone and let 13 them say something when I know it is false. They didn't 14 commit --

THE COURT: No, I --

MR. WRIGHT: -- perjury up there. Those witnesses gave false information and it was 11 of them aided by the State. And that is unethical and improper. I didn't say anything about that in my closing argument. I didn't say it was unethical. It happens to violate the prosecutorial function of the district attorney's office.

THE COURT: Well, perhaps I misheard you because what I heard was something about their licenses or something like that --

MR. WRIGHT: I did not.

MR. STAUDAHER: That's what the State --1 THE COURT: -- which, to me --2 3 MR. STAUDAHER: -- heard, as well. THE COURT: I'm sorry? 4 MR. STAUDAHER: That's what the State heard, as 5 6 well. 7 THE COURT: I heard something about their licenses, 8 which, to me, is their license to practice law which suggests 9 that there should be a disciplinary action taken against them. 10 You know, again, I -- I didn't say anything during when the 11 comment was made. 12 They didn't object, but, to me, I think it was getting to disparaging opposing counsel by suggesting that the 13 -- I mean, the suggestion was, I thought, that the State Bar 14 should, you know, take some action against their licenses. 15 That was -- you didn't say that explicitly, but that was the 16 17 suggestion. For the record, Ms. Weckerly, what else are you 18 19 alluding to? 20 MS. WECKERLY: I just wanted -- I just wanted to clarify on the record, seeing Mr. Santacroce felt like it was 21 22 necessary to add that in, that, you know, there were a lot of things said during defense counsel's argument. We didn't 23 24 object. Certainly objecting during that point is sort of a 25 strategy call --

1 THE COURT: Right. MS. WECKERLY: -- for us. But it's not like it's 2 3 proper argument. And it went way over the line in my mind. And it's -- you know, we don't have a remedy to that, so it 4 should --5 THE COURT: Yeah, but I think --6 7 MS. WECKERLY: -- be on the record. THE COURT: -- I think it's important, Ms. Weckerly, 8 9 if it ever comes to an appeal and the Court's looking and 10 doing some kind of a totality analysis or something like that, 11 what exactly you're referring to that Mr. Santacroce did. 12 MR. SANTACROCE: Did I do something that -- she 13 didn't object. 14MR. WRIGHT: I don't understand. Tell me the line. I mean, I'd like a ruling. Tell -- tell me a line I crossed 15 16 over. I didn't engage in prosecutorial misconduct. I didn't 17 do what went on in this courtroom. 18 THE COURT: No one --19 MR. WRIGHT: And so --20 THE COURT: All right. 21 MR. WRIGHT: -- all I did --22 THE COURT: All I'm saying -- no one is saying that 23 you did anything wrong in your questioning of the witnesses or your presentation of the evidence or that you were unethical 24 25 in any way.

The implication was sort of, I thought, and I think 1 2 Ms. Weckerly and Ms. Staudaher thought, was -- maybe I heard it wrong, was that you were somehow suggesting that they 3 should be disciplined by the bar in some way. I mean, I 4 5 thought heard licenses or something to that effect. I'd don't remember the --6 7 MR. WRIGHT: I said a lawyer exceeds his license. 8 That's a phrase --9 THE COURT: Okay. 10 MR. WRIGHT: -- I use as an officer -- when I'm in 11 here I exceed my license when I put a witness up there and I 12 let them say something --13 THE COURT: There is nothing to -- you know, I think 14 that that's certainly fine comment that -- that they put up, 15 you know, witnesses who testified inconsistent with what was known in the documents. You said that. I don't know that --16 17 MS. WECKERLY: Right. But that doesn't mean that 18 they're lying. 19 THE COURT: That doesn't --20 MS. WECKERLY: That's their perspective. We don't 21 show them the procedure books and go, hey, Marion, count this 22 back up, you're wrong on that assessment. 23 MR. WRIGHT: I got news for you. I can't put a witness on, but I -- I get some nutcase that thinks it's --24 he's going to put my client somewhere else or something, and I 25 JRP TRANSCRIPTION

