Q In a deposition, correct.

A Yes, the case that I gave deposition testimony was not in that day.

Q All right. Now, you had occasion to review the medical records of Mr. Meana; correct?

A Yes, I did.

Q And I have those -- some of those records here. If there is anything you need to refresh your memory, please let me know.

A I will.

Q Could you generally describe for the jury what medical records you reviewed?

A As best as I remember, I hope I'm not forgetting one, I reviewed medical records from the Endoscopy Center of Southern Nevada. I reviewed medical records from Mr. Meana's primary doctor, Junari (sic) or something like that was his name. I reviewed medical records from a gastroenterology consultant he saw, Dr. -- it was Sood or Soot. And I reviewed medical records from the Philippines from two hospitalizations he had in the Philippines. And I think that covers it, although there may be one or two in there that I'm not recalling.

Q All right. And did you also have the opportunity to review the coroner's report, as well as the autopsy report relating to Mr. Meana?

A Yes, I did.

Q And do you recall what the cause of death was in the death certificate of Mr. Meana?

A It might --

Q If you need --

A -- help if I read it.

Q Sure.

A I mean, I recall, but I don't want to say something wrong.

Q I'm handing you State's Exhibit 18 and 20.

A Okay. Shall I read it?

Q Sure.

A So this is -- it says certificate of death, it's from the Philippines. It says immediate cause of death, hepatic and uremic encephalopathy, antecedent cause says sepsis, and then it says underlying cause is hepatitis C and chronic kidney disease.

Q And with respect -- did you also review the conclusions of the coroner in this case?

A Yes, I did.

Q And as well as the autopsy report?

A Yes.

Q And do you recall what the conclusions in those -- those persons and entity were?

A Maybe I can just check here. They may not be

in here.

MS. STANISH: May I approach with my copies --

THE COURT: You may.

MS. STANISH: -- to expedite it?

THE COURT: That's fine.

MS. STANISH: Thank you.

BY MS. STANISH:

Q That's a big package there.

A Okay. Well, this one is the coroner.

Q Right. Okay. I'll leave this one with you.

A Okay.

Q I'll take that.

A So the coroner's final pathologic findings, and these are pathologic findings from looking at the tissue in the organs, it says hepatitis C infection genetically typed, hepatic cirrhosis, splenic fibrosis. It says acute to subacute pneumonia bilateral, and it says nephrosclerosis mild to moderate.

Q Now, based on your review of all the medical records, as well as the coroner's report, etcetera, can you opine with a reasonable degree of medical certainty whether Mr. Meana died because of the hepatitis C that he contracted on September 21, 2007?

A Given everything else, you can't say that that is the reason he died.

Q Now, I want to explore your conclusion in some detail. But before I do that, when we use the term medically certainty, what does that mean to you?

A A reasonable degree of medical certainty would be, to me, this is the most likely thing that happened or out of several possibilities what within the understanding of medicine most likely was the cause of injury, cause of death, or cause of whatever.

Q And as you sit here today, do you know what caused the death of Mr. Meana?

A I can say there were several factors, and I can't say which one was the immediate cause.

Q Now what I'd like to do, sir, is I'm going to take you through a chronology of your review of Mr. Meana's medical records, starting with what you observed in his medical records prior to his visit to the -- to the gastro center for a colonoscopy. All right? Did you note anything in Mr. Meana's medical records prior to that date that caused you concern?

A There were a couple medical problems that were concerning and probably played a factor over the next few years. One is he had hypertension that was being treated. Another condition he had was benign prostatic hypertrophy, which is an enlargement of the prostate gland that seemed to be causing urinary obstruction so the urine wasn't flowing

properly, and that might have been increasing the pressure in the kidney.

So I noticed, for one thing, two things that were affecting his kidneys prior to then. And I also noticed on a CT scan that I believe he had in June of 2007 there were a couple of liver findings. And one in particular was dilated extra hepatic bile ducts. So the bile ducts that take the bile from the liver to the intestine were abnormally dilated. And I noted he had also had his gallbladder removed at some time prior to that, so suggesting that there had been and might have still been some low grade obstruction of the bile ducts in Mr. Meana.

Q Okay. And we're going to come back to that in a moment because a lot of that you're going to have to explain.

MS. STANISH: May I approach, Your Honor?

THE COURT: You may.

BY MS. STANISH:

Q I'm going to show you what's been marked as Exhibit DD-1. Did you review this document?

A Yes. DD-1 is the results of a liver biopsy that Mr. Meana had on July 25, 2008.

Q And there is a second page on that. If you could identify that, as well.

A Yes, that's a continuation of the description

that was on the previous page.

MS. STANISH: Your Honor, I'd move for the admission of DD-1.

MR. STAUDAHER: No objection.

THE COURT: All right. DD-1 is admitted.

(Defendant's Exhibit DD-1 admitted.)

BY MS. STANISH:

Q Now, we'll come back to that exhibit in a moment. But would you please explain to us in the most layman terms you can what you just described regarding Mr. Meana's -- the condition of his kidney?

A Well, the kidney, from what I saw, was he had hypertension that was being treated with one or two medications. And he also had obstruction of the flow of urine from his kidney out of his body. So both of those things over time can damage the kidney.

High blood pressure or hypertension, by causing the part of the kidney where the blood is filter, by getting scarred so it doesn't work too well. And a urinary obstruction is just really like a plumbing problem. The pressure backs up into the kidney, and the kidneys over time can be damaged. So with regards to his kidney, he had, at least in 2006 or 2007, two processes that could have been contributing to damaging his kidney over time.

Q And I should have dropped this off while I was

up there, but I need the exercise so let me give you what's already been admitted as Defense Exhibit AA-1. You had also mentioned that you noticed a cyst, a right renal cyst or -- could you describe what that means to us?

A Yes, there's -- there's -- well, let me just read this carefully. Hang on. So there's a cyst in the kidney and that could mean many things. Many cysts are benign in the kidney. Sometimes they could be causing -- contributing to obstruction. I can't really say just based on this.

Q And turning your attention to the second page of Defense Exhibit AA-1, an exam that was conducted on June 7, 2007. If you would review, sir, the impressions there that relate to the kidney and the extra hepatic bile ducts. Could you explain those impressions to us?

A Okay. Well, really, No. 3 is what stood out to me, which are the distended extra hepatic bile ducts. Distal obstruction is not excluded. Changes of cholecystectomy, probably small cyst of the liver, hepatic nodule not excluded. And then they say a different type of CT scan of the abdomen could be used to further assess the liver and also to previously describe -- some previously described kidney problems on here.

And it's important to look up into the finer print when I talk about the findings. There's distention of the

extra hepatic bile ducts up to ten millimeters in diameter, and normally they're not more than six millimeters in diameter. So, again, suggesting that there was some chronic obstructive process obstructing, in this case, his liver. The bile flowing from the liver into the intestine.

Q And I need you to go more basic than that. Could you start off with explaining to us what an extra hepatic bile duct is?

A Okay. So the liver sits in the right upper quadrant of your abdomen, and the liver makes bile. And bile is composed of several things. It's composed of bile salts, which are salts that the liver makes from cholesterol. It helps you digest food. It also has bilirubin in it, which comes from the breakdown of red blood cells.

And in the liver there are small bile ducts that take these substances and collect them and they go into larger and larger bile ducts. And the bile ducts that you see outside of the liver are called the extra hepatic bile ducts. And those bile ducts lead to the intestine where the bile that contains these substances is led to go where it helps with digestion or some things are excreted that way.

Q And the fact that those are somehow enlarged, is that what I'm understanding you to say?

A They're abnormally dilated, yes. They're -- they're diameter is bigger than normal.

Q What does that mean and why would you be concerned as a doctor about that?

A Well, I would be concerned that if something like that were present over time, which it seems like it was not terribly symptomatic, but over time something like that can cause damage to the liver in terms of scarring or fibrosis.

Q And the fact that the findings also say that there was no focal hep -- hepatic lesion seen at that time in June of '07, how does that factor into the findings in your analysis of this document?

A You know, focal hepatic lesions, you know, those could be things like cancers or tumors or benign cysts or things like that. And those aren't really that relevant to Mr. Meana's progression and that they're not there doesn't really contribute one way or another.

Q All right. Was there anything else you saw prior to the September '07 visit to the gastro center that you believe is important to determining Mr. Meana's ultimate demise?

A I think the chronic insults to the kidney and this dilated bile ducts that might say there's something wrong with the liver are the two most relevant things.

Q All right. Now, let's move to the next period in time, that would be after Mr. Meana goes to the clinic in

September of '07, but before he leaves the country for the Philippines. And more particularly after he's diagnosed as having hepatitis C, was there any other indication of medical problems that cause you concern?

A Well, certainly the hypertension and the -- most likely the prostatic obstruction, although I didn't see specific records at that time, continued. Otherwise, he had hepatitis C, he had an acute infection that resolved and, you know, the liver got better. He continued to have the virus in his body with the fluctuating viral load, and at some points the virus was detectable at a very low level, later to intermediate level. And then really the liver biopsy that he had in July of 2008 showed some other things that were going on.

Q And that's already been introduced into evidence, so I'm going to throw this -- my copy up on the screen. And if we can -- if you could show us, if I need to go to the next page, let me -- let me know. But if you could -- you can point to that screen, by the way, and touch it, and it will highlight information. And if you want to get rid of a highlight just tap it on the bottom --

MR. STAUDAHER: Lower right.

BY MS. STANISH:

Q -- right. Okay?

A Sorry.

Q That was very good. And so will you explain to us and maybe point out for us so we're clear what your concern is about this liver biopsy result. And by the way, what was the date and who recommended it?

A The date was July 25, 2008, and it says Dr. Sood is probably the doctor who recommended this, but I see there's names of another doctor there, too, that I don't recognize. I may actually have --

Q Can you read that okay? Are you looking at the right one?

A Oh, here we go. Dr. Sood, and there's another doctor's name above it. Can -- how do I get the arrow? There we go.

Q All right. So what is it in this lab -- point out to us in this lab report what causes you concern.

A Well, the essence of the results are really up here. I guess I just can't do this. Do you see the --

THE COURT: If you drag your finger, that would like make a line.

THE WITNESS: How's that? This --

THE COURT: Or, Ms. Stanish, just --

MS. STANISH: Well, you could actually --

THE COURT: -- move the paper.

MS. STANISH: -- make me look at what I circled here.

THE COURT: Just make a mark and she'll move the paper.

THE WITNESS: Start right there where it says diagnosis and read down. Okay?

BY MS. STANISH:

Q Okay. Go ahead.

A So there were a few things here --

Q We won't try the high-tech. Just explain it.

A Okay. Diagnosis, and here you can see it says core biopsy. That means I stuck a needle into the liver and took a tiny piece of liver tissue out. Well, it's gone.

Q No, see what I'm doing, I'm zooming in for those of us --

A Okay.

Q -- that have to actually read this. And, again, if you would tap on the bottom right with your fingernail.

A Okay. Okay. So it says chronic hepatitis. Hepatitis means inflammation of the liver. It says clinically hepatitis C, and that means the pathologist is basing that on the clinical history, and he or she even writes here that there was hepatitis C virus detected in the patient below over -- over here. Now, it says with moderate activity, Grade 3 out of 4, and periportal fibrosis, Stage 2 out of 4. So those are important when you talk about, one, the degree of

inflammation, the inflammation is inflammatory cells in the liver. Like if you banged yourself and it gets read and inflamed, at a microscopic level similar things are going on in the liver. And the second thing is fibrosis. That's the amount of scar tissue in the liver.

So the amount of liver that's been replaced by a scar. If you cut yourself and get a scar, fibrous tissue. That's the fibrosis. And secondly there is a second problem going on in Mr. Meana's liver here. Maybe not the most dramatic, but certainly something else contributing here, which is mild microvesicular and macrovesicular and steatosis. And what that, steatosis simply means is fat in the liver. And microvesicular and macrovesicular basically means the fat are in little, little, little tiny drops when you look under the microscope or the fat is in slightly bigger drops in the -- within the liver cells when you look under the microscope.

Q I'm just going to call that fatty liver.

A That's okay. That's what most people call it.

Q And let me -- before we talk about fatty liver, let me go back to this finding or this diagnosis that relates to the fibrosis. Could you explain to us what exactly is fibrosis?

A So fibrosis simply is scar tissue. The same scar tissue if any of you have ever cut yourself or had a surgery and the normal skin is replaced by scar tissue, over

time as the liver gets damaged, you get scar tissue in the liver. And that can result from many, many processes. It can result from viral hepatitis, such as hepatitis C, it can result from fatty liver, it can result from obstruction, it can result from drugs, it can result from maybe alcohol is the most common cause in our country. So that's something that can result from may long term insults to the liver.

Q And just to be clear, does hypertension or the kidney issue relate to the fibroid condition at all?

A No, what's going on in anyone's kidneys, or specifically Mr. Meana's kidneys, doesn't relate to this.

Q And sticking with the fibrosis for awhile, explain to us what Stage 2/4 means.

A So in hepatitis C the degree of scar tissue in the liver is generally graded from 0 to 4. Zero means there is no scar tissue in the liver. 4 means there is full blown cirrhosis in the liver. Cirrhosis is when the liver has sort of balls of liver cells, if you will, sort of surrounded by scar tissue. 1, 2, 3 are varying advancing degrees between nothing and that, and 1 actually, if you want to get a little technical, it's scar tissue confined to just little parts of the liver called the portal tracts.

Stage 2 is what I think the pathologist actually described here as periportal. So it means the fibrosis, the scar tissue is extending from these portal tracts where the

blood vessels enter the liver into the major body of the liver itself. And Stage 3 is a little more advanced fibrosis where the scar tissue is stretching across parts of the body of the liver called the lobule.

Q So this -- this is the sample, the liver samples collected on July 25, 2008. Can you say with any medical degree of certainty whether the hepatitis C virus that was contracted in September of 2007, approximately -- was that 10 months before this, did that cause the fibroids?

A The fibrosis? I think it would be extraordinarily unlikely that hepatitis C, in less than one year, can lead to this degree of fibrosis. I mean, typically, hepatitis C takes decades for the fibrosis to advance, at least several years.

Q Would it matter that, you know, he was -- had acute hepatitis C at one point and had a viral load that goes up and down over time?

A Viral load doesn't really correlate with the progression of fibrosis in hepatitis C, so that shouldn't matter.

Q And if you would, please give us a clarification on what is the term viral load?

A So viral load, when you measure hepatitis C in the blood, we measure hepatitis C virus in the blood because it's hard to go measuring it in the liver, you do a technique

where you can actually amplify the RNA, which is the genetic material in a virus, and quantify it, get some idea of how much virus there is in the blood, which roughly correlates with how fast the virus is replicating in the liver. So roughly a high viral load might mean the virus is replicating or dividing very rapidly in a person, whereas a low viral load would mean roughly that the virus is not replicating so rapidly in the liver.

Q Now, is there -- on page 2 is there anything else in the -- is this somehow connected to -- tap the screen, please. Again. And again. Bottom right. There you go. And does this document relate to the first page, or does it show something different or more information?

A It says that there is mild microvesicular and macrovesicular steatosis once again, which is --

Q A fatty liver.

A -- confirming what the pathologist wrote in the main diagnosis. Otherwise, most of this looks like negative or pretty much non-contributory descriptions of what's going on here.

Q Now, let me return you to the subject of fatty liver and have you explain that to us like we were three year olds. What -- what is fatty liver?

A So simply fatty liver is abnormal accumulation of fat within the liver, within the cells of the liver, fat

accumulates.

Q And is that something I need to worry about?

A Possibly.

Q Okay. What -- what -- that term fat. What is it that causes fatty liver so we can all be forewarned and understand this document?

A So there are really two major causes. There are other causes, such as drugs and other things, but the two major causes is, one, excessive alcohol drinking, and the other one, which is probably much more common in America now, is being overweight and being insulin resistant. So fatty liver now in the United States has become an unrecognized endemic maybe, probably. Some estimates say 25 percent of a population have excess fat in their liver. And in some cases over time that could also make low grade inflammation that can cause scaring in the liver.

Q So fatty liver can -- can actually cause cirrhosis?

A Fatty liver by itself can cause cirrhosis, yes.

Q And by the way, just clarify for me, you know, we've already seen that he -- he -- the liver biopsy shows fibroids in his liver. How does fibroids relate to cirrhosis? Is it the same thing or a matter of degree?

A So fibrosis, fibrosis is sort of the early

process that leads to cirrhosis. So cirrhosis is actually defined pathologically and anatomically as regenerating nodules of liver cells with fibrosis. So cirrhosis in a way is very advanced fibrosis or scar tissue where the liver begins to regenerate in an abnormal fashion. So earlier stages of fibrosis such as you see here in various liver diseases over time can progress to cirrhosis.

Q Now, I want to address a different subject during this time frame after the colonoscopy, but before Mr. Meana goes to the Philippines. Did you review the documents pertaining to his treatment following the diagnosis of hepatitis C?

A Yes, I believe after this biopsy or perhaps even a little bit before, I can't remember the exact time, but his gastroenterologist, I know he had seen a few, but I know at least Dr. Sood and maybe another recommended that he be treated for hepatitis C.

Q And what would that treatment have been?

A The treatment then would have been a pegylated interferon and ribavirin.

Q And in your opinion, based on your review of the medical records, is that something that would have been beneficial for Mr. Meana to undergo shortly after this diagnosis or biopsy, I should say?

A Well, with acute hepatitis C there's a real

benefit of starting treatment early. Most patients with hepatitis C who get treated, they have it for years or decades, so starting fast doesn't often matter that much. But the one time where it does seem to matter to start sooner is when the infection is acute because there's data that say when you're acutely infected, if you start treatment sooner, you have a better chance of clearing the virus.

Q And do you recall seeing that Mr. Meana ultimately did at least try to undergo the treatment in March of 2009?

A Yes, I can't remember the exact date, but I do remember it was sometime in 2009, not as early as his doctors had recommended.

Q And does that have any significance to you?

A Well, he may have had a better response if he was treated earlier. And from the records I have, it's not entirely clear why once he started treatment he stopped. He tried a couple times and just seemed to not do it, so I can't say.

Q Okay. Now I want to move to your review of the medical records in the Philippines. Can you first tell us why was it he was hospitalized in the Philippines?

A So from my reading of those records, he was hospitalized twice in the Philippines, once in late March or early April of 2012, and again later in April of 2012.

Q And can you explain to us what was the reason for his first hospitalization?

A So as best as I could ascertain from the records from the Philippines, the first hospitalization appeared to be for some confusion and some lab abnormalities they were attributing to hepatic encephalopathy, which is some confusion people can sometimes get when the liver doesn't work well, and also for some kidney problems. He had a rise in creatinine, which is a test of kidney function in the -- in the blood. So it seemed like a mixture of, you know, I'd say low grade problems or medium grade problems with his liver and his kidneys not working well.

Q And can you tell us what happened during his first -- well, let me ask you this. With respect to the Philippine medical records, were they understandable to you and organized for -- for your review?

A They were legible. They were understandable, but they were not, I should say the best medical records. There were not admission notes in there or discharge notes. It was not like in -- typically in the United States where you have much better summaries of why the patient came in and what the situation was when they went home. It was more small notes and sentences.

Q All right. Could you discern from the medical records what happened during the course of his first

hospitalization in late March or early April of, what was it, two thousand --

A 2012. And I think he was discharged around April 6, 2012. And apparently they treated him, from as far as I can see, fairly conservatively. And I noted right before his discharge it said hepatic encephalopathy resolving. Then they put -- said something like chronic kidney diseases, and benign prostatic hypertrophy. That's the big prostate.

Q Now I need you to stop and decode that for us. What does that mean?

A The enlarged prostate that he had had even several years previously.

Q And what was resolving?

A What was resolving was the hepatic encephalopathy. The note said, and it was just a small note, but that would be the confusion he might have had from his liver not working well. And I saw that he was discharged in a wheelchair, awake and alert, and went wherever he went from the hospital in the Philippines to his home or a relative's home or wherever that was.

Q And then when did he return to the hospital, if you can recall?

A He returned to the hospital approximately two weeks later.

Q And what was the reason for his admission into

the hospital?

A The admission into the hospital, as far as I could tell from the notes, was it said uremic and hepatic encephalopathy. But from looking at the records -- and it also said sepsis. From looking at the laboratory tests he had a markedly elevated creatinine saying that the kidneys basically stopped working in the two weeks since the previous discharge and this admission. And also he had an elevated white count, white blood count, that got even higher when he came in, suggesting that he had -- or very strongly suggesting that he had a source of infection. And they noted in the notes urosepsis, which is an infection from the urinary system.

Q And so the -- and correct me if I'm wrong, the primary reason he was admitted was because his kidneys stopped working and he had an infection due to a urinary blockage?

A It's not clear exactly if the infection was in his urine or what the cause was, but that was their clinical impression, and he did have some findings on his urinalysis, many red cells in his urine and some white cells in his urine suggesting there may have been an infection in the urinary tract. But I'd say the main reason he was admitted were those two reasons, kidney failing, and he was, in fact, started on dialysis, and infection for which he was given antibiotics.

Q Was there any indication that he had pneumonia

at the time of admission?

A As far as I was able to tell, none of the doctors had mentioned pneumonia as a high suspicion. Whether I can say he had it or not, I can't.

Q And did you -- did you find it, as you reviewed the records following the second admission into the hospital, did you find appropriate testing of the blood or other labs?

A I think there was, as far as I can ascertain from those records, some testing was appropriate. What I didn't see in there was a blood culture, which was a little atypical to see if there was an infection in his blood. And, again, I don't know if I missed it or it wasn't in there, but I didn't see that in there. But for the most part I think they treated kidney failure appropriately with dialysis. They treated him for an infection, even though they may not have known the exact cause, with antibiotics. And, you know, once you're infected and your kidneys fail, it's possible that some of -- some liver not working well was contributing. And they gave him some medication to also help with the confusion that may have come from his liver, too.

Q Give me a moment. Now, how long -- could you describe for us how they treated the kidney failure? You said they put him on dialysis?

A Yes, he received hemodialysis.

Q And what exactly does that mean?

A Hemodialysis is where an external machine basically filters your blood. So it's an artificial kidney, if you will, to some extent. You generally put a patient on that three times a week, and it helps get rid of the things that the kidney normally gets rid of.

Q And could you describe for us what you -- what you noted in his -- in the hospital records as he -- his health progressively declined during his hospital stay?

A I can't say much from those records except they dialyzed him, they gave him antibiotics. He didn't get better, his blood pressure dropped, they tried to maintain that with types of drugs that raise blood pressure, but ultimately he died.

Q And now let's discuss the findings of the -- the coroner in -- in the Philippines. Did I give that to you up there, or is it --

A Yes. Well, I have the coroner from Clark County.

Q All right.

MS. STANISH: Is it part of the Philippine package?

Court's indulgence. I've got to dig for this. I might have it up here.

THE COURT: There's maybe a copy up here, as well.

MS. STANISH: Oh, okay. Thank you.

MR. WRIGHT: What are you looking for, Margaret?

THE COURT: Is that what you're looking for?

MS. STANISH: Yeah, I believe it is. Court's indulgence.

THE COURT: I'm not sure if that's what -- what you wanted.

BY MS. STANISH:

Q Let me start with the -- I'd like your medical opinion on reviewing the findings in the autopsy. After you reviewed the medical records, what is your evaluation of the findings of the autopsy?

A Well, the autopsy report focuses on hepatic failure, cirrhosis, and chronic hepatitis C, and it does mention pneumonia. But what's a little bit striking to me about the causes of death in the autopsy, even though this pathologist mentions the condition is the lack of saying that the kidney disease contributed to death here. And in particular, even on the death certificate and from looking at the records, it really looked like kidney disease was a major player and also infection and why he came in in his final hospitalization.

Q And the -- and if you turn your attention to the death certificate, with respect to the finding of pneumonia, how was that characterized in the death certificate?

A Well, in the death certificate it's referred to as sepsis because I think the clinician knew he was infected, but wasn't sure it was from the lungs or from the kidneys or somewhere else. But clearly the patient had an overwhelming infection that they called sepsis on the --

Q Okay.

A -- death certificate.

Q That's where I was getting confused about your testimony about you didn't see pneumonia as being part of the hospitalization, but there is this infection. And so could you explain to me a bit more?

A So the clinicians who were taking care of him knew he had an infection, a severe infection because his white blood count was very high, his blood pressure was very low. And, you know, you call that, when it's a severe infection, sepsis, or you can call it septic shock when a blood pressure drops. So when the infection gets so bad, it gets into the blood and your body really begins to fail. They didn't really know what the cause was.

They suspected the urinal -- the pathologist, both the coroner in the pathologist in the Philippines, when they looked at his lungs under the microscope, they noticed that there was inflammation in the lungs or pneumonia. Now, it's hard to say whether pneumonia was the cause of that sepsis that resulted from that sepsis. But from -- clinically you

can say you had a severe infection, and at the autopsy one organ that they saw was acutely infected was the lungs, so they call that pneumonia.

Q Now, we've heard testimony about the condition of Mr. Meana's liver. By the way, how big is the liver? Is it the size of volleyball, football, what?

A The normal liver is about 1,500 grams, so that's --

Q Oh, okay.

A -- roughly --

THE COURT: And we thought it was 1,600 grams, so --

THE WITNESS: So my guess is Mr. Meana's liver at the end was a little bit smaller. It's up -- I don't know, that big, right here.

BY MS. STANISH:

Q How big? How big is this?

A Maybe the span -- the normal span in the front, in the right midclavicular line, the right middle of your chest might be about 10, 12, 14, 15 centimeters. So divide that by two and a half will give you inches.

Q Well, we don't need to go that --

THE COURT: And while we think about that, the jury tells me they need a break right now.

MS. STANISH: All right.

THE COURT: So, ladies and gentlemen, we'll take a

relatively quick break. The bailiff will let me know when you're ready.

During the break you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. Don't read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case, and please don't form or express an opinion on the trial.

Notepads in your chairs, and through the rear door.

(Jury recessed at 2:59 p.m.)

THE COURT: One of the jurors feels sick, and that's why we needed to take an immediate break.

You can take your break. We don't need you for this.

THE WITNESS: I cannot practice medicine in Nevada.

MS. STANISH: Do they need a liver doctor?

THE COURT: So that's why I said as long as the jury needs. So we'll see what's up with that.

MS. STANISH: I'm almost done, Your Honor.

THE COURT: Yeah, I mean, she just said like she needed an immediate break.

MS. STANISH: Okay.

THE COURT: So that suggested to me like a stomach type of an issue. That's why I --

MR. SANTACROCE: Which one?

THE COURT: Ms. Booker.

MR. SANTACROCE: I saw her kind of moving -- moving around.

THE COURT: Yeah, so we'll see. So we'll -- I'll update you.

Yes?

MS. WECKERLY: I just wanted -- well, Mr. Wright left. But I wanted to put -- just enter something as a Court's exhibit. When Dr. Carrera testified, the defense entered a community letter, proffer letter into evidence after, and Mr. Pitaro was present in court when that happened. After court Pitaro contacted me and said he thinks that's the wrong letter or the witness thinks it's the wrong letter. I provided the right one to the defense. I told them if they want to switch it out that's fine, or we can leave it how it is because it was admitted, but I'd just like to have this as a Court's exhibit that I provided it to the defense on the day I got it.

THE COURT: Okay. And then, Ms. Stanish and Mr. Santacroce, how do you want to handle that?

MR. SANTACROCE: It matters not to me.

THE COURT: I mean, do you want to substitute for the correct one?

MS. STANISH: I have it --

THE COURT: I don't know what the --

MS. STANISH: Yeah.

THE COURT: -- difference is between the two.

MS. STANISH: I don't know either, so let me talk to Mr. Wright about it. I think he stepped out.

THE COURT: Okay. You might want to compare it to the other one to see really what the difference is.

MS. STANISH: Right. Thank you.

MS. WECKERLY: Yeah, so -- all right.

THE COURT: Okay.

(Court recessed at 3:02 p.m., until 3:14 p.m.)

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Ms. Stanish, you may resume your direct examination.

MS. STANISH: Thank you, Your Honor.

BY MS. STANISH:

Q So, Dr. Worman, right before the break I was about to broach with you the subject matter of Mr. Meana's cirrhosis. We've had testimony, and I think that the document of the coroner shows that he had cirrhosis, he had at the -- during the autopsy evidence of ascites?

A Ascites.

Q Yeah, that's what I meant. So can you explain to us how he got to that point in comparison to where he was

prior to the September 2007 time period? What happened to Mr. Meana?

A Well, all I can tell from these records is the degree of fibrosis in his liver progressed from a State 2 in 2008 to a Stage 4 sometime in 2012, which would be cirrhosis. And, you know, that would be extraordinarily atypical to occur just because of hepatitis C.

Q And I'll come back to that in a moment, but I want to go back to something I meant to ask you about the mental condition of Mr. Meana when he was hospitalized. What's that word? I know I can't pronounce it.

A Encephalopathy?

Q Yeah, it sounds like something from Sesame Street, that elephant. But the -- that -- that issue, what causes that?

A So encephalopathy is a broad term, really, just meaning that the brain is not working right. It can happen in end stage liver disease or in very severe acute liver disease, but that's not the only cause. It could also result from kidney failure, which he had at the end. And, you know, looking at the death certificate and the medical records, they were attributing that to both his liver not working and his kidneys not working.

I should say after he left the hospital the first time, as best I can remember it says encephalopathy was rather

mild. He just had problems sleeping and perhaps was a little bit confused, but still awake and alert and knew, for the most part, where he was and, you know, what was going on.

Q And just briefly on the topic of dementia. Are you familiar with whether or not the medicine regiment for hepatitis C treatment, does that cause dementia?

A No, absolutely not. Interferon and ribavirin does not cause dementia. No.

Q And does having either acute or chronic hepatitis C cause dementia?

A Dementia? Absolutely not. No.

Q Are you familiar with any literature that supports that?

A There is no mainstream medical literature on that. And if you look in terms of treatment at the labels, the FDA approved labels for the drugs, dementia is not an adverse event. I mean, dementia is something different. I mean, liver disease can cause neurological problems and so could the medicines, but not dementia. Absolutely not.

Q Okay. Returning to Mr. Meana now. Based on your review of the medical records, can you -- can you tell us with any degree of medical certainty whether the hepatitis C was a direct and immediate cause of his death?

A Direct and immediate cause? I cannot say that based on reviewing all the records.

Q Thank you.

MS. STANISH: I have nothing further.

THE COURT: All right. Thank you.

Mr. Santacroce, do you have any questions?

MR. SANTACROCE: No, Your Honor.

THE COURT: Cross, Mr. Staudaher.

MR. STAUDAHER: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. STAUDAHER:

Q Sir, I want to ask you a couple of questions first about your training that counsel went over with you. I noticed on your CV that it said board certifications you have two; is that correct?

A No, I'm board certified in internal medicine.

Q American Board of Internal Medicine?

A Yes.

Q Is that the only one you hold?

A Yes.

Q On your CV it says National Board of Medical Examiners back in 1986.

A Oh, yes. That's the -- means you passed all of your exams and you're certified to become a -- do an internship and become a physician. That's not a medical specialty.

Q Oh. So when it said -- the confusion there I

wanted to make sure I was clear was that you're not a medical examiner; correct?

A No, I'm not a medical examiner.

Q You're not trained in pathology?

A I have learned liver pathology in part of my training as a hepatologist, but I'm not a pathologist.

Q Okay. And that's what I'm talking about, a pathologist who studies disease of various organs and the like; correct? I mean, that's their focus.

A Well, I study disease of organs, but I'm not formally trained as a pathologist.

Q Okay. Have you ever opined or have you ever given testimony as to cause and manner of death in any case?

A Cause of death? No, I don't believe so until --

Q Until today --

A -- now.

Q -- right?

A Well, I've looked at cases and, you know, looked at what -- well, actually, I take that back. I probably have opined as cause of death in drug overdose cases related to the liver, yes, I have.

Q Okay. How many cases have you reviewed for that kind of a thing? I mean, actually primarily you're looking at why somebody died, the reasons behind it.

A In terms of legal cases how many have --

Q In general. I mean, have you ever been asked to come in and say, hey, why did this guy die?

A Well, we do that sometimes at conferences or --

Q You specifically. Not just at conferences.

A So in legal cases maybe three or four times.

Q Well, let's talk about those. What were the three or four times?

A Those were cases where there were overdose of a drug where a patient died.

Q So all of them were like that?

A Those cases all involved drug alleged overdose or possible overdose.

Q And what was the drug?

A The drug was acetaminophen.

Q Because that's toxic to the liver; correct?

A It's toxic to the liver only if you take it in excess. That's correct.

Q You were asked some questions. I'm going to use my -- I don't know what the exhibit is. I'm going to use the one that counsel gave me for -- to go through this.

MR. STAUDAHER: And, Madame Clerk, I don't know what the exhibit number is on this.

You may actually have a copy up there.

MS. STANISH: Yeah, I think it's up there.

THE COURT: I think it's --

THE WITNESS: DD-1?

BY MR. STAUDAHER:

Q DD-1.

A Is that correct?

Q I'm going to leave that with you so that you've got it if you need it. A couple things I want to ask you about related to this. First of all, this is the date up here is the 25th of July of 2008; correct?

A Correct.

Q So this would have been if the infection occurred to Mr. Meana in September 2007. We're talking about the next year, mid-summer.

A This is approximately ten months after that.

Q So in this report, the part that you were asked about, and I'm going to zoom in on this a little bit so that we can see it. The part you were asked about was here where it said related to the diagnosis chronic hepatitis, clinically hepatitis C, and then it comes across here and it says with immediate -- or moderate activity Grade 3/4. What does moderate activity Grade 3/4 mean?

A That's the degree of inflammation. So you look at the inflammatory cells in the liver and you grade it.

Q So he -- his liver was pretty inflamed then at

that time?

A Well, it's exactly what it says, it's moderate inflammation Grade 3 of 4. I don't know what pretty means, but that's a pretty good --

Q Well, your --

A -- that's a good --

Q Give me the range.

A -- pathological description.

Q What does 3 of 4 mean?

A They grade it from zero to 4. This would be considered moderate.

Q Okay. So what to you does -- if you have a scale of 1, 2, 3, 4, and 3 is what we're looking at here, is that significant inflammation?

A I would say that's moderate inflammation.

Q Is it significant?

A It's moderate. I can't answer that. I'm sorry.

Q So when we look down here where it says periportal fibrosis, what does that mean exactly?

A That means fibrosis or scar tissue that's extending beyond the structures in the liver known as portal tracts. So portal tracts are these areas all throughout the liver where an artery and a vein and a bile duct can be found that enter and exit the liver. And those areas, when you have

many types of hepatitis, not all, but many types of hepatitis are the first areas that get inflamed. And this means -- periportal means it's beyond the portal tract, it's periportal, extending beyond the portal tract.

Q Okay. This is still within the liver, though.

A This is within the liver. This is a microscopic portion of the liver, right.

Q Now, you said, if I understood you correctly, that you don't know that this was caused by hepatitis C; is that correct?

A I can't say that all that fibrosis was caused by hepatitis C, no. It would be very atypical.

Q You're familiar with the medical records of Mr. Meana?

A Yes.

Q You've reviewed all the pre-2007 September medical records available; correct?

A I've reviewed what I was given. That's what I reviewed, yes.

Q Well, what were you given?

A I was given not that many medical records prior to September 2007. There were a few medical records from his primary care doctor, and there was maybe one or two sets of labs in there. I don't have records going further and further back.

Q In the medical records you saw, limited as they were, did you see any evidence that he had fibrosis, liver disease, anything like that? Any of his labs or reports, anything like that?

A You can only tell that by liver biopsy, which he hadn't had.

Q I'm asking you based on the liver studies, whatever you saw as part of the medical records. Was there any evidence at all that he had any kind of liver disease prior to September 2007?

A There was evidence of liver disease, which were these dilated extra hepatic bile ducts, or a process that could affect the liver. Fibrosis you need a biopsy. I can't say whether he had fibrosis or not.

Q So the extra hepatic ducts, and that was in --

A June.

Q -- June of 2007. I'm putting that up right now. June 2007 report; correct?

A Yes, a report of a CT scan, I believe.

Q And do you see where it says CT scan of the abdomen?

A Yes.

Q Now, the part that you mentioned that was significant to you I've highlighted here. It says distended extra hepatic bile ducts, distal obstruction is not excluded,

changes of cholecystectomy. Do you see that?

A Yes.

Q So extra hepatic means what? Outside the liver; correct?

A Yes.

Q And bile ducts -- and it says distal obstruction on this. Let me go briefly again. Distal obstruction is not excluded. What -- what does that mean, distal obstruction?

A That means an obstruction beyond where the bile ducts are dilated. This scan cannot exclude that.

Q Okay. So that would be even further away from the liver; correct? An obstruction potentially?

A In the bile ducts outside of the liver, yes.

Q Now, what would cause the bile ducts to dilate?

A Oh, it could be a stricture, it could be a stone, it could be a tumor, it could be things that are unusual, it could be congenital, there could be many, many causes.

Q But outside the liver; correct?

A But when you have bile ducts dilated outside the liver, it's connected to the liver. You can't image the interior hepatic bile ducts with this type of scan, so you can't look at those.

Q Not my question. The obstruction was away from the liver causing the actual dilation; correct?

A That would be most consistent with this, yes.

Q So the dilation didn't come from something inherent within the liver according to this report; correct?

A Inherent within the liver? No. But it's part of the biliary system that drains the liver.

Q Any indication from this report that there is actual liver disease other than the dilation caused by an obstruction away from the liver?

A Well, this is not the type of test you would do to determine that, so I can't say.

Q So when I asked you if there was any evidence of any liver disease or anything related to it before September of 2007, you pointed to this. So I want to know what part of this you're saying shows liver disease in Mr. Meana.

A I'm saying that the extra hepatic duct dilation suggests there's an obstruction. An obstruction can cause, or a subclinical obstruction, damage to the liver over time. But this test did not look for that specifically.

Q So there is no evidence that you reviewed and had access to that showed any evidence of liver disease prior to September of 2007?

MR. SANTACROCE: I'm going to object to his

categorizing that as evidence. It was a medical record. I think he just misstated.

THE COURT: Well, no, he said he can -- he's -- that's overruled. He can answer if he's seen any evidence --

THE WITNESS: I can --

THE COURT: -- suggesting --

THE WITNESS: Sorry.

THE COURT: -- liver disease prior to 2007.

THE WITNESS: I can say I've seen evidence of a process that can affect the liver.

BY MR. STAUDAHER:

Q Later; correct? A process that could affect the liver later?

A Later?

Q Than this.

A Or at this time. I don't know.

Q I'm going to ask you this the third time. Is there any evidence at all of active liver disease at the time before September of 2007?

A I'll answer it again just by saying I can see evidence of a process that can affect the liver.

Q So the answer is no?

MR. SANTACROCE: Objection, Your Honor.

THE COURT: Overruled.

You can answer. Is the answer no?

BY MR. STAUDAHER:

Q Yes or no?

A And I think I've --

Q Yes or no?

A -- given my answer. You cannot look at the liver itself with this test.

Q That isn't my question. Is there any evidence of disease?

A Yes, of bile duct disease there is evidence. Yes.

Q Now, have you -- have you heard of -- well, I think you've mentioned them, benign cysts in the liver and the kidneys and things like that?

A Yes.

Q And benign to you means what?

A Benign usually means it's not causing any significant problem. In cancer it's not a cancer. It's a mass that doesn't grow or metastasize.

Q In fact, in kidneys, over -- people over the age of 50, typically half the people will have a cyst in their kidney; correct?

A I don't know the number, but it's not uncommon to have kidney cysts.

Q Nothing to do with any disease process, it just happens; correct?

A It's an abnormal process, but it's not serious and not significant.

Q What about the liver? Is that something that happens congenitally? It just -- it just happens, it doesn't cause any real problem?

A People may have benign liver cysts for sure.

Q You were asked about interferon. Do you recall that? Interferon ribavirin, I think, was the combination that you actually studied?

A Interferon-alpha, peg interferon-alpha is what we use to treat hepatitis C, yes.

Q And you studied that back when?

A Oh, I mean, I've been using it clinically for years. The clinical trials I did were probably in the very late '80s to early '90s.

Q Have you done --

A I take that back. I take that back. I'm sorry. It would have been the -- I was at Columbia in '95. It would have been the late '90s to around 2000.

Q Because I've got your reports, your studies, if you want to look at them. Would that help?

A No, the dates were in the late '90s where I did interferon and ribavirin.

Q Okay. Late '90s. So as far as those studies are concerned, what -- what were you studying? What were you

doing?

A Treating hepatitis C.

Q And -- and what did you find? When you -- when you said that you treated, I mean, are there different effects on different genotypes of the virus, I mean, as far as how well it works?

A Interferon-alpha and ribavirin, people with genotype 2 and 3 respond more commonly than people with genotype 1 infections or genotype 4 infections, which are extremely rare.

Q Which, in the scheme of things, a 1, 2, or 3 is going to respond less effectively?

A Well, genotype 1 probably responds to that treatment 40 to 50 percent of the type than genotype 2 and 3, closer to 60 or 65 percent at a time.

Q Okay. So we've got Mr. Meana as genotype what?

A He was 1a, I believe.

Q So he would fall under that 40 to 50 category?

A And looking at the general population for chronic hepatitis C, yes.

Q So if I understand you correctly, 40 to 50 percent of the people that were -- had his genotype will respond positively to interferon therapy; is that correct?

A With chronic hepatitis C, yes.

Q You mentioned acute. What is your definition of acute hepatitis?

A Acute is hepatitis lasting less than six months. That's a generally accepted definition.

Q So after six months we're at the chronic phase?

A You call it chronic. It's somewhat arbitrary, but that's the accepted term.

Q Now, within that time window, is that when people usually will exhibit symptoms if they're going to exhibit symptoms?

A Interestingly, most people with chronic hepatitis C don't exhibit --

Q No, I'm --

A -- symptoms.

Q -- talking about acute. I'm sorry. The acute phase.

A Oh. Interestingly, most people with acute hepatitis C don't develop symptoms. But the ones who do, it's roughly from a month or two after infection up to about six months after infection.

Q So the window would actually -- for that acute time, when you said would be the most effective at treatment would be when people are exhibiting their symptoms then primarily?

A Well, the truth is actually the sooner you start treatment after an acute infection the better. There's not a lot of data that looks at if you start seven months or eight months or ten months or twelve months, but the general consensus is the sooner you start treatment after an infect, the better the chance of response.

Q So you, as a person who has studied this, you're a hepatologist by trade, essentially; correct?

A Yes.

Q And that's what your specialty is?

A That's what I do clinically, yes.

Q Knowing that someone like Mr. Meana with Type 1a serotype virus, the response rate in the 40 to 50 percent range for that, can you say that Mr. Meana would have responded positively to that -- to that therapy if he had been able to tolerate it?

A Okay. Just a correction, genotype virus, not serotype.

Q I'm sorry. Did I say that --

A We don't serotype --

Q -- incorrectly?

A -- the virus. I can only say he would have roughly a 50 percent chance perhaps if he were treated earlier better because there just are data that suggest the earlier the treatment the better. But I can't give an exact number.

Q So he's got maybe a 50/50 chance at even having it have any effect at all on him?

A I think he has a chance of responding to treatment that was -- I would put roughly in the 50 percent range.

Q And there's clearly side effects related to that treatment?

A Some people have side effects, some people don't. Most people who are treated go through it without having to stop the treatment.

Q Now, related to that, are neurologic conditions -- I'm not talking about related to the end stage liver failure that causes the toxins and the encephalopathy. I'm talking about in general the virus itself and the treatment, interferon with -- what was it, ribavirin?

A Ribavirin.

Q Ribavirin.

A That's okay.

Q With the treatment and -- and the actual infection, were you saying that there is no mental component to this that can be affected, that the virus doesn't affect the brain at all?

A The virus doesn't affect the brain, no. And also I was saying there's no dementia, was the question I was asked.

Q Oh. I'm sorry. So -- well, let's -- let me follow up with that. No dementia.

A No.

Q And the virus does not affect the brain?

A The virus itself does not affect the brain. You cannot find hepatitis C in brain cells or in the central nervous system.

Q I've got four articles here and I want to ask you if you're familiar with any of them. The first one, it was published in Metabolism and Brain Disease, and it's entitled Hepatitis C Virus Infection in the Brain. Have you ever read that article?

A I haven't read it. May -- may I see it? You're asking me --

Q Sure.

A -- to comment on things --

Q Absolutely.

A -- I've never seen.

Q I'll give you a copy. Have you ever seen that one?

A No, I haven't seen this.

Q Okay. I've got another one here called Emerging Evidence of Hepatitis C Virus Neuroinvasion. And I'll give you a copy of that one, too. I've got another one here called Hepatitis C Virus Neuroinvasion Identification of

Infected Cells, Journal of Virology. And one last one. It's entitled Hepatitis C Virus Infection and Health Related Quality of Life.

Now, that last one was in the World Journal of Gastroenterology. The next one was in the Journal of Virology. The next one was in the Journal AIDS, and then the last one was in the Metabolism and Brain Disease Journal, as well. All of those related to actually infection in the brain, virus getting into the brain. You say you're unfamiliar with this at all?

A Hepatitis C virus does not infect brain cells. You can show me all the articles like this you want. This does not prove anything. These are publications that are suggestive.

Q Suggestive. If we go to the one entitled Hepatitis C Virus Neuroinvasion Identification of Infected Cells, just look at the abstract. I know you haven't had a chance to read the whole thing, but take a moment and read that abstract and tell me again if you believe that that -- there's no evidence whatsoever in any peer reviewed journal that there's evidence of an infection of the virus hepatitis C into brain cells.

A I'm going to need a moment to --

Q Sure.

A -- read this.

Q Take a moment.

A [Witness complied]. Okay. I've glanced through it.

Q Okay. And the other two, the one that says Emerging Evidence of Hepatitis C Virus Neuroinvasion, and also the one that says Hepatitis C Virus Infection of the Brain, if you want to just look at the abstracts of those briefly because it talks about the same neuro-cellular invasion in the brain, all three papers, three different journals.

A Which was the other one you were talking about now? I'm sorry.

Q Hepatitis C Virus Infection and the Brian, the Metabolism and Brain Disease Journal, and also Emerging Evidence of Hepatitis C Virus Neuroinvasion in the Journal AIDS, 2008 and 2005 respectively. Actually, published in 2009 on the first one, 2005 on the second one.

A On this one I do not have the entire paper, I don't believe.

Q Which is that?

A Hepatitis C Infection and the Brain.

Q I'll let you have my copy.

A Okay.

Q Okay. Do not all of those, all three of those, those last three that I gave you, indicate the astrocytes, macronuclear invasion of the virus into the brain,

actually into the brain?

A I would say these three papers prove nothing. These are suggestive papers in second or third tier journals that just point towards more research. This is not generally accepted in the medical community.

Q So the Journal of Virology and AIDS and also the -- what was it the, World Journal of Gastroenterology, the -- what was the last one? Brain Metabolism -- Metabolism and Brain Disease, you don't consider those peer reviewed journals to be any evidence whatsoever of hepatitis C virus infection in the brain or proof thereof?

A Any suggestive evidence whatsoever, or does this conclusively prove that hepatitis C virus can damage the brain by infecting it? Those are two very different questions for me.

Q Well, does it revise your opinion at all --

A These papers --

Q -- seeing that there's some -- there's some literature out there on this very subject?

A No. In fact, I --

Q Because you were fairly unequivocal that there was no evidence whatsoever --

MR. SANTACROCE: Your Honor, I'm going to ask him to finish his last answer.

THE COURT: Yeah, let him.

You can finish.

THE WITNESS: Well, may I read a few things from these papers?

BY MR. STAUDAHER:

Q If you wish.

A Because you're asking me --

Q Go ahead.

A -- to look at abstracts and titles. In fact, look at Hepatitis C Infection and the Brain, their last paragraph. This still hypothetical scenario connecting HCV infection and functional CMS changes could be summarized as follows. This still hypothetical scenario. Okay. We're dealing with hypothetical here. Okay.

In your prestigious journal Metabolism and Brain Disease, which I've never heard of before, while the HRQL reduction in depression may be discussed as caused by multiple factors, blah blah blah -- here we go -- it is suggested that alterations in brain function also play a role. I mean, these are the type of literature that are small studies, suggestive, oh, we did microcapture microscopy and we were able to amplify hepatitis C virus RNA from a few brains.

That is a far cry from saying that hepatitis C virus infects the brain. Now, I'm a peer reviewer for many journals. I'm an editor of medical journals, an editor of a scientific journal. There is a big jump from saying this

proves anything to that this is suggestive -- some suggestive laboratory test.

Q Fair enough. So when it talks about detected CD69 positive cells and HCV RNA also found in astrocytes which are contained in the brain; correct? It's talking about the HCV RNA is contained in the astrocytes within the brain. Does that not mean that it's in the brain?

A Can I say that from this? Absolutely not. Do I know he's actually looked at astrocytes? Do I know there was no contaminating cells in the sample? This is just not mainstream accepted medical stuff. This is suggestive stuff from a few laboratory experiments. I can tell you that's how the medical literature works. You make an observation, you publish it, it needs further testing. You won't find this in a review in a New England Journal of Medicine. You won't find this in a textbook. This is very early suggestive stuff that may very likely be wrong. That's all I can say about these papers. I'm sorry.

Q Well, you did say just a moment ago that there was no literature at all, isn't that fair?

A Well, we have to talk about literature at all, or -- I'm sorry, maybe I'm saying is this literature that makes people believe this to a reasonable degree of medical certainty or probability?

Q So the public --

A This is just a paper describing some experiments. That's different than proving cause and effect or anything.

Q So the public medicine website, which is where these came from, which is where a lot of journal articles reside, you don't think that that's -- that's an outlet for medical providers for people looking at this to see whether or not there's any validity to it?

A I guess -- I'm sorry, sir. I guess you don't understand peer review in the medical literature. I'm very sorry. You publish things that are not necessarily facts. You publish observations. This is science. You make an observation. You amplify RNA from a cell from somebody's brain. More people have to do it. Have I seen a bigger series? Have I seen a paper in nature saying that hepatitis C virus conclusively infects the brain? Based on observations published in these small journals we have now proven. That's how medicine works. Not you get a paper from --

Q Fair enough.

A -- this journal published in China and tell me it's proof. I'm sorry.

Q Is that journal published in China?

A This is a Chinese journal, the World Journal --

Q And you're familiar --

A -- of Gastroenterology.

Q -- with it?

A Yes, I am. I even was on the editorial board for awhile or something.

Q Oh, you were even on the --

A Yes.

Q -- editorial board of that journal.

A That's right.

Q This obscure journal that is worthless --

A And I'm not saying --

Q -- as far as the scientific --

A I'm not --

Q -- community is concerned?

A And that does not mean everything is right in there.

Q But you're on the editorial board; right? Or you were.

A To help keep -- to try to help keep papers out that weren't right, except I didn't review every one of them.

Q Okay. But you --

A Okay.

Q -- were on the editorial board of that very journal that I brought up to you.

A The journal where I tried my very best to keep papers out that were not based on solid science.

Q Fair enough. You -- not based on solid science. I'm glad you asked -- you said that because in the case that you -- that counsel asked you about that you actually came in and testified in this -- gave a deposition in this particular city; correct? Related to a non-genetically matched patient?

A An alleged hepatitis C infection, yes. I testified in one case of that.

Q Okay. And in that you said that the patient didn't get hepatitis from the -- from his colonoscopy; correct?

A As best as I was able to tell from looking at all those records, I couldn't say to a reasonable degree of medical certainty that it did.

Q What was your scientific basis for that determination?

A I haven't looked at those records and I haven't looked at that report in a long time.

Q I've got your deposition. Would you like to see it?

A We can go through the deposition line by line if you like. I mean --

THE COURT: Well, no --

MR. SANTACROCE: Your Honor --

THE COURT: -- we can't.

MR. SANTACROCE: -- I'm going to --

THE WITNESS: I mean, I just felt there was no evidence.

THE COURT: But if Mr. Staudaher wants to ask you look at it to refresh your recollection, he's welcome to do that.

BY MR. STAUDAHER:

Q Specifically in that deposition did you not say that you believed that there was no connection, that there was no connection from a scientific or whatever your perspective is, that the person had hepatitis derived from that clinic?

A That person?

Q Yes.

A That person, if I remember correctly, there was a large window where he may have contracted hepatitis, a several month window where anything could have happened.

Q Well, was it not true that even a few weeks before he had had a negative study or a negative test for hepatitis C?

A I can't remember how many weeks before.

Q But you definitively said that he did not get it from the clinic, did you not?

A I said to a reasonable degree of medical probability I couldn't say he got it from the clinic.

Q And other than that clinic, according to the records you reviewed, there was not a single other risk factor that you identified, isn't that correct, other than the clinic?

A I didn't identify the clinic as a risk factor.

Q Oh, I forgot. You didn't identify them, but I'm saying there were no -- taking the clinic aside, there were no other risk factors that you identified?

A In that case, I don't remember. I can look at my report and see what I wrote in there.

Q Do you recall where it is in your deposition, because I can help you with that.

A Yeah, I --

Q And I believe that if you go to page 13, and you can read as much of it before and after as you need to get context.

A Page -- I'm sorry?

Q 13.

A [Witness complied].

Q And then I want you to hop forward to 24.

A Well, it's kind of hard to hop forward.

MS. STANISH: Your Honor, may we approach?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: All right. Mr. Staudaher.

BY MR. STAUDAHER:

Q Now, when you said before that you did not exclude that -- the person who had gotten hepatitis C at the clinic on 13, do you actually say that you do not believe that he got hepatitis C at the clinic?

A I think I say here he contracted it sometime in a time span roughly six months before that time or from going back a couple of weeks before that time and I think that there's many possible ways he could have contracted because, and I don't believe it was from a colonoscopy.

Q Okay. The colonoscopy is -- maybe I misspoke. I guess it could have happened at the clinic, but not from a colonoscopy according to you; correct?

A Well, it didn't happen from a colonoscopy. I think I can say exactly what I said here. There are many possible ways that it could have happened.

Q But not from a colonoscopy; correct?

A From an actual colonoscopy, no. I mean, I'm sorry. I have to read.

Q Read. Feel free.

A I can't take a sentence out of context and --

Q That's why I said read as much as you wish.

A [Witness complied]. As far as I can tell, he was not infected at the clinic.

Q Okay.

A That's all I can say.

Q And your scientific basis for that was what?

A The lack of any evidence that he was infected at the clinic. Can you tell me evidence that he was? I haven't seen any.

THE COURT: All right.

MR. STAUDAHER: All right. I'll move on, Your Honor. I'll move on.

BY MR. STAUDAHER:

Q I want to move to a different case. Sears v Foote Hospital, do you recall that case?

A Wow. That was quite some time ago, but I --

Q It dealt with --

A -- vaguely remember.

Q -- endoscopies; right?

A Yes, it did.

Q Okay. And scopes were -- people, at least three, I think, or so were coming in complaining, or at least alleging that they got their hepatitis C infections from the scopes.

A As best as I can remember that, yes.

Q What was your opinion in that case?

A Well, I looked at a few cases, and one had a blood transfusion as an infant. There was another cause of hepatitis C. I cannot remember the other two. One was

somebody who was incarcerated and was injecting himself with different dyes and sharing needles to tattoo people. I can't remember the other case. But those cases there was no acute hepatitis C and they all had other risk factors for hepatitis C.

Q But you stated that it was not from the scopes; correct?

A It absolutely wasn't from the scopes in those cases.

Q You mentioned incarceration. Did you not involve -- or were you an author on a paper involving whether or not it was appropriate to give interferon therapy to incarcerated persons or to wait because it doesn't -- I mean, there's a window of time that you have that it's not going to cause a problem?

A In chronic hepatitis C, yes.

Q Well, after --

A People --

Q -- six months you're into chronic; correct?

A No, no, no. You're playing with words a little bit. I said the sooner you're treated, the better. But if you're someone who has been in jail and you've been infected for 10 or 15 years waiting a year or two isn't going to matter. But if you're in jail and you're infected six months, seven months, eight months, ten months, there may be

reason to do that. That -- that was dealing strictly with people who were long term infected.

Q What about people that would have been in jail that might be having some symptoms?

A I didn't comment on that in that paper.

Q Well, I'm asking you.

A Having symptoms or get acutely infected in jail?

Q I'm talking about cirrhosis, things like that, direct causes.

A Well, once you have cirrhosis, that's -- you're having symptoms from it, the treatment may not do that much. The goal of treatment is to prevent getting complications of cirrhosis.

Q So back to this exhibit, and this is the defense exhibit. And I think it's DD whatever it was, DD-1. In this particular case you say that once the cirrhosis or fibrosis or whatever is onboard that it's not really effective to have the treatment anymore; correct?

A Once you have established cirrhosis and complications, the treatment doesn't help that much.

Q So we've gone from our 40 to 50 percent down to what?

A Sorry, I don't understand.

Q Well, you said that in somebody with genotype

1a that they would have a 40 to 50 percent, 45, 50 percent. You said, I think, 50 to be fair. 50 percent chance of getting benefit from that therapy.

A Of being cured by that therapy, yes.

Q Okay. Somebody who starts to have cirrhosis or signs of cirrhosis, where does it drop down to as far as affectivity of any treatment?

A Oh, I don't know the exact numbers, but you lose some efficacy once there is histological cirrhosis.

Q In this case there is histological cirrhosis here, at least development of that; isn't that correct?

A No, that doesn't matter. I say when there is established cirrhosis, whether there's Stage 2, that's not going to really change the effectiveness that much. That's --

Q But this is histological result, is it not?

A Fibrosis. This is not cirrhosis. You were asking me about cirrhosis.

Q Oh, that's good. That's good. Okay. So fibrosis.

A Yes.

Q What's the difference between fibrosis and cirrhosis?

A Oh, as I explained before, fibrosis is scar tissue that forms in the live. Cirrhosis is a very advanced stage of liver disease where you have regenerating nodules of

liver cells with scar tissue all around those nodules. So fibrosis is just a scar tissue itself. Cirrhosis is very advanced fibrosis with abnormal regeneration of the liver.

Q And you said -- when was the first time you saw this document here?

A I don't remember.

Q Today?

A Oh, no. No, I saw this at least a few months ago.

Q Those documents that are sitting right up there, those medical records from the Philippines, when was the first time you saw those?

A I saw those a few months ago. Although, I should say I saw a clearer copy today. The copy I was provided with was a little bit hard to read, but I had seen those records before, too.

Q But you reviewed those literally before you came and testified today; correct?

A No, no. I reviewed these records, I don't remember the exact date, but one or two months ago. I just --

Q But most recently you reviewed them just before you testified?

A Just to make sure that there was nothing missing from the copies that I received, there was really nothing significant missing.

Q In Defense Exhibit DD-1, you indicated that what's listed there, the chronic hepatic -- hepatitis, clinically hepatitis C with moderate activity, Grade 3/4 and periportal fibrosis and mild microvesicular and macrovesicular steatosis; is that correct?

A Steatosis, yes.

Q Steatosis, which is a --

A Fatty liver.

Q -- fatty liver. Right.

A Right.

Q Now, with regard to the next portion, I mean, you said that the circle part, that there is no way to determine that that -- the hepatitis C infection has anything to do with that; correct?

A From -- I'm sorry. I didn't --

Q That the hepatitis C infection had anything to do with that.

A Had anything to do with what? The --

Q What's listed there, the diagnosis.

A The steatosis?

Q No, all of it, any of it.

A I didn't say that.

Q Oh, I'm sorry.

A I said --

Q What did you say?

A I said he had chronic hepatitis that clinically was hepatitis C. And then I said he had periportal fibrosis, which may have been from hepatitis C or other causes, and he has another insult in his liver, which is the fatty liver.

Q Okay. And that one actually has -- is the only one that says mild, is it not?

A It's mild.

Q Okay. It's mild. Now, when we go down here to the lower portion of this under comments, pertinent laboratory values found within Qwest Diagnostics Laboratory are as follows. Do you see that?

A Yes.

Q And it's got a date, 6/3/2008. So that's before this study on 7 -- it was -- I think the sample was taken 7/25/2008; correct? Does it say that?

A This was 7/25/2008.

Q So go down there and look at that, each HCV RNA PCR quantitation at, it looks like 8,850 international units per mil; is that correct?

A Yes, I commented that when I talked about this before. I said there was some data showing that he had hepatitis C virus RNA at a low viral load, yes.

Q And it's PCR quantitation which means that somebody did what?

A Oh, you want me to explain --

Q Sure.

A -- how PCR is done? So the virus is an RNA virus. There's an RNA genome. We have DNA. The virus has RNA. You have to take the RNA and convert it to DNA in one reaction, and then there's a reaction called PCR where you can amplify the DNA and you can semi-quantify how much virus is present in the blood. And in this case this would be a relatively or quite low value of 8,850, but the hepatitis C virus RNA was present in his blood.

Q So when it says here quantitation 3.9 log, what does that mean?

A That -- that's -- to the 10. 10 --

Q So it's 10 to the 10 --

A -- 10 to the 3.9.

Q -- to the 10 to the 10?

A No, 10 to the 3.9. So it's a little different. I mean, if you take that, I don't know, that would come out to maybe 10,000. No, it would come out to 8,850; right? Because that's the same number.

Q And if you move across here, again, it says genotype 1a.

A I think that's been established, yes.

Q Okay. No question that there's at least genetic linkage in this particular case; correct?

A There's -- I can tell from this there's genotype 1a virus. What do you mean by genetic linkage?

Q You're familiar that there was a genetic link in this case for this particular patient?

A Can you ask me a more specific question?

Q Are you aware that there was a genetic link to a source patient in this particular case --

A Oh, I'm --

Q -- with this -- with this particular patient?

A I'm aware looking at data from the Southern Nevada Health District and the CDC that there were several patients on that day that had genetically similar isolates, yes.

Q Now, with regard to the -- the test here, I mean, clearly there's evidence of disease that you even acknowledge could be caused by hepatitis C; correct?

A Well, I don't think you can get Stage 2 fibrosis after just 10 months of hepatitis C.

Q In the medical records that you saw before September 2007, did you see any evidence of anything that could have led to this? We're talking about alcoholism, infections of other kinds, whatever.

A No, the -- the bile duct obstruction and also the fact that he had microvesicular and macrovesicular steatosis here, he may have had that for quite some time.

Q And you're not a pathologist; right?

A I look at liver biopsies, but I'm not a pathologist.

Q Okay. Do you feel competent to opine as to cause of death when looking at records that two coroners, two medical examiners looked at?

A I feel competent to opine on cause of death because I've looked extensively at these medical records. I've looked at their reports, and I've looked at the death certificate, yes.

Q Extensively at medical records that -- which medical records are we talking about?

A The ones that I mentioned when we began today.

Q Did you not say that it was relatively sparse, the medical records that you had?

A I looked extensively at what I had, and it was --

Q Okay.

A As far as I --

Q So even if you didn't have very much, you looked at it really heard; is that right?

A As far as I know, it's the same medical records that these pathologists looked at. If there's other ones, I assume they would have been given to me. Are -- are there other medical -- I guess I --

Q I don't know.

A -- can't ask questions, but --

Q I don't know what you actually looked at. With regard to the kidney, I want to ask you about an issue related to that that you testified. Already we've established that little cysts, benign hepatic or renal cysts, they don't really cause an issue; correct?

A The cysts in this place were not a major contributing factor, if at all. I --

Q So the cysts don't cause any issue.

A That's true.

THE COURT: Let him finish.

MR. STAUDAHER: I'm sorry, Your Honor.

THE COURT: Did you finish?

MR. STAUDAHER: I'm sorry to the witness.

THE WITNESS: I said that's true, the cysts that were found on the radiology scans were not major factors here.

BY MR. STAUDAHER:

Q You said that one of the concerns that you had was the benign -- benign prostatic hypertrophy; correct?

A It could be a concern, yes.

Q That it might cause backing up of the urine which might affect the kidneys, that kind of thing?

A Yes.

Q If you have backing up of the urine into the

kidneys, what do you get as a result, typically?

A You can get infections, which he possibly had, but over long term you can get damage to the kidneys.

Q In what form? I mean, what do you usually see as a harbinger before the damage occurs?

A Well, I'm not a kidney pathologist, so I don't want to get into the details of what can happen, but as an internist I know having chronic kidney obstruction you can get kidney disease.

Q Do you see things like hydronephrosis?

A You might see hydronephrosis. You might --

Q And what is that?

A Hydronephrosis is when the -- the kidney where the urine is collected expands, and you can see it perhaps on an x-ray or an imaging study.

Q Okay. And there was no evidence in these imaging studies?

A On that scan, no, but we don't have any imaging since then, so I don't know.

Q Okay. Do you know what hepatorenal failure is?

A I know what hepatorenal syndrome is.

Q Okay. Tell me about hepatorenal syndrome.

A So hepatorenal syndrome is when you have a normal kidney. So your kidney has no structural kidney

disease. There is no damage to glomeruli. There is no nephrosclerosis. There is no chronic kidney disease. So a perfectly normal kidney in a person whose liver fails, that kidney can stop working because the liver fails. Now, if you changed a person's liver, the person gets a liver transplant, that kidney works normally. If you take the kidney out of that person and put into a normal person, and this is a dog experiment, you don't do that in people, but that kidney works normally. So that's when the kidney fails solely secondary to the liver failing.

Q Isn't it true that approximately 40 percent of patients with combination cirrhosis and ascites, which was the case in this particular instance, will get renal failure as a result, and that's what is termed hepatorenal syndrome?

A That's an interesting question because there's two types of hepatorenal syndrome. So when you put that big number on it, that sort of literature saying there is a low grade renal insufficiency that some of them get, but the full blown hepatorenal syndrome where your kidney completely fails, that's a much, much, much smaller number.

Q But it's progressive renal failure caused by liver cirrhosis; right?

A That -- that can happen in a structurally normal kidney. Correct.

Q And that's what we actually have here is liver

failure; correct?

A We have a structurally abnormally kidney, though.

Q And what are you basing that off of, again?

A I'm basing it on your -- your coroner and your pathologist reports.

Q And which reports were those?

A Those would be --

Q And read me the grossly or structurally abnormal results there.

A Okay. So this is the -- okay. This is the autopsy report from the Philippines. And I see here hypertensive nephrosclerosis kidney. I think the pathologist from -- from here in Nevada -- I can't quite find that one. I think I have it.

Q I've got a copy.

A Okay. So this is from the Clark County Coroner. It says nephrosclerosis, but I think there's a more extensive -- kidney, dissection shows mild to moderate nephrosclerosis with associated interstitial fibrosis. There also appears to be mesangial thickening within many of the remaining glomeruli, as well as the presence of excessive amounts of proteination and fluid within Bowman's space. Occasional foci of interstitial chronic inflammation are present. There is patchy parenchymal congestion, but no frank

hemorrhages observed. Occasional foci of arteriosclerosis are present. So this is describing several structural kidney lesions here.

Q Well, aside from the atherosclerotic issue, the narrowing of the arteries in the kidney, isn't that -- doesn't that seem to match up with progressive renal failure due to cirrhosis?

A No. I have nephrosclerosis here and interstitial fibrosis and mesangial thickening. This is a description of damage to the glomerulus itself. This is not just arteries being hardening. This is the unit that filters the blood in the kidney is damaged in this patient.

Q So how does cirrhosis cause renal failure.

A That doesn't cause it by doing that.

Q Well, I'm asking you.

A It causes it by hormonal and blood flow problems. The kidney is structurally normal. If it was purely hepatorenal syndrome and took the kidney out, the kidney would not have any of these changes in it. Your glomeruli look completely normal. It's because you get an imbalance of hormones, such as renin, angiotensin, aldosterone. These are hormones that control blood flow to the kidney. You get problems with that and essentially you get decreased profusion of the kidney because the liver fails. But once you start seeing these things, that's structural

damage to the kidney that probably resulted from years of hypertension and perhaps resulted from years of low grade obstruction.

Q But your opinion is that the liver had nothing to do with that?

A I'm saying he had structural kidney disease.

Q I'm not asking you whether there was structural kidney disease.

A I cannot --

Q I'm saying the findings in the kidney beyond the structural disease, is there any --

MR. SANTACROCE: Your Honor, I'm going to object. This is getting to the point of argumentative. It's been asked and answered.

THE COURT: Well, let him -- no. He can --

BY MR. STAUDAHER:

Q Is there any portion of the cirrhosis, the liver disease, that could have affected that?

A That could have? Yes. But can I say that from looking at the history in this? I don't know.

Q Now, you mentioned in the -- in the -- I think it was the -- gosh, the -- well, first of all, do you think based on your review of the medical records that he had a hepatorenal syndrome?

A I can't say he had hepatorenal syndrome from

the medical records, not with this degree of structural kidney disease. Also, the necessary --

Q The --

A -- tests for hepatorenal syndrome --

THE COURT: Let him finish again.

MR. STAUDAHER: I'm sorry.

THE WITNESS: The necessary tests to diagnose hepatorenal syndrome were not in the labs in the Philippines.

BY MR. STAUDAHER:

Q The medical records that you have up there, specifically the 4/20 -- this is the second hospitalization, the one where he died, 4/24/2012, a note indicating that he was declared to be in hepatorenal syndrome -- in the hepatorenal syndrome with associated hepatic encephalopathy.

A Can you show -- I -- I'm sorry. I can't find that in here.

Q Well, I'm asking -- I've given you the date. You've got the records in front of you.

A What was the date?

Q The date was 4/24/2012.

A You're going to have to help me a little more. I have doctor's notes and nurse's notes here --

THE COURT: Mr. Staudaher --

THE WITNESS: -- and other notes.

THE COURT: I'm sorry. Now I'm interrupting you.

THE WITNESS: I'm sorry. It's okay.

THE COURT: If you're aware of where that is in the record, can you --

MR. STAUDAHER: I know it's on that date. I don't know if it's --

THE COURT: -- can you maybe --

MR. STAUDAHER: -- tabbed or not. I can try and look.

THE COURT: -- try to kind of facilitate this.

THE WITNESS: There's doctor's and nurse's notes. I'm sorry.

MR. STAUDAHER: Well, Your Honor, I've got the date, but it may be the wrong -- wrong one here at the time. So I'll look at that for later on.

THE COURT: Okay.

BY MR. STAUDAHER:

Q If the record had shown that, and we can look at it another time, but if the record had shown that, would you -- would that change your opinion at all?

A Well, it would depend how the record showed that. If it's just a doctor writing a note, I did see a note in here at one point that said diagnosis, question mark, hepatorenal syndrome, that would not affect me at all. If I saw laboratory evidence, that might affect me, but that's not in here as far as I know.

Q What laboratory evidence would you need?

A Well, you need to check the urine sodium and see if he had extremely low urine sodium.

MR. STAUDAHER: Your Honor, I pass the witness.

THE COURT: All right. Thank you.

Redirect.

MS. STANISH: May I approach?

THE COURT: You may. You may move freely.

REDIRECT EXAMINATION

BY MS. STANISH:

Q I have the exhibit from the Philippines. Is this -- from your review of this record, was it a complete medical record in your experience? What's missing, I guess?

A Again, as I said, that's not at the standard of medical records we would have at New York Presbyterian Hospital or most U.S. hospitals. I didn't find good discharge summaries. I didn't find detailed admission notes. And I think some laboratory tests that you probably should have done on a patient like this I didn't see in there.

Q Do you know if there was reference to labs in -- if you recall, was there reference to labs, but the lab reports themselves were not contained in these records?

A Not that I can recall, no.

Q Now, the -- Mr. Staudaher had indicated that you just had to scurry to review these records before coming

to testify this -- in the morning today. You were -- when did you first received these records?

A So I actually received two copies of those records. One was a hard copy that I'm going to estimate about six to eight weeks ago. Then I subsequently received a scanned .pdf of the same records, and some of them were just difficult to read. So the only thing I did today was re-review them to see more clearly the pages that I couldn't see in the scan copies and photocopies that I had.

Q If you recall, do you remember if the copies you received had what we call little Bates stamps showing at the -- it was discovery provided by the State?

A I believe that either you or your paralegal sent a note that said these were provided by the State, but I cannot be sure.

Q Do you know if you have reviewed all the documents that the State of Nevada provided with respect to Mr. Meana's medical records?

A I've --

MR. STAUDAHER: Objection. Speculation. It's what he was provided by defense counsel. He doesn't know what we provided.

BY MS. STANISH:

Q Were you provided medical records that indicate -- had Bates stamps on them?

A Some of them at least did, yes. And maybe perhaps all of them, but there are Bates stamped records for sure.

Q With regards to peer review articles versus what you refer to as suggestive articles, can you explain why the three articles that Mr. Staudaher gave you don't fall into the category of what's accepted by -- in general by the medical community? Maybe I need you to explain the standard, to clarify that for us.

A Well, it's -- in biomedical research, it's very typical that small interesting observations often get published that are never followed up upon and never proven to be conclusive. And I would consider these type of publications in these type of, some of them highly sub-specialized journals, and some of them even journals, you know, that are not of even a middle caliber. I would say these are at best suggestive.

I mean, these are certainly types of experiments that you cannot hold to a reasonable degree of medical certainty or a reasonable degree of scientific certainty. These are suggestive findings and a few experiments. These are not in textbooks. These are not in the New England Journal of Medicine. They are not in nature. They are in science. These are small suggestive findings. This is not where I would base decisions of treating a patient, life and

death, or in a court determining, you know, causation or problems.

Q But Mr. Staudaher seemed to think it was significant that you were on the editorial board of one of those. Can -- can you explain how these middle -- what did you call them, middle range periodicals?

A Middle range journals. How'd they get me on the editorial board?

Q I don't know. Were you on the editorial board when it -- that was written?

A I was on the editorial board for awhile. I was invited to give a lecture in China and I met the editor of that journal, and he said would you be on the editorial board? And I said, sure, I'll review a few papers a year. And my only contribution to that journal was reviewing a few papers.

Q Did you review that one?

A Nope.

Q If you did, would you have let it into the -- recommended it be published?

A I haven't read it in its entirety, but I would say I certainly have a lot of questions about it.

Q All right. Now, you're not a pathologist. So are you sitting here today rendering an opinion as to what caused Mr. Meana's death?

A Well, yes, I think as an internist and a

hepatologist I can review all these records and come to a conclusion.

Q And explain to us why -- explain to us what your conclusion is based on that review.

A Well, I think Mr. Meana had several underlying medical problems. He had medical problems that were affecting his kidneys from as early as 2006, 2007. He had medical conditions that were chronic, that were to some degree affecting his liver as manifested by biliary obstruction, and also by fat in his liver. He got infected with hepatitis C on top of that. He became quite sick with both kidney failure and with liver disease and liver failure. But to look at all these records and to say it was infection with the hepatitis C virus on September 21, 2007, that led to his death, it's just not possible.

Q Why? Isn't medicine a science of certainty?

A Medicine is a science of probability. There may be some things that are 99.99 percent certain, but not looking at a complicated patient with multiple problems who had something happen to him four or five years ago and then later say, oh, it's that that killed him. I just -- as a physician and as a scientist, I cannot do that based on everything I looked at here.

Q Thank you.

MS. STANISH: I have nothing further.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: Thank you.

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, Mr. Staudaher asked you about a case many years ago that involved scopes where you ruled that out as the mechanism of transmission of hep C. Can you tell me a little bit more about that case, how long ago was it? I don't need an exact date. Was it like ten years ago?

A It was -- it was roughly ten years ago, I would say.

Q And in that particular case you ruled out the scopes because the patients or the individuals that were infected had other possible means of catching that disease. For example, you said one had blood transfusion, one, I believe, had some shared needles, and the other one you couldn't think of; correct?

A I can't remember the other one, but I know all those cases were -- there was no evidence of acute hepatitis C infection, and they all had other risk factors for hepatitis C.

Q And in that particular case you weren't making a global determination that hepatitis C can't be transmitted through scopes. That was just a fact specific case; correct?

A Correct. I was looking at those specific

cases that I looked at.

Q And, in fact, how long can hepatitis C virus live in the environment outside of the human body?

A Oh, boy. I don't know the exact number. There is some period of hours or something, but I don't know.

Q We had from 16 hours to four days. Does that comport with your knowledge?

A I would not argue with that, but I don't know for sure.

Q And it's a blood-borne pathogen; correct?

A Yes.

Q So that means it passes through blood, blood to blood contact?

A Blood-blood is the only way to really get it, yes.

Q And blood lives in fecal matter; correct? Or can be present in fecal matter?

A Can be. I would say that would be a quite low, low, low, low risk way of transmitting this virus, but it's theoretically possible.

Q Okay. And it can be passed through -- well, first of all, you're not here to make a determination as to mechanism of transmission in this case; correct?

A Correct. I was asked to look at Mr. Meana's medical records and comment on his medical history and medical

condition and how he ended up.

Q So when Mr. Staudaher asked you about the scopes, you weren't opining in this particular case the mechanism of transmission of the disease?

A All I did when he asked me that is read what I had said in my deposition from two to three years ago in a different case.

Q Okay. And your -- your testimony is emphatic that hepatitis C does not cause dementia; correct?

A It does not cause dementia.

Q If I was a neuropsychologist and I did a study of 19 people and I have had that some sort of correlation between hepatitis C virus and that these 19 individuals had some sort of neurological damage, and then I concluded that one of them, at least, had dementia, would that be a valid study?

A That would probably not even get published in some of these journals. There is no controls, there is no methodology, there is -- it's never been peer reviewed as far as I know, so, no.

Q Thank you.

THE COURT: Mr. Staudaher.

MR. STAUDAHER: No redirect, Your Honor.

THE COURT: Counsel approach.

(Off-record bench conference.)

THE COURT: Doctor, I have a couple of juror questions up here.

THE WITNESS: Okay.

THE COURT: A juror would like to know if Mr. Meana had not been infected with hepatitis C on September 21, 2007, can you say that he would probably have died from liver -- I'm sorry, from liver complications in 2012?

THE WITNESS: Boy. It's just really not possible to say that based on the records. I mean, I would say probably, maybe not from liver disease. From kidney maybe, but I -- I just can't say. That would be speculating.

THE COURT: Okay. And then another juror would like to know can hepatitis C accelerate existing kidney disease or liver disease or does it have no effect?

THE WITNESS: Well, obviously, if there is more than one insult to your liver, it can accelerate it. So a classic example is people who have hepatitis C and also drink alcohol. They do progress faster. So having two or three different diseases can make your liver worse than having one disease. Kidney disease, hepatitis C rarely affects the kidney. There are rare circumstances where you can get something called cryoglobulins where hepatitis C can affect the kidney, but there's no evidence that he had that and it's, you know, not really common.

THE COURT: Ms. Stanish, do you have any follow up

to those last juror questions?

MS. STANISH: Court's indulgence.

THE COURT: I guess that would be no.

MR. WRIGHT: I'm shaking my head no.

MS. STANISH: Can we approach, Your Honor?

THE COURT: Sure.

MS. STANISH: Thank you.

(Off-record bench conference.)

THE COURT: Ms. Stanish. Oh, I'm sorry. We need to wait for everybody to get back to their seats.

FURTHER REDIRECT EXAMINATION

BY MS. STANISH:

Q Dr. Worman, did you review all the medical records that our office forwarded to you?

A Yes.

MS. STANISH: And, Your Honor, may the record reflect that the medical records forwarded to Dr. Worman were provided by the State of Nevada and we forwarded all that we received from them to Dr. Worman.

THE COURT: Okay.

MR. STAUDAHER: State will -- will take the representations of counsel, Your Honor.

THE COURT: All right. Then that will be reflected in the record.

MS. STANISH: Nothing further.

THE COURT: Mr. Santacroce, anything else?

MR. SANTACROCE: No, Your Honor.

THE COURT: Mr. Staudaher, anything else?

MR. STAUDAHER: No, Your Honor.

THE COURT: All right. Doctor, thank you for your testimony. You are excused at this time.

THE WITNESS: Thank you.

THE COURT: And I'm sorry. We didn't have any other juror questions? I forgot to ask.

All right. Thank you, Doctor. You're free to leave.

All right. Ladies and gentlemen, in a moment we'll be taking our evening recess. We will not be in session tomorrow. On Thursday we will resume. I anticipate that we will have the closing arguments on Thursday, and following that the case will be submitted to you.

Now, trial is not over, so obviously the prohibition about discussing the case or anything relating to the case is still in effect. You are additionally reminded that you are not to read, watch, or listen to any reports of or commentaries on the case, any person or subject matter relating to the case. Do not do any independent research by way of the internet or any other medium, and please do not form or express an opinion on the trial.

If you would all please place your notepads in your

chairs. And I forgot to tell you when to come back. We'll see you back here at 9:00 a.m. on Thursday morning. 9:00 a.m. Thursday morning.

(Jury recessed at 4:39 p.m.)

THE COURT: All right. How about 10:30 for us tomorrow, or is that too early?

MS. WECKERLY: No, that's not too early. I'm just hoping we can get the proposed defense ones tonight so we can look at them.

MS. STANISH: I believe so. You know, we have 15 special jury instructions. Many of them are evidentiary right out of the Ninth Circuit pattern book. And then it's really the elements of the offense relating to the negligent charges that I think they want to focus on, but we will get those to them.

THE COURT: Well, they may want to focus on the ones from the Ninth Circuit, which by virtue of the fact that you say --

MS. WECKERLY: We're in State Court.

THE COURT: Well, we're in the -- under the -- by virtue of the fact that you say they're from the Ninth Circuit book suggests we normally, and I'm sure we normally don't give them, so, I don't know, they may have objections on those, as well.

MS. STANISH: I understand.

THE COURT: All right. We'll see you back here tomorrow at 9 -- I'm sorry, 10:30.

MS. STANISH: Thank you.

(Court recessed for the evening at 4:41 p.m.)

CERTIFICATION

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

AFFIRMATION

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

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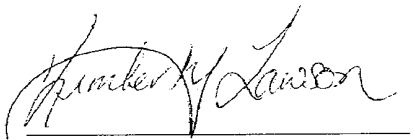

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CLERK OF THE COURT

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

STATE OF NEVADA, Plaintiff vs. DIPAK KANTILAL DESAI, RONALD ERNEST LAKEMAN, Defendants	)	CASE NO. C265107-1,2 CASE NO. C283381-1,2 DEPT. NO. XXI **Transcript of Proceedings**

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 45

THURSDAY, JUNE 27, 2013

APPEARANCES:

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

RECORDED BY: JANIE OLSEN, COURT RECORDER
TRANSCRIBED BY: JULIE POTTER, TRANSCRIBER

JRP TRANSCRIPTION

INDEX

LAS VEGAS, NEVADA, THURSDAY, JUNE 27, 2013, 9:06 A.M.

(Court was called to order)

(Outside the presence of the jury.)

THE COURT: All right. Excuse me. We're still missing two jurors. I wanted to finish up on the last remaining matters before we bring the jury in. As I said, there are two jurors who are not here, so we can't start with the jury anyway.

Ms. Weckerly, did you make all of the changes to the jury instructions that we talked -- we went over the last copy yesterday?

MS. WECKERLY: Yes, and I emailed them to everybody, including the Court.

THE COURT: All right. And did Mr. Santacroce, Ms. Stanish, did you both have an opportunity to review the jury instructions with the final revisions that we had discussed?

MR. SANTACROCE: Yes, Your Honor.

THE COURT: All right.

MS. STANISH: Yes, Your Honor. We were just trying to refresh our memory on the ultimate ruling on the instruction dealing with the term petty larceny.

THE COURT: I thought we were pulling the grand larceny instruction and we were just going to do theft under 250 and obtaining money under false pretenses under 250, and I thought the agreement had been that that's just obvious.

I had suggested giving a lesser included, but then my understanding was between the attorneys the feeling was that it was just obvious, they either meet the 250 or they don't meet the 250 and they could choose the appropriate verdict on the verdict form. That was my understanding of how we had left it yesterday afternoon.

MS. WECKERLY: Okay. Well, that's fine. That can just be pulled out --

THE COURT: Okay.

MS. WECKERLY: -- that instruction.

MS. STANISH: And that was the only thing we saw, Your Honor.

THE COURT: And I don't believe we went through and numbered that in our numbering.

MS. WECKERLY: No, I just think it's in the -- you know, the blank number. You know, it's just in the packet, so it probably isn't in the Court's packet if you pulled it out.

THE COURT: Okay. And then you made the changes onto the verdict form; correct?

MS. WECKERLY: I did, and I dropped it off.

THE COURT: All right.

MR. SANTACROCE: And when you're done with that, there's one other matter.

THE COURT: I still have to go over their rights to testify.

MR. STAUDAHER: And the State has a couple of other matters, as well, Your Honor.

THE COURT: Okay.

MR. STAUDAHER: Minor matters.

THE COURT: All right. Did the defense receive copies of the revised verdict form?

MS. WECKERLY: It should have been on the last email that I sent in the Word format.

MR. SANTACROCE: Was it at 6:30 last night or something?

MS. WECKERLY: Yes.

MR. SANTACROCE: Yes.

MS. STANISH: Yes, we received that.

THE COURT: Okay. The theft, the one I just was handed, does not have the misdemeanor, the theft under 250, and the obtaining under 250.

MS. WECKERLY: I think that --

THE COURT: Do you have a different one, Denise?

THE CLERK: This is what Sharry gave me.

THE COURT: Oh, okay. All right. So this is -- she gave me a different one.

All right. And, Defense, your copies have the -- yes, okay, this is correct. It reflects what we had discussed yesterday.

All right. Just to make sure that everyone has the

correct jury instructions from the completed packet that Ms. Weckerly has emailed to everyone and my JEA just printed out, shall we go through and number them again together?

MR. WRIGHT: Yes.

THE COURT: All right. Instruction No. 1, members of the jury.

2, if in these instructions.

3, an indictment is but.

And, State, you've omitted the count relating to the Veteran's Administration?

MS. WECKERLY: Yeah, correct. It just says omitted.

THE COURT: Okay. 4, you are here only to determine.

5, a separate crime.

MR. WRIGHT: Wait. I've got it is the duty.

THE COURT: That is part of Instruction 3.

MR. WRIGHT: Okay.

THE COURT: Just when it was printed out it went to a new page.

All right. So 5, a separate crime is charged.

6, a conspiracy is an agreement.

7, it is not necessary.

8, each member of.

9, evidence that.

10, where two or more persons.

11, mere presence.

12, any person who.

13, a person who.

14, you have heard.

MR. WRIGHT: Just a minute. I'm on 13. 14, you have heard.

THE COURT: Everybody on the same page as the Court?

15, a professional caretaker.

16 -- 15 goes to a second page.

Then 16 is a certified registered nurse anesthetist.

17, both the reckless endangerment.

18, as used in these instructions.

19, count 25 charges.

20, counts 26 and 27.

21, if you find.

22, the term intent to defraud.

23, murder is.

24, malice as.

25, murder of the second degree.

26, murder in the second degree.

27, the second degree felony murder.

28, in regard to the crime.

29, as to an offense.

30, as to the element.

31, to constitute the crime charged.

32, the defendant is presumed innocent.

33, it is a constitutional right.

34, you are here to determine.

35, the evidence which.

36, the credibility or believability.

37, you have heard testimony.

38, you have heard the testimony of.

39, certain charts and summaries.

40, a witness who.

41, although you are to consider.

42, in your deliberation.

43, when you retire.

44, if during your.

And 45, now you will listen.

Is that what everyone has?

MS. STANISH: Yes, Your Honor. And for the record, I had given your clerk a complete copy of our jury instructions.

THE COURT: All right. All right.

All right, Mr. Staudaher, you indicated the State had some matters.

MR. STAUDAHER: Yes, just a couple of items, Your Honor.

THE COURT: All right.

MR. STAUDAHER: First of all, the charts that are

the -- I know that the charts we're talking about that are in evidence, the smaller versions of those, we have larger versions of those that we wish to -- I know they're not going to be for --

THE COURT: To use as demonstrative evidence?

MR. STAUDAHER: And that goes back -- can go back to the jury so that they can actually see a larger version of the small chart, those right there, which are mirror copies of them. I'm talking about the large charts that were -- that would be displayed in court, so that they can have those instead of all of them poring around a small version of that. So we're asking --

THE COURT: Are you talking about the charts that have the detailed information?

MR. STAUDAHER: Yes. Yes.

THE COURT: All right. Does the defense have any objection to the large copies of the charts that we've been using throughout the trial going back to the jury? That's the breakdown by the days --

MR. WRIGHT: Yes.

THE COURT: -- and the rooms?

MR. WRIGHT: Yes. I don't want replaced blown-up charts of the State's exhibits after we rest the case. I would have blown up all of my exhibits to big charts that they can carry around and prop up. The evidence is in and closed.

THE COURT: All right. The jury will get the smaller evidence. Obviously, you can use whatever blowups, whatever demonstrative evidence you want to use. And however you choose to blow up or enlarge the evidence that's been presented is fine.

MR. STAUDAHER: And the ones that the Court has comply with all the orders so far --

THE COURT: Okay.

MR. STAUDAHER: -- and our corrections.

THE COURT: And those are all admitted --

MR. STAUDAHER: Yes.

THE COURT: -- the graphs and everything that have been revised according to the Court's orders.

MR. STAUDAHER: With regard to -- we both, as the Court had ordered earlier with regard to any PowerPoints or whatever, we have lodged as Court's exhibits copies of both presentations as we anticipate providing them today. Also, we have provided as -- and I think those are going to be Court Exhibits 24 and 27.

There's also Exhibit 26, Court's Exhibit 26, which is the basis of the location of the seizure document related to the affidavit, which was the center of discussion yesterday. Although, we know that that has been removed as a Court's exhibit, we wanted to have at least a record of where it came from, specifically what computer it came off of, all

of that kind of stuff. So that has been lodged and that is Exhibit 26.

25 --

THE COURT: Right. And just to reiterate so it's clear in this portion of the record, the Court did find that there was nothing to suggest that the police had acted inappropriately or anything like that in obtaining that document.

MR. STAUDAHER: Right. And as far as the -- early in the trial there was some discussion about R&R Partners and -- and some meetings and so forth and whether attorneys were present and who had hired them and that kind of thing.

We went back through some of those records. We compiled emails and so forth from the -- and this was all discovered and it was provided to defense counsel. And we just want to make this a Court's exhibit, a record of that, which was Exhibit 25 related to the meetings and so forth. No argument about it. I just want it for the appellate record in case they want to review what the basis was on that issue.

With regard to -- well, I know that there are a couple of outstanding exhibits that have -- the clerk and I have been working with trying to identify that they are -- they're not a major issue. But two of them, I believe, are Court's exhibits, or would be a Court's exhibit. One is actually an admitted exhibit that apparently has gotten lost

in the process.

THE COURT: Okay. Do we --

MR. STAUDAHER: I've tried to reproduce that.

THE COURT: Okay. I'm not concerned about the Court's exhibit at this point. I am concerned about the trial exhibit that needs to go back to the jury.

MR. STAUDAHER: Yes, it's one single --

THE COURT: So are we missing a trial -- I mean, a trial exhibit that would go back to the jury or --

MR. STAUDAHER: Yes.

THE COURT: Okay.

MR. STAUDAHER: There is one page of -- it's one memo related to, I believe, Ms. Rushing's testimony when those documents came in. The clerk has identified it to me. I'm going to try and go back and find a replacement copy of it. It is not something we intended to argue at all today --

THE COURT: Okay.

MR. STAUDAHER: -- in court. So I just wanted to make sure the Court was aware of that. Also --

THE COURT: All right. Just to -- so we all understand, what -- do you know what exhibit number that is?

THE CLERK: 202.

THE COURT: 202? Okay. And you'll make sure you get that and get with the --

MR. STAUDAHER: Correct.

THE COURT: -- clerk and obviously show the defense what it is that you're adding or putting in as the exhibit.

MR. STAUDAHER: Sure.

THE COURT: Okay.

MR. STAUDAHER: And it's my understanding it would be a replacement of one that was already shown and admitted --

THE COURT: Okay.

MR. STAUDAHER: -- at one point. With regard to one other document, there was, and I've shown this counsel, the only witness who did not come in and actually physically testify or present on a video demonstration -- or video deposition was that of Carole Grueskin.

THE COURT: Ms. Grueskin.

MR. STAUDAHER: I displayed in opening with Court's and with counsels' approval her picture, and I intend -- and it may be coming up, it will come up again in closing here. So I wanted to make sure that we had at least as a Court's exhibit a copy of that -- that picture that would be used so that we're not just displaying things to the jury that are not evidence that didn't come into the case. So I've shown that to both counsel. It's my understanding that they are not --

THE COURT: No objection --

MR. STAUDAHER: -- have no objection to --

THE COURT: -- to him displaying --

MR. STAUDAHER: -- it and we can --

THE COURT: -- the picture of Ms. Grueskin?

MS. STANISH: Correct, as demonstrative evidence.

THE COURT: Right. It won't go back to the jury. It's a Court's exhibit as part of the -- a Court's exhibit, as well as part of the PowerPoint that has also been made a Court's exhibit.

Is that correct --

MR. STAUDAHER: That's correct, Your Honor.

THE COURT: -- Mr. Staudaher?

MR. STAUDAHER: Yes.

THE COURT: All right. Is that all that the state needed to clear up?

MR. STAUDAHER: Yes.

THE COURT: All right. We're going to go over the right to testify and the right not to testify, which we did not do yesterday. I'm going to begin with Mr. Lakeman.

Mr. Lakeman, would you please stand. Mr. Lakeman, do you understand that you have the right to take the stand and testify on your own behalf? Are you aware of that right?

THE DEFENDANT LAKEMAN: I do. I understand.

THE COURT: All right. Do you understand that if you choose to take the stand and testify on your own behalf, the deputy district attorneys will have the opportunity to cross-examination you and anything you say, whether it be in response to a question on direct examination,

cross-examination, or a question from one of the jurors or the Court will be the subject of fair comment by the deputy district attorneys in their closing arguments? Do you understand that?

THE DEFENDANT LAKEMAN: I understand.

THE COURT: All right. Conversely, you have the right not to take the stand and testify. Should you avail yourself of your right not to testify, the deputy district attorneys are precluded from commenting upon this in their closing arguments. Do you understand that?

THE DEFENDANT LAKEMAN: I understand.

THE COURT: All right. Also, if you choose not to take the stand and testify, the Court will give an instruction if asked to by your attorneys, and they have requested the instruction.

The instruction essentially says it is the constitutional right of a defendant in a criminal trial that he may not be compelled to testify, thus the decision as to whether or not he should testify is left to the defendant on the advice and counsel of his attorney. You must not draw any inference of guilt from the fact that he does not testify, nor should this fact be discussed by you in your deliberations in any way. That will be the instruction, and Mr. Santacroce, I understand, would like that instruction given.

Is that correct?

MR. SANTACROCE: That is correct.

THE COURT: All right. Do you understand all of that?

THE DEFENDANT LAKEMAN: Yes, Your Honor.

THE COURT: All right. Also, if you choose to take the stand and testify and you've been convicted of a felony crime within the past ten years or you have discharged your sentence of parole, probation, or imprisonment within the past ten years, the deputy district attorneys would be permitted to question you about that.

And I don't believe that there are any prior convictions as to Mr. Lakeman that could be used for impeachment; is that correct?

MR. SANTACROCE: That's correct, Your Honor.

THE COURT: All right. Have you had a full and ample opportunity to discuss your right to testify, as well as your right not to testify with your attorney Mr. Santacroce?

THE DEFENDANT LAKEMAN: Yes, Your Honor.

THE COURT: All right. Do you have any questions that you would like to ask the Court about either of these rights?

THE DEFENDANT LAKEMAN: No, ma'am.

THE COURT: All right. And it is my understanding, Mr. Santacroce, that your client does not wish to testify; is that correct?

MR. SANTACROCE: That is correct.

THE COURT: All right. Did I cover that to your satisfaction?

MR. SANTACROCE: Yes.

THE COURT: To the State's satisfaction?

MR. STAUDAHER: Yes, Your Honor.

THE COURT: All right. Thank you.

Mr. Lakeman, you may be seated.

Dr. Desai, I need you to stand up. I'm going to cover the same rights that I just covered with Mr. Lakeman. All right?

You have the right to take the stand and testify on your own behalf. If you choose to take the stand and testify on your own behalf, the deputy district attorneys can cross-examine you and anything you say in response to any questions, regardless of who asked it, whether it's your attorneys, the deputy district attorneys on cross-examination, the Court, or one of the jurors, will be the subject of fair comment by the deputy district attorneys in their closing arguments.

Also, if you choose to take the stand and testify and you have been previously convicted of a felony crime within the past ten years or discharged your sentence of parole, probation, or imprisonment within the past ten year, the deputy district attorneys can question you about that.

And I don't believe that pertains to Dr. Desai; is that correct?

MR. STAUDAHER: That is correct, Your Honor.

THE COURT: All right. Conversely, you have the right not to take the stand and testify. And should you choose not to testify, the deputy district attorneys are forbidden from commenting upon that in their closing arguments.

Also, and I believe Mr. Wright and Ms. Stanish have asked the Court to give this instruction, and the Court will do it if requested, that tells the jury that it is a constitutional right of a defendant in a criminal trial that he may not be compelled to testify. That's the decision, as to whether he should testify, is left to the defendant on the advice and counsel of his attorney. You must not draw any inference of guilt from the fact that he does not testify, nor should this fact be discussed by you or enter into your deliberations in any way. Do you understand those rights that I've just gone over with you?

MR. WRIGHT: Yes.

THE COURT: Okay. And Mr. Wright, to the best of your ability, you have discussed those rights with your client, Dr. Desai, along with your co-counsel, Ms. Stanish; is that correct?

MR. WRIGHT: That is correct.

THE COURT: All right. And I understand that Dr. Desai is not going to be testifying; is that correct?

MR. WRIGHT: That's correct.

THE COURT: All right.

MR. WRIGHT: The [inaudible].

THE COURT: That's fine. Just one final thing. And just, I think it's already clear on the record, but to the extent that it may not be, you are requesting that the Court give Instruction No. 33, inform the jury that it's the constitutional right of a defendant in a criminal trial that he may not be compelled to testify; is that correct?

MR. WRIGHT: That's correct.

THE COURT: All right.

MR. WRIGHT: Okay. Do the -- on the determination not to testify, after Monday, maybe it was Tuesday -- yeah, Tuesday noon when you were mentioning the -- right before the noon hour, I started to address Dr. Desai about -- and I told him this morning to look at you and I would like to explain throughout the course of the trial what has transpired, and at my instructions after jury selection commenced.

It is clear to me, I'm just telling you my representations from me. I'm not getting into whether it's right, wrong, as the Court says exaggerated or not exaggerated, he has difficulty taking in if he multitasks, look, listen, speak. If you just do one thing, like

concentrate on listening and not looking and mixing it up, only listen, it goes in better was my understanding that we worked out during jury selection.

And so he would sit either eyes closed, looking down, or whatever. It's not that he can't see or anything. He is simply concentrating exclusively on listening, and then we would discuss it with him. Even with that, and those -- those efforts, like at the -- on Tuesday at the noon hour when I discussed with him what had occurred here.

He was mixed up as to Dorothy Sims, a witness I had called for the defense, you know, and why she testified that syringes were used patient to patient at the clinic. Well, of course, it wasn't at the endoscopy clinic. The testimony was about a Maryland Parkway clinic. But the -- that didn't get in by -- by -- I mean, that wasn't fully comprehended by Dr. Desai.

And then there were discussions in the court about the alternate jurors and who is still available, who may -- may -- who have pressing issues that may be a sitting juror, may need to be excused. And all he -- he thought certain jurors had been excused and replacements had taken place and didn't understand. I am pointing that out because that's the most recent efforts of me explaining to him and understanding what was going on.

Based upon all of that, in my judgment, he is

incapable of testifying. His memory is not good for the five and a half year ago past. He mixes up what has happened here in the courtroom when I've talked with him. I do not have transcripts of the proceedings to go over with him. It probably wouldn't make any difference anyway, to tell you the truth.

But his condition in assisting me, he's not able to testify, his assistants, at times he has given me misinformation is the way I would characterize it as opposed to useful information that I am able to use. And essentially his ability to assist has been the equivalent of him being tried in absentee.

THE COURT: All right. Well, Mr. Wright, we're not going to, you know, re-litigate the competency --

MR. WRIGHT: I understand.

THE COURT: -- issue here. More than an ample record has been made on this issue before the case even was transferred into this department. You know, what I noted when we began, the admonishment the other day is that Dr. Desai's posture was markedly different from the posture that I had observed throughout the weeks of this proceeding, meaning, you know, he was stoop shouldered and hanging his head in a manner that I had not seen previously, and that suggested to me that he was exaggerating through a physical manifestation, his ability to comprehend, and that's what I said. And I still

believe that.

Now, today his posture is good. He is standing up and he's looking at me. I've also, you know, looked over at him in the trial. From time to time, you know, I catch his eye, he catches mine, and then he immediately looks down. Your -- you know, I believe that your representations that you're making here today are well intentioned. But as I've said in the past, your representations are only as good as the information that's being imparted to you by your client.

And so you've made your representations on the record. Again, we're not going to re-litigate this whole competency issue. The Court has, in its view, made whatever accommodations have been requested in terms of taking recesses, you know, if we need to break so that you can confer privately with your client, we've made the vestibule room available so that you and Ms. Stanish can confer privately with your client where we can't witness the discussions and whether or not your client is communicating with you. I would note that's not something that's ordinarily done in murder trials or any other kind of criminal trials.

So I just -- I think the record is already clear as to the numerous accommodations that the Court has made that the Nevada Supreme Court indicated should be made, and we were happy to make them. So I think -- you know, I just wanted to put that on the record again, but I think that the record

already is abundantly clear and beyond what I've already said we're not going to visit the competency issue again. I don't know if the State wants to place anything on the record at this time.

MR. STAUDAHER: No, I think I would submit it, Your Honor.

THE COURT: All right. Is there any --

MR. WRIGHT: I was just -- I was just giving an explanation. He was caught cold Thursday after -- before the noon hour. I had not discussed with him the issue even coming up. So, I mean, when he did get up he was caught by surprise.

THE COURT: Okay.

MR. WRIGHT: Thank you.

THE COURT: All right. The final issue, then, concerns Juror No. 1. And I will give the defense the option because of some of the concerns that were expressed mid-trial by Juror No. 1 that had not been expressed during jury selection. If you would like Juror No. 1 to be made an alternate, as I previously said, the Court is not going to shuffle the alternates. The alternates come in order. So the next alternate would be, I believe, the gal in Chair 14.

MR. SANTACROCE: Your Honor, I'm going to -- if I have made an objection to Ms. Pomykal in the past, I'm going to withdraw it. I think her other issues are moot at this point.

THE COURT: Right. Her other issues are moot and -- the health -- meaning the health issues. And as you know, we made it quite plain to her, and my bailiff has been, I think, attentive not just to her but to all of the jurors to make sure that there were no problems that she would need a break or need to see a physician or anything like that. So there haven't been any further problems in that regard.

MR. SANTACROCE: So we will withdraw any objection if we made one. I think she should sit as a regular juror.

THE COURT: All right. Is that also true for the defense, Mr. Wright?

MR. WRIGHT: Yes. Knowing who the alternate is, I think the medicine is worse than the cure. So --

THE COURT: That's your -- that's your decision. As I said, you know, we knew at the outset of jury selection that the alternates would be placed in numerical order and we don't change the order of the alternates, unless there is some new issue with a health issue or something like that with an alternate.

Those are the only remaining matters that I can recall. Is there anything that we need to address from the State's perspective?

MR. STAUDAHER: No, Your Honor, at this time.

THE COURT: Is there anything else we need to address from the defense perspective?

MR. WRIGHT: No, Your Honor.

THE COURT: Mr. Santacroce?

MR. SANTACROCE: No, Your Honor.

THE COURT: All right. What we're going to do, as I believe all the jurors are now here, we'll take just a couple of minutes for a break. And then when we come back in Kenny will bring in the jury and the defense can rest, and we'll proceed with reading the jury instructions.

(Court recessed at 9:34 a.m., until 9:41 a.m.)

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the deputy district attorneys, the presence of the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

Defense, Mr. Wright?

MR. WRIGHT: We rest.

THE COURT: All right. Thank you.

Mr. Santacroce?

MR. SANTACROCE: Defense rests.

THE COURT: All right. Does the State have any rebuttal evidence?

MR. STAUDAHER: No, Your Honor.

THE COURT: All right. Ladies and gentlemen, that concludes the presentation of evidence in this case. As I

told you at the outset, that is followed by the instructions on the law, which I shall read to you in a few moments. After the instructions on the law are read to you, the attorneys have the opportunity to make their closing arguments. Because the State has the burden of proving this case, they both open and close the closing arguments.

It is important that I read to you these written instructions exactly as they are written. I am precluded from trying to expound upon them or clarify them in my own words in any way. You will have a number of copies of these written instructions back in the jury deliberation room with you so that you can refer to the written instructions during your deliberations. You will also have all of the exhibits that were admitted into evidence back in the jury deliberation room with you. The instructions are all numbered for your convenience.

(Jury instructions read by The Court.)

THE COURT: Ladies and gentlemen, that concludes the instructions on the law.

Is the State ready to proceed with their closing argument?

MS. WECKERLY: Yes, Yes.

MR. WRIGHT: May we approach for a moment?

THE COURT: Approach?

MR. WRIGHT: Yes, Your Honor.

THE COURT: Sure.

(Off-record bench conference.)

STATE'S CLOSING ARGUMENT

MS. WECKERLY: Good morning. The crimes that are charged that relate to patient care in this case, which are performance of an act in reckless disregard of persons or property or criminal neglect of patients, those are crimes that are actually classified under the Nevada revised statutes as crimes against the public health or crimes against public safety because the County or the State has an interest in ensuring that the public doesn't get reckless treatment from the healthcare providers.

No one in this courtroom is on trial for not following the highest gold standards of the CDC. The Endoscopy Center of Southern Nevada certainly fell far below that on several fronts. There was bad scheduling, there was bad charting, patients were rushed through that were not here because someone didn't get a blanket in recovery, that are not here because someone had to wait a long time before their procedure happened, and were not even here because of bad charting or bad care overall.

We're here because nine people were the victims of a gamble taken by the healthcare providers at the center. And the people that lost the gamble were the seven named victims in this case and the two other individuals that you heard

about that contracted hepatitis C on September 21, 2007. The defendants gambled and the victims lost.

They fell below the lowest standard of care in providing care to those individuals and they did it knowingly and they did it recklessly. And when that happens the case moves into a criminal realm.

Now, when you get into a criminal investigation, things change a little bit. Things open up. With a criminal investigation you no longer have the anonymity that might be available in a Health District investigation. That anonymity veil is pierced and people have more at stake once things are out in the open.

Compromises people might have made you know, come to light. Ethical breaches are inquired about. And maybe behavior that people weren't that proud of because -- essentially becomes known. And criminal cases are conducted on the record and out in the open, so they're different than a healthcare or a Health District investigation.

And there's no doubt that the police were justified in conducting an investigation in this case. We had nine people in our community contract a communicable disease from a healthcare provider, and that never, never should have happened. The police investigation was thorough. It took months and months.

They interviewed a bunch of people. They went back

and interviewed some if people wanted to offer additional information. And that's to be expected. We shouldn't expect our detectives to do any less than always interview, always try to be collecting information, always be working on the case. And they did that in this -- in this case.

Because this case sort of has two facets of investigation, the healthcare investigation by the Southern Nevada Health District, and the investigation conducted by the police department, you will actually kind of see and assess the -- the information that you know as a result of those two investigations. And you're actually in a unique position in this case because you see if there are any differences in what people are willing to say anonymously versus what people are willing to say to the police, if there's any difference at all.

You will assess whether people are worried about protecting their professional licenses, and you will be able to assess if that is relevant at all. And you can weigh all these motivations and all these factors of all the witnesses that you heard throughout the presentation of this case.

Now, Ronald Lakeman and Keith Mathahs are the only CRNAs who were charged criminally. They were the only CRNAs who each treated a source patient, someone with known hepatitis C, and they are the only CRNAs that perpetuated it to the victims that you've come to know in this case. In that

regard they're unique among the CRNAs in terms of the lowest quality of care they provided.

Now, Dr. Desai is the only doctor charged in the case, as well. He's not being charged because he was a capitalist or because he made a lot of money through his clinic. He set the standards at the endoscopy center. He made the environment at the endoscopy center what it was. He directly advised to -- advised the CRNAs to engage in risky behavior.

All of the treatment was done according to his vision. He was in control. And there was a risk associated in his methods administering healthcare. And that risk, you know, ended up being very costly to nine individuals in 2007. And he has to answer for that. And he's no longer able to duck out of a press conference. He's in criminal court with criminal charges with a jury assessing the charges against him.

Now, when you go back to deliberate, you will have all of the evidence that has been admitted in this case, and it's all going to be available to you. You'll have all the propofol log books. You can count up how much propofol was checked out every day for the year. You'll have the procedure log books. You can count up all those procedures. You'll have the patient files of everybody, even the non-named victims you'll have patient files.

And you can look at all of that evidence and go through it all and make sure you understand what happened in this case and make sure you understand that the -- that the evidence is what we're all saying it is and you can make your own assessment as to the value you assign each piece of evidence.

Now, in terms of the procedure log books there's been some discussion about how many procedures were actually conducted each day, what was the count? And a lot of the employees came in and said, wow, there were like 80 procedure that day or there were 70 procedures that day.

And whether that is accurate, whether it was 65 and they remember 70, or whether, you know, it was 82 and they remember, you know, 60 really doesn't matter. The point of their recollections and the point of their testimony was they felt really, really busy. They felt really busy at the place. They had to cut corners on their charting. They had to move people through quickly, and they had concerns about how quickly people were being moved throughout the clinic.

The second consideration with the -- with the number of patients that were treated each day relates, of course, to the insurance counts. With that type of clinic and that type of busy practice, it seems extremely unlikely that someone is doing some leisurely interview in pre-op before a patient goes under the anesthesia or is spending a particularly long time

with a single patient in recovery. So it relates to that, as well.

Now, you heard about a lot of poor documentation and poor charting, and that certainly is reflective of the number of patients that were moved through and the inability of the staff to sort of keep up with the case load. And it also sort of coincides with the actual experiences of the victims in this place.

Remember Stacy Hutchison? On the -- on the day of her procedure she wakes up in the recovery room and no one is around her and so she gets up and gets herself dressed and gets to her car before someone tells her, hey, you need to come back in here. So no one was watching her terribly closely.

Or remember Mr. Sharrieff Ziyad? He was dizzy and put in a chair, you know, moved off of his gurney because apparently it was needed for someone else. And so he was left to sit and let the medication wear off.

The overall point of this evidence was to show you or illustrate for you that this was an assembly line where profits were important, and it was volume over patient care. So the question of do the doctors who weren't charged in this case bear some responsibility regarding what happened? And the answer is, yes, they do. But there is limitations and constraints in every type of case and it's an imperfect

system. So the bottom line is they will not be prosecuted for their -- their share of the responsibility.

Now, you heard from in this case literally the world's expert on hepatitis C transmission, and Dr. Alter had, in my view, a personality consistent with her credentials. She was -- she had a big personality. But this wasn't just a CDC investigation.

This case was also investigated by Detective Whitely who was with us during the trial, and he doesn't have necessarily the same personality as Dr. Alter, but both of these investigations were extremely important in terms of what evidence was presented to you during this trial. The case is an epidemiological investigation, but it's coupled with a regular general criminal investigation, as well.

And the evidence came to you that way in two forms. Criminal investigations are a little broader. The Metro detectives interviewed all employees, not just nurses, not just doctors. They interviewed GI techs, they interviewed people who were working in the office area to get a broader sense of what was going on at the clinic.

And Detective Whitely sort of had to dig through all the documentation, determine what was relevant, and untangle it to a certain extent. And as jurors you'll have that same -- same role, in a sense. You'll be assessing the evidence, fitting it into different pieces, seeing how it corresponds to

the crimes that are charged.

Another difference is, of course, in a criminal investigation it's sort of presented in a multifaceted way. It's presented witness by witness by witness. It's a little tedious. Each witness has a tiny piece of information, and you hear it sometimes in a little bit of a disjointed manner. And now you're called upon to look at it cohesively, put all the pieces together.

Now, the Southern Nevada Health District and the CDC and Miriam Alter explained that their focus when they came out to investigate what happened at the clinic was on public health, and rightly so. That is their responsibility. They are charged with the public health.

And they go out, they identify the problem, they try to figure out what's causing, they try to stop it, and they want people to get tested as soon as possible. And all of those people had substantial credentials in terms of disease outbreak investigation. Certainly Dr. Alter did. And the two -- the two doctors from the CDC, in her view, conducted the epidemiological investigation in an appropriate way.

So they go out and they make an assessment about the mode of transmission and they get their response together from a public health perspective, and that is to make this notification to people. But their -- their conclusions are drawn very quickly.

And Brian Labus from the Southern Nevada Health District, he's the one who was primarily in charge of the investigation locally with the CDC. And this case, interestingly or fortuitously or not fortuitously, sort of plucked Mr. Labus from relative anonymity. Because nine cases from a single clinic is something that wouldn't happen in years. I mean, they could go years without someone getting hepatitis C.

So this was an event that was going to garner a lot of media attention one way or another. But the medical attention was focused on Mr. Labus. He had a lot of scrutiny over his results and how he was going to -- or how he did the investigation. But he would have because of that scrutiny no motivation whatsoever other than protecting the public health and getting it right. He knew there was going to be scrutiny. He had every reason to be very careful about the conclusions that he drew during his investigation as to the source of transmission.

And all of these years later, after all of the review, his conclusions are the same. And Dr. Alter reviewed his work and his conclusions, and she is -- concurs with his findings that it was the unsafe injection practices with the propofol that caused the transmission. And you all saw Dr. Alter testify. She seemed like kind of a tough grader to me, and if she didn't agree with something she would certainly not

hold back her opinion.

In fact, when she was testifying on the stand, she did mention one statistic Mr. Labus had in his report that she thought didn't make any sense, and she said so on the stand. But overall she said the investigation was appropriate and that she concurred with the conclusions of the investigation.

Now, the -- the sort of concurrent or complimentary, you know, Metro investigation started a little bit after the CDC and the Health District left the clinic in 2008. And some of the premises or some of the aspects of the -- of both of the investigations rely on some common facts or some -- some factual givens that have to be present in order for the -- in order to understand the mode of transmission.

And one of these is that the two source patients on each day, on July the 25th and September the 21st both got over 100 milligrams of propofol injected into them. And the reason why that's important, as we all have learned, that only 10 cc syringes were used at the clinic. So if those two individuals got more than 100 milligrams, at least another syringe or at least another dose of propofol had to have been given to them from a re-accessed vial.

If either of those people, Mr. Rubino or Mr. Ziyad had only received 100 milligrams of propofol, there wouldn't necessarily be any contamination of the vial, would there? Because they would pull it out, it would have all fit in one

syringe, it would have been injected into the patient, and there would be no possible means of contamination of the vial because it would never be re-accessed.

And this is similar, actually, to -- to saline injections which have been mentioned quite a bit through this trial. There is no reason to ever re-access a saline vial. Once the saline -- once the vein is flushed, no one goes back and reflushes it again. But with the propofol it's different because during the procedures patients need to be redosed as the procedure moves along.

The other -- another give of both investigations is how the -- I guess the scientific facts of how the disease itself is transmitted, that it's a blood-borne disease. And so there's a limited number of ways at the endoscopy center that -- that it could have been transmitted. It had to be through some sort of blood transmission.

So first, let's talk about the scopes. The scopes were certainly eliminated by the CDC. And they did what they called an epidemiological comparison between different procedures on people and found no distinction between those who got the disease and didn't get the disease based on the scope, so it was eliminated as a factor for the CDC in terms of a mode of transmission.

Now, the Metro investigation -- and, well, incidentally, though, the defense expert that you heard from

two days ago, he also said a scope would be a really low, low, low chance of causing transmission of hepatitis C. So we may -- we may get agreement on that.

Now, the Metro investigation is maybe more fact based, maybe more common sense. If you look at the patient charts on September the 21st, and I'm sure you can all see that really clearly, Mr. Rubino up here is the first patient. The next patient is the Lakota Quannah and he gets infected. We know he gets infected that day.

So unless the exact same scope was used, like literally pulled out of Mr. Rubino, not taken to any cleaning room and immediately used on Lakota Quannah, it can't be the scopes. It wouldn't have been enough time to even clean the scope to use it on Mr. Meana because the timing is just so short and their process took so long.

So it wasn't effective cleaning of the scopes. They were -- these -- these individuals didn't have the scope and the cleaning wouldn't have been short enough in time to have been used on the same people. So that can be eliminated from sort of a fact based perspective, a little bit different than how the CDC analyzes things.

And you also know from the testimony of Jeff Krueger, and the review of the records of the clinic that the Medivator was actually working on the infection days and there was no indication that they were doing the hand washing or any

of those things before. So the scopes are pretty much eliminated as a source of transmission.

So let's talk about biopsy forceps. This was one thing the CDC also eliminated. And what they did was, of course, compare pecple who got biopsies and people who didn't get biopsies and see, well, you know, is there any difference in who contracted it and who didn't based on biopsy forceps, which is appropriate for an epidemiological investigation. And they found no connection between the use of the biopsy forceps and someone contracting hepatitis C. So from an epidemiological perspective, that was eliminated.

Now, from a police prospective or from a more, I guess, common sense perspective, if you look at -- this is a close up view of July the 25th. We know Mr. Sharrieff Ziyad was the first patient of the day. And Michael Washington isn't the next person who actually got a biopsy. If you pull patient file 3 and 4 you will see and you'll have those in the deliberation room that they also got a biopsy, and they were treated before Michael Washington and they didn't contract hepatitis C. So the biopsy forceps can be eliminated as a source of transmission, as well.

This was Dr. Carrol's idea, a rogue employee was responsible, at least it was his theory at one time, for infecting the people at the clinic. This one, this idea, was pretty much eliminated early on because of the genetic link

between the source patients on both days and the people that ultimately got infected. It's sort of an impossibility that someone could have gotten Mr. Rubino or Mr. Ziyad's blood and randomly injected people. And the genetic relatedness certainly dispels any idea that this could have been caused by -- by a rogue employee.

So then here was the saline flush. Now, for the CDC and the Southern Nevada Health District, their observations of the pre-op area were enough to eliminate that as a source of transmission. Because when they observed the nurses in pre-op they didn't find any breach of aseptic technique. Everything was done appropriately.

So what did the police bring to the table? What was the result of the police investigation? Well, you saw and you heard the testimony of Lynette Campbell. She -- the woman who administered the hep-lock on several of the people who ended up getting infected on September the 21st. And you heard her describe step by step by step how it is that she administers the hep-lock and what process she goes through.

You also heard her testify that she never breached aseptic technique and that she never flushed the hep-locks twice. And you can take -- you can, I guess, put whatever weight you want as to her testimony. She was a brand new nurse. This was her first job. She had every reason in the world to want to do things correctly. And when she was

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.

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

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

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

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

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

Now, the Metro investigation, of course, was broader. You heard from Ruta Russom. She was a GI tech. She saw syringe reuse by Mr. Lakeman within a single patient. You heard from -- statements from Linda Hubbard that talked about syringe reuse. You heard from Keith Mathahs. He talked about syringe reuse of the same syringe from -- within the same patient. Which, of course, is the first step; right?

I mean, you either -- you either need to have many, many, many vials of propofol, one for each patient, or you need to be using a whole lot of syringes in order to accomplish the administration of the anesthesia aseptically. And the endoscopy center was wrong on both ends. They didn't have enough vials of propofol, and they didn't have enough syringes. So that's why the disease occurred.

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

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

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

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

You all sat -- think of the -- think of the testimony alone of just Dr. Miriam Alter, which was -- it was -- it was a good chunk of the day, but not nearly as long as nursing school, right, which would be several -- several months, years, endeavor. And she talked about syringe reuse for maybe, you know, a certain amount of her testimony, a certain portion of her testimony. I bet none of you have a doubt about the danger of syringe reuse, and you've heard less than one day of testimony about it. How it escaped the knowledge of Mr. Lakeman and Dr. Desai is just not -- is just 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 wouldn't have known the risk? I mean, in Keith Mathahs's case, if that had really been accurate that he just didn't know up until that 30 year point in his career, that should have been a pretty seminal moment in his working life. But when he testified on the stand, he barely remembered the conversation. More than that, he indicated that prior to that conversation he had a discussion with Dr. Desai about the risk of reusing syringes, indicating that he was aware of it.

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

accurately in this case, the I don't know could be something like I didn't know that my anesthesia time related to 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

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

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

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 doctors had, and they certainly knew of the dangers of this. And remember, Dr. Desai is a gastroenterologist. He treats people with hepatitis C regularly. Surely, someone who does that would be familiar with the risk factors associated with hepatitis C transmission, and he certainly didn't need to ask his boss, Dr. Carrol, about any sort of facts about transmission. Desai also had conversations with Keith Mathahs and Linda Hubbard, which indicated a knowledge of the risk, but he went forward anyway.

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

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

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 overall did the best. She's the youngest. She didn't have severe acute symptoms. She felt ill, she felt tired, and she says she still feels that to this day. But it was -- you know, it's taken a toll that she hasn't undergone Interferon treatment. So maybe she did the best, but she still had to change her life, and you saw her testify. This isn't an easy thing for her. She still had to take precautions. She still had the stress of wondering if the disease was going to surface, and she certainly suffered.

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 went a different path. These women actually underwent the

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.

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

Carole Grueskin didn't seem to ever recover from the stress of learning what -- learning that she actually had been infected by -- infected with hepatitis C at the clinic. You heard from Dr. Lewis that there was no sign of dementia. There was no sign of her loss of competency prior to her going to the clinic and learning of the diagnosis. And now she -- she doesn't know where she is, she doesn't know what her name 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 that are -- that are relating to patient care, and this is performance of an act and reckless disregard of persons or property. And the elements of this crime, essentially, a reckless act sort of disregarding the safety of another, but it doesn't have to be by a healthcare provider. It's just a reckless act that unreasonably risks the safety of another individual. And this is where direct liability and conspiracy 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 starts off with Clifford Carrol covering both rooms. And he's clearly not in, you know, two places at once, so these -- these room times, as we've talked about it again and again, they don't -- they don't represent real time because otherwise he would be in two places. But Dr. Carrol does this procedure, this procedure, this one, this one, and he kind of goes back and forth as they testify between the rooms.

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

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

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 -- associated 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.

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

Now, with regard to the patients that Lakeman didn't treat, meaning Mathahs's patients on the 21st. Lakeman has what we call aider and abettor in conspiracy liability for those patients. As the Judge instructed you, conspiracy liability occurs when there's an agreement to do something illegal. And if you agree with another person to engage in an illegal act, you're responsible for the foreseeable 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 they shared their supplies against all their training. We know that propofol now went back and forth. And there really is no tie of one patient to another in terms of the care. There were -- the way the infection perpetuated, it was possible to infect this many people because both of them were willing to engage in these dangerous practices. And once they violated the standards, it was sort of up to fate as to who was going to get infected and who wasn't. It wasn't tied to a particular CRNA. So Ronald Lakeman has liability for Keith Mathahs's patients, as well.

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

And Dr. Desai we all know is many things, but one of

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

six months earlier that there was the discussion about using saline with propofol, which would have put the time at the -- at the end of 2007. And he was clearly wrong about that because Ann Lobiondo said she was at that meeting, and she had 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 Hubbard testify I don't remember, I don't remember. And you know Linda Hubbard is the person who never seems to have the glove on, who is capping needles, who is pulling off needle caps with her -- with her mouth, who is still pulling propofol after the CDC comes, who is still willing to use the 50s even when there is a memo or an edict that she's not supposed to do that. Now, do you really think that woman is capable of conjuring up this subtle conversation just -- just to benefit the police, or is she actually recalling something that was actually said?

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

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

There was nothing that wasn't controlled by him. He was focused on saving money at every turn. And it wasn't like some eccentric personality that you have with like a paternal relative that, well, he just doesn't like lollygagging and, oh, he just doesn't like waste or people standing around. 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 the care of the patients is the criminal neglect of patients. This one is a little different in the sense that it -- you have to be a professional caregiver for the crime to apply to you. There's a recklessness aspect to it to where you have to have engaged in reckless behavior and it has to be a departure from the standards of an ordinary prudent person, and the harm 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.

It's also a fair bet that the harm would be

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

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

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 --

give or take ten hours on the -- on July the 25th and on September the 21st. He actually billed a little over 14 hours 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. Remember that memo, the PacifiCare memo? You can look at that in the deliberation room where he is actually instructing the staff not to put PacifiCare members in -- in close succession with each other. And you also know that he told Ann Lobiondo, hey, remember to make your time 31 minutes. And he told her that more than once, and that was for the insurance claims as well.

And you also know from his conversations with Tonya

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

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

consider that instructions -- that instruction in your 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.

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

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

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

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 or commentaries on the case, person or subject matter relating to the case. And do not form or express an opinion on the trial.

Notepads in your chairs, and please follow the bailiff through the rear door. We'll take about ten minutes.

(Court recessed at 11:23 a.m., until 11:36 a.m.)

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Mr. Wright, are you ready to proceed with your closing argument?

MR. WRIGHT: Yes.

THE COURT: All right. Thank you.

DEFENDANT DESAI'S CLOSING ARGUMENT

MR. WRIGHT: My name is Richard Wright, as I start with every witness. You all know by now that's Margaret Stanish. We represent Dr. Desai. And first of all, myself and the Desai family want to thank you for your terrific effort. We understand.

I stood here two months ago and talked to you about this case and we do know the -- the individual efforts in that which you have given up to be here to participate in this. It is an awesome undertaking when you're talking about like ten weeks of being here, all to help the State and the defense try

to achieve justice in this case, which is what this is about.

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

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

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 -- all we will do is cross-examine witnesses. We can bring in witnesses if we want to. You saw by the end of the case we brought in Dorothy Sims and we brought in Dr. Howard Worman from Columbia University. Other than that, the defense rested.

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

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

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

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

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

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

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

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

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

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

And it's -- even though we've talked about it generically and generally, clinic practices and everything else, we are dealing with discrete individual counts, crimes in the indictment. There's like 27 separate crimes in there and nine, ten, eleven, twelve of them, twelve deal with the 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 methodical, but you have to count by count because you're going to see that -- and I will -- I will put up a chart for you all and you can go through the calculations. You're going to see that the grand total, the grand total in the case of the total false billing if we just use absolutely the doctor's note times, in other words, the time when the doctor started his procedure until the time he ended his procedure.

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

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

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

that as the anesthesia time, you will see that the total 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.

She would say each of them, if it was eight units, if there was a base units of five for payment, and then the first 15 minutes got you one unit, second 15 minutes got you a second unit, five, six, seven. And then if you went over 30 minutes you got a third unit you add, so that's eight. And Margaret would say, what if it's eight, how much do you get? 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 accusation that they got paid too much, more than they were entitled to because of the excessive time. The charge is not they were entitled to nothing. You can read every single insurance fraud billing count. I will just use one as an example, which is Count 14, insurance fraud. And the -- the theft counts and insurance counts, the theft counts, fraudulent billing counts, and obtaining money under false pretenses counts all use the same factual allegation of

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

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

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 out so low.

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

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 without 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

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

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

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

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.

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

And this was a witness not called by the defense. This is a witness called by the State and then testified for the State. And he testified that that is the correct billing method and practice in his judgment and he so advises his clients. And the questions were asked by the State, you mean to tell me someone like an anesthesiologist could be billing for more than one patient at the same time?

And his answer was absolutely correct. You've got that right. I can -- I can have like three patients I am responsible for. I can have two in the waiting room. When

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

get to use it and show it to you, but it doesn't go into the jury room. The exhibit that's in evidence is Z1, and that has the times I'm talking about. This was a chart that Margaret put together and was introduced thrcugh, I think, Whitely or 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 physician is, who the CRNA is, time of procedure, colonoscopy or endoscopy, doctor's note start time. Lord knows we've heard a lot about times in here about which ones are correct, which ones aren't correct. This -- the -- this doctor start time, report process start time from the doctor's note. This -- this, I believe -- recall your own recollection, but I believe the -- the evidence has been that like the -- the best, most reliable, consistent time between nurses times, computer times, rhythm strip times, because all clocks are a 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. And, of course, once again you heard testimony as to that. Doctor finishes the procedure, patient is being tended to by CRNA, doctor goes to the computer, all the photographs have been taken of the internal testing, and then he puts the findings, conclusions, whatever it is, all of the notes that he puts on there, and then he punches the signature button and that produces to the second and end time.

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

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, this -- this would be the procedure end time out in the end room. Because you know they unhook the patient in the procedure room, roll them out, hook them up again to new rhythm strips, blood pressure, heart monitoring, and they're out in the recovery room, and that like takes 10 to 15 to 25 minutes, whatever your recollection is of it, and then they unhook them out there, which is at the time they're going to take them over, get them dressed, see the discharge nurse.

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

If we use those times in brown, brown would be Lawrence Preston, yellow would be ultra conservative billing purposes, like face to face time, ignoring everything else, if we use Lawrence Preston time, you can see it's 26, 29, 20, 34, 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

should be the correct way.

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

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.

So what -- what do the totals come out to? $219.40

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.

But if you're firmly convinced beyond a reasonable doubt, ah-ha, they conspired to do this and they knew what they were doing, then when you got through it you'd say, okay, I'm firmly convinced they knew what they were doing and their conscience said ha ha ha, I'm cheating, if that's your 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.

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

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

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 which patient it was, none of these -- 76 bucks is the highest one. So for obtaining money under false pretenses, it would be under $250, whichever patient it is. It may be one of the none ones. I don't remember. And then when you get to the false medical billing case, the amount of money doesn't matter. Okay? It has to be a false billing and some money.

If it's none, there isn't any because they've alleged an overpayment. But if there is $16.40 and you believe that that was done intentionally and willfully, then on that the answer would be guilty. On the -- there are nine counts, nine different patient charges. So you go through them on each and figure it out. Now, that -- that's essentially the billing fraud component of the case.

And if we could take a lunch break, Your Honor.

THE COURT: All right.

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

THE COURT: Can I see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our lunch break now. We'll be in recess for the lunch break until 1:30. Obviously the case has not been submitted to you. The case is not over yet. So please be aware and mindful of the admonition, which I am about to give you.

Do not discuss this case or anything relating to the case with each other or with anyone else. Do not read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research by way of the internet or any other medium. And do not form or express an opinion on the trial.

Please place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 12:28 p.m.)

THE COURT: All right. I'll see counsel at the bench regarding scheduling.

(Off-record bench conference.)

(Court recessed at 12:32 p.m., until 1:40 p.m.)

(Outside the presence of the jury.)

MS. STANISH: Judge, is the jury instruction on the petty larceny --

THE COURT: It was wrong.

MS. STANISH: Yours was changed.

THE COURT: So I adlibbed it, and then I had my JEA type it to be correct because I caught it. And that is Instruction No. 21. And so these are the originals and if you want to look and make sure you're --

MS. STANISH: No, I trust you did it.

THE COURT: -- fine with the change.

MS. STANISH: I just wanted to make sure.

THE COURT: But, right, I saw that it was wrong and so then I just --

MS. STANISH: Good cover.

THE COURT: -- corrected it and -- and then she's changed it. And so the packets are all correct. We made 12 copies so that all of the jurors will have their own copies of the instructions.

(Pause in the proceedings.)

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Mr. Wright, you may resume your closing argument.

MR. WRIGHT: Thank you.

DEFENDANT DESAI'S CLOSING ARGUMENT (Continued)

MR. WRIGHT: Ladies and gentlemen, now to the medical criminal neglect, reckless disregard portion of the case on the hepatitis C, the causation, and what the conduct

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

Now, remember, again, two months ago at the beginning of the case when I talked about negligence, auto accidents, reckless disregard, driving the wrong way down the street, and tried to give you a little example by drawing it 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 elements of the crimes charged, and I will show you that it has to be the equivalent of someone not just driving the wrong way on the freeway, but knowing they're going the wrong way on the freeway and intentionally going the wrong way, as opposed to accidentally or mistakenly doing something.

And the example I gave you I'm going to talk about because it fits right with the jury instructions. Because in any ordinary negligence case, I think I gave you the example of someone turns the wrong way out here on Fourth Street. That's a one-way street downtown here. And all the time I drive on it carefully because tourists and other people invariably don't know it and turn the wrong way and are driving the wrong way on a one-way street, and it can cause an 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, well, I'm late, I'm going to be late for this important meeting, there's no traffic coming, I can whip around real fast and go the wrong way. I know what I'm doing, I know it's risky, but I'm going to attempt it anyway. And I do that and 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 conscious of it, and I said hell with it and threw caution to the wind and did it anyway. That's what crimes are made out of in these reckless endangerment type cases.

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,

I have a blowout in my tire because I didn't replace the tires and they were -- they were too -- the tread was too low. And 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, which I am going to show you had nothing to do with proximate cause of the transmission of the hepatitis C at the clinics on those two days. And we spent literally weeks hearing about the lousy business practices, starting colonoscopies too soon, ending them too fast, using all kinds of cutting-corner cheapskate practices all intended to enflame you all, to make you think this is a guy that's worthy of convicting and take your eye off of the ball. Because all the evidence is clear that the only accusation and the only evidence that matters in this case is the accusation that unsafe injection practices by the CRNAs caused the transmission of the hepatitis C.

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?

CDC, Melissa Schaefer, all of them testified that 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 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, there is a yuck factor, but there is absolutely no factor of transmission of any type of disease.

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

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

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

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

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

This case is about arrogance. I could stipulate to all of those things and would make no difference in the outcome of the case. Because this case is about conscious, reckless disregard of a dangerous practice that I know is dangerous and 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 get hep C out of this or may get sick and die out of this, but Mr. Lakeman and Mr. Mathahs supposedly just conspired with each other and agreed to say I know all of that, but hell with 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.

The act -- and then that's just the first step. We've got four of them. The act or omission is such a

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

They were using a reasonable man standard. That means a reasonable practitioner standing in their shoes at the same time in September and July 2007 in this community would have recognized that this is absolutely dangerous, life-threatening behavior. And that's why, when I get to it, we brought in the evidence of what else was going on in every single clinic at the same time. Because it matters what the 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

caregivers.

And there's another statute that's just called reckless disregard. And this statute applies to each patient or just leaves out a couple of the medical elements. This can apply to anyone, whether you're a dcctor or not. But as you'll see, it has the same elements. A person who performs an act in willful or wanton disregard of the safety of persons is guilty of reckless disregard of persons. Willful means what? Voluntary and intentional. I'm intentionally doing the 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 dc 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 they are what we call the principals. They are the ones who did the act, and so they must have had all of these. They must have satisfied every one of these elements that my client, as an aider and abettor and conspirator, because he's the owner of the joint, must have said, yes, I know you all are doing that and I want you to do that and I agree with it. 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. That's his theory.

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

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

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

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 Dorothy Sims was in charge of the BLC investigation. She was the equal of Brian Labus for the State of Nevada and was there for the -- for the 9th through the 17th investigating with two other investigators. And -- and I'm having to show her her notes, having to show her everything she had written to try to 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

inspections.

And what did they find? I'll get to that. That was the BLC report I made her read about finding an MD anesthesiologist on February 2008, a doctor reusing needle and syringe between patients, nothing that is ever even alleged to have occurred here. Those were the practices they're finding. So what do they do? They call CDC, they have an Epi-Aid, CDC sends people out, and they inspect all 51 ambulatory surgical centers in Nevada.

MR. STAUDAHER: Your Honor, I'm going to object to that. I don't believe that that's the state of the evidence or -- and I'm just -- I don't want to interrupt his argument, but --

THE COURT: All right. Yeah.

MR. WRIGHT: I don't mind if you think I'm --

THE COURT: I don't recall it that --

MR. WRIGHT: I'll explain. I'll explain it.

THE COURT: And, ladies and gentlemen, as I've told you, you know, Mr. Staudaher may object or it may go the other way. I may not recall, I may recall incorrectly. So it is your collective recollection of the evidence that's important. And if any -- you know, this is argument. It's not evidence. So if anyone says anything in their argument, that's different than your recollection. It's your recollection that should control us to what the evidence was.

All right. Go on, Mr. Wright.

MR. WRIGHT: Melissa Schaefer from CDC testified that -- because I showed her an article to refresh her recollection. Because CDC used the results of the Nevada -- I can't remember what they call it -- investigation. The Nevada investigation, Melissa Schaefer testified that they, the CDC, then used that to go to three other states and conduct an investigation in three other states to see if the practices nationwide on these pilot of three states were the same as the 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

governor of the state of Nevada saying to do this? And she didn't remember five and a half years ago. And so I show her the report out of her own office and walk up and say look at 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 witness? I subpoenaed the witness who I've never interviewed, and I said who did you talk to? Mr. Staudaher and Ms. Weckerly. Anyway, I subpoena you, you come here with your lawyer from the Attorney General's office. I don't talk to you, and they get to talk to you, and now your memory isn't refreshed by your own documents from the agency. This is what you deal with when you defend cases like this.

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

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

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.

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

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.

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

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

teaching me how to do it when I first came to work and he taught me. And he really didn't say to do it, but he just 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.

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

The -- the inability of the defense to get witnesses to be interviewed, to offer them immunity in exchange for testimony is one of the hurdles. And that's why all -- all we can end up with is our, the defendants' right of confrontation, where at least the least I get to do is 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 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

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

We knew -- we knew from day one, or the State did,

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

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

And all of this while we're having this orchestration, this drumbeat of assembly line out of control, too many patients, how many can you do in an hour? And the entire time they have every -- every single record book, every single patient on every single day. And they have done the math and they knew the numbers. And they knew for 2007 it is 59 patients per day average. They know that the highest 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.

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

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

Is that her name, Marie?

MS. STANISH: Ann Marie.

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

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

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

And then once again, they -- the State has the evidence. They have all of the computers. They subpoenaed all of the records. They know what every vial of propofol costs. And they know from 2004 until the clinic closed in 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 10,000th of a cent. Well, on two occasions 50s were cheaper. So there was absolutely none of this motive to save money by going to 50s that the State said in their opening. And then they affirmatively put on evidence by which you could infer that.

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

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

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

Q Were you aware as to how many scopes were to be cleaned before the solution was changed?

A The -- my understanding -- I actually saw it in the protocol, but I can't tell you what it is now, but it was my understanding that the machine, given this is a relatively automated system, indicates when it needs to be changed.

Q Well, that's the third or fourth step in the process.

A Uh-huh.

Q There's processes before that. Are you aware of those processes?

A The specifics of each step?

Q Uh-huh.

A No, I could not repeat them to you.

Q Well, you are aware that scopes are a potential mechanism for transmission of the hep C virus; correct?

A No.

Q You're not aware of that?

A No. However, I would consider them in any investigation I did, but there has never been an instance in which that has occurred, in which it has been shown to occur despite the misleading titles of some articles.

Q Are you anticipating where I'm going?

A No, I don't know how I could possibly anticipate such a thing.

Q I don't think I asked a question about that, but okay. Are you -- you're aware of the article posted in the New England Journal of Medicine on patient -- patient transmission of hepatitis C virus during colonoscopies; correct?

A Yes, I am.

Q Why don't you tell us the background of that case?

A Well, it was the first one ever published, which is why it was in the New England Journal, considered one of the top medical journals in the world. But on closer reading of the article, you'll find that the investigators -- and by the way this --

Q Ma'am, I asked you to tell me the background --

A I can't.

Q -- of the article.

A I'd have to look at the article again.

Q Okay. Well, let me show it to you.

MR. STAUDAHER: Your Honor, I think she was answering his question. He said background of the article.

MR. SANTACROCE: She was trying to dispute --

THE COURT: Well, okay --

MR. SANTACROCE: -- the validity of the article.

THE WITNESS: No, I am not.

THE COURT: Okay. All right. She is going to look at --

THE WITNESS: Sorry.

THE COURT: That's okay.

She's going to look at the article, and then Mr. Santacroce will ask the questions, and the witness, as she did on the prior question, if she can't ask the question as phrased, she's obviously more than able to say I can't answer this question.

THE WITNESS: I'm sorry. Okay.

THE COURT: All right.

BY MR. SANTACROCE:

Q Have you read the background information?

A I don't know what background -- what you refer to as background information. My --

Q Well, let me --

A The importance --

Q Let me explain what I mean if you don't know. Can you tell me how many patients were involved?

A No, I don't remember.

Q Okay. Well, I just showed it to you, but I'll show it to you again.

A I didn't have a chance to actually look at the

page.

Q Okay. Well, take all the time you need. Read this part here.

A Yes.

Q Okay. Now, just to be clear, this is an article you downloaded three days ago; right?

A No, I've had it in my files forever. It just so happens I might have downloaded a new copy of it, but --

Q What does it say on the bottom.

A Okay. Sorry. I'm distinguishing between having downloaded a copy because my files -- and what I have in my files. So, yes, I downloaded it to send three days ago, but it was already in my files. It's been in my files since it was published.

Q When you downloaded it three days ago, did you read it?

A No, because I had already read it and I knew what it said.

Q Okay. Well, after having reviewed it now, how many patients were involved?

A Two.

Q And a source patient; correct?

A Presumably. I didn't get that far.

Q Okay. Well, it says Patient 2 contracted hepatitis C from a source patient in this particular study;

correct? In fact, they were a husband and wife who underwent endoscopic procedures; correct?

A If that's what it says.

Q Well, ma'am --

A I didn't have a chance. I didn't read it in that detail. I was looking at the paragraph that you pointed out. There were the two patients, the procedures, and they were talking about how the endoscopes were disinfected, cleaned and disinfected. That was what I was reading. I don't know -- I didn't see husband and wife. I didn't see -- I just don't remember. But what I know about the results of the investigation lead me to a different interpretation.

Q Well, why were they discussing the cleaning of the endoscopes?

A Just because -- because it's considered as a potential.

Q In fact, it was the leading likely cause of transmission of hepatitis C in this study.

A Only according to those investigators, but not according -- not in my opinion.

Q Are you saying these investigators weren't competent?

A I'm saying -- no, you said that. I did not say that.

Q Well, you said only according to these

investigators.

A As I explained, if you look at the discussion you will see that the investigators themselves admit they could not distinguish whether transmission occurred by the -- through the actual scope or through injection practices, unsafe injection practices used to administer anesthesia. It says that in the discussion. They didn't rule out or rule in either one because they couldn't do an analysis, an epidemiologic analysis. All they did was genetic sequencing to determine that the patients had the same virus as the source, and this is where they found it in the -- in the -- in that setting.

And I will tell you that when we went to New York in 2001, the New York Times, before we even arrived had already, of course, heard about it. And the first thing they -- they interviewed somebody, an expert, whatever, and whose first comment was they're not disinfecting the scopes properly, it's the scopes, it's the scopes. I heard that for a year before we were convinced, you know. So there actually is no documentation that the scopes are directly associated with infection. It has occurred in that setting, but that does not in any way -- as the authors themselves admit, they can't distinguish between the two. They just buried it in the discussion.

Q Well, I don't read it that way. It says we

suggest that during disinfection of the colonoscope after the procedure on the patients, we describe two recommendations on the endoscopic disinfection made by the American Society for Gastrointestinal Endoscopy and the British Society of Gastroenterology and the Working Party of the World Congress of Gastroenterology were not followed. From our investigation it appeared that the biopsy suction channel was never cleaned with a brush, and that the accessories that breached the mucosa, such as biopsy forceps and dia -- diather -- how do you pronounce that? Diathermic?

MR. STAUDAHER: Diathermic.

MR. SANTACROCE: Thank you, Mr. Staudaher, my resident medical expert.

BY MR. SANTACROCE:

Q The loop were not autoclaved after each use.

A Autoclaved? They're never --

Q Now, it says --

A -- autoclaved.

Q -- to me here, from our investigation that the scopes, the improper cleaning of the scopes, the failure to autoclave the reusable biopsy forceps were absolutely causally connected to the hepatitis C infection. You disagree with that?

A Yes, I do.

Q And you disagree with the authors of this

article?

A No. Read the discussion.

Q I have read --

A I'm sorry.

Q -- the discussion.

A It's a very misleading -- it's mis -- they say that, but they can't show an association between that -- between that and the infections.

Q So you say that there's a failure in their methodology?

A Well, they didn't have enough patients to show an association.

Q Okay.

A They had to consider -- you need to let me finish. They had to consider --

Q I didn't say anything that I know of.

A They had to consider all types of exposures, regardless of what the preexisting -- preexisting conceptions might be going in. And they don't mention it there, but when you then read the discussion, they come right out and say they couldn't distinguish between that and unsafe injection practices.

Q And this was an article published in the highly acclaimed, as you say, New England Journal of Medicine, and yet their investigation was flawed?

A I think they over -- they over -- I think their conclusions were not supported by the data in what you read. However, when you read the discussion, it is very -- they completely change their -- their perspective and say directly they could not distinguish between the role of what the scope might -- a poorly disinfected scope and the -- or unsafe injection practices.

Q What they say is they could not prove that the procedure was the cause.

A Okay.

Q Okay.

A Uh-huh.

Q But they spent a lot of time discussing the scope cleaning. And they actually said, as we've already read, that from their investigation that these scopes were not cleaned properly, nor were the biopsy forceps cleaned properly, and that these were potential causes for the transmission of the disease, which you flatly and categorically deny that hepatitis C can be transmitted through the scopes.

A I didn't say that.

Q Okay. What did you say?

A I said it hasn't happened -- it hasn't been shown to happen yet. It hasn't been shown to happen. And if you would give me a copy of the entire article, I would then

go on to read the part where they withdraw a little from their strong position about the scope.

Q Okay. Well, I'm sure Mr. Staudaher will give that to you. We've had other experts, other hepatitis C experts in this courtroom testify. Now, granted, they weren't world renowned, they were only local Las Vegas doctors, but they've testified that hepatitis C can be transmitted through reuse of dirty scopes. Do you disagree with that?

A It could happen. I suppose any germ could be -- could be transmitted through if it's contaminating a piece of equipment that's used on another patient. So, yes, it's possible, it just hasn't been shown to happen yet.

Q Were you aware that some GI techs and nurses testified that after the scopes were cleaned and hung to dry that they observed fecal matter coming from the supposedly clean scopes?

A No.

Q Were you aware that the clinic was reusing biopsy forceps?

A I was aware. It was in the report. It stated that they were reusing them.

Q Were you aware if the clinic had an autoclave system or not?

A A sterilization system? I don't know. I don't remember.

Q Well