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know it's absolutely false, and I'm just going to stick it on? 1 THE COURT: Well, I don't --2 MR. WRIGHT: I got a better shot --3 THE COURT: Okay. 4 -- at doing that --5 MR. WRIGHT: THE COURT: I don't know if --6 7 MR. WRIGHT: -- as a defense attorney --THE COURT: -- the State wants to --8 9 MR. WRIGHT: -- than the State does. 10 THE COURT: -- defense themselves. But I think, you 11 know, when you went through the numbers and you said, oh, 12 there was 77. I'm looking at -- well, 60 to 80, I don't know, 13 that fits in there. I don't think it was so far above what 14 was in the books to suggest that it's deliberate prosecutorial 15 misconduct. MS. WECKERLY: We brought in the books. 16 THE COURT: And that was their -- that was their 17 18 perception, that they were rushed. And so, you know, I don't know if the State wants to defend themselves in any way, but 19 20 that was my perception of -- right or wrong. I'm sitting here, I'm listening to everything, that was my perception. 21 Mr. Staudaher, in your own defense --22 23 MR. STAUDAHER: Part of it was, and I laid it out for the jury in the very beginning and I said it in opening. 24 25 I said, look, these witnesses -- these witnesses are going to JRP TRANSCRIPTION

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1 come and we -- you're going to have to evaluate what you
2 believe and don't believe with regard to them because
3 obviously they -- they have different issues.

They saw everything going bad at the clinic and I didn't do anything wrong, which is inconsistent with the evidence. I'm telling them that up front that there's going to -- they're going to hear stuff from these witnesses that's inconsistent with the evidence as we know it and that it's in. So I don't know what more to do to even preface that.

10 I wasn't required to do that, but I think that that 11 was something we did in advance to give them, the jury, a 12 heads up that these are not clean, untainted witnesses that 13 are going to be coming in in this case, that they got 14 information, that you're going to have to evaluate it. And 15 there's an instruction on that that the -- that the Court gives. So I don't know what to say, I mean, other than 16 17 it's --18 THE COURT: Well, I -- I don't know. 19 MR. STAUDAHER: -- I thought it was improper, as 20 well. THE COURT: I think that the defense would be 21 22 complaining if they had shown them all the books and said, hey

24 day, then the allegation would be witness coaching. So, I
25 mean, I -- I don't know --

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there's 55 on this day, make sure you say there's 55 on this

MR. WRIGHT: I disagree. I don't -- I think you're trying to sugarcoat what occurred here. I've moved for mistrials over it.

THE COURT: All right. Well, I --

5 MR. WRIGHT: I think it was absolutely improper back 6 at the beginning of the case when they -- when they said that 7 a motive of this was to save money on propofol and that's why 8 they went for 50s, and they put witnesses, and they put up --9 THE COURT: Hey.

MR. WRIGHT: -- false --

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11 THE COURT: Wait a minute. First of all, I'm not 12 trying to sugarcoat anything. Secondly, I agreed with Mr. 13 Santacroce who said it was misconduct. Thirdly, I agreed with 14 you on the Nancy Sampson testimony on the dosages and the 15 vials and everything else which wasn't accurate.

However, I do not agree with you that if a witness's perception is 70, and the true number is 55, that somehow the State should show them the book and say, hey, you're wrong. Look, it's 55, testify to 55. To me that is clear witness coaching and would be -- would be not what they should do. I mean, it's their perception as Ms. Weckerly said. So, no, Mr. Wright, I don't --

MR. WRIGHT: But --

THE COURT: -- agree with you on that. That doesn't mean I'm trying to sugarcoat anything that the State may have

1 done. All I'm saying is that is my perception sitting up 2 here. My perception may be right, it may be wrong. But all I 3 can tell you is what my honest perception is.

And my honest perception is when I look at those 4 numbers and that's what people perceived, that the State is 5 not knowingly putting forth perjured testimony, number one. 6 7 And number two, that it would have been wrong from them to 8 tell these people, hey, no, that's the wrong number, testify 9 to this right number here, which we can show you in the book. 10 I mean, they can't do that because if they're 11 mistaken, that has to come out, and then that goes to their 12 overall memory and credibility. Like, hey, they said it was 80, what else are they confused about? What else are they 13 mistaken about? 14 15 I'm not going to debate this with you. That's my 16 perception. 17 Ms. Weckerly, do you want to put --MS. WECKERLY: No. 18 THE COURT: You know, you said Mr. Santacroce did 19 something wrong. I didn't really catch it, but I think to be 20 fair to Mr. Santacroce, you ought to say what it was. 21 MR. SANTACROCE: Yeah, I'd like to learn. 22 23 MS. WECKERLY: No, I'm not -- no, that's not where 24 my objection was. 25 THE COURT: Okay. Because like I didn't -- I didn't JRP TRANSCRIPTION 250

1 catch anything and --

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2 MR. WRIGHT: I didn't -- I didn't state it was 3 perjury of the witnesses, and I don't think if you read the 4 prosecution function in the ABA standards --

THE COURT: Mr. Wright --

MR. WRIGHT: -- what they are not supposed to do is 6 7 ask the witness the question and -- and pull it out of them 8 when they know. I didn't say tell them to give a different 9 answer. The prosecutor cannot elicit information or 10 inferences that are false, and you don't bring it out. And it's right in the ABA standards for the prosecution function. 11 12 And that's exactly what happened here, and it happened with the propofol pricing, also. 13

THE COURT: I agree with you on the propofol part. MR. WRIGHT: Okay. That is unethical and it violates the standards of practice. And when I pointed it out, it's like I'm doing something wrong for pointing it out to the jury.

19 THE COURT: Who said you were doing anything wrong? 20 MR. WRIGHT: I thought I crossed over the line and I 21 can't find the line.

THE COURT: Well, perhaps I misheard you or perhaps I didn't articulate it, but I think Mr. Staudaher and Ms. Weckerly kind of heard it the same way I heard it, which was somehow suggesting, you know, that they, I don't know,

shouldn't be lawyers or shouldn't -- that's kind of how I 1 heard it, but I don't know what they heard. 2 MR. WRIGHT: I didn't intend that. And if I -- it 3 came out that way, I apologize and I misstated it. Because I 4 -- I didn't intend -- I don't go -- I don't complain and send 5 6 anybody to the bar. I didn't -- on my go -- go free letter 7 was Scott Mitchell. I didn't run to the bar and say you were unethical or something. I don't do that, and I didn't intend 8 9 to. 10 THE COURT: All right. Well, maybe it was misheard 11 or whatever. 12 MS. STANISH: Judge, just to note, I see that some of the State's exhibits have tabs all over them. I just want 13 to make sure all the little go-to marks --14 THE COURT: Okay. Basically --15 MS. STANISH: -- are taken off. 16 17 THE COURT: -- we're making sure that the tabs are off, and you folks have made sure that any highlighted 18 19 exhibits have been substituted out for non-highlighted 20 exhibits; correct? MR. STAUDAHER: I believe so. 21 22 THE COURT: Okay. If -- I'm sure she won't catch anything. If she does catch something, then obviously the 23 24 court clerk will contact you and make sure we have a clean exhibit. But I think --25

MR. STAUDAHER: The only --1 2 THE COURT: -- they've all done that already. 3 MR. STAUDAHER: -- highlighting that we ever did was in yellow. A photocopy of that doesn't show up. So if 4 5 there's an issue with -- and I think I saw the same thing with defense counsel's exhibits. We can just have them make a copy 6 7 as far as that's concerned. 8 THE COURT: Yeah, I don't foresee an issue. 9 What time are they coming back? 10 THE MARSHAL: 9:30, Judge. 11 THE COURT: Okay. 12 (Court recessed for the evening at 7:11 p.m.) 13 - 000 -14 I hereby certify that I have truly and correctly ATTEST: transcribed the audic/video proceedings in the above-entitled gase to 15 the best of my ability. 16 17 18 <u>eranĝoriber</u> 19 20 21 22 23 24 25 JRP TRANSCRIPTION

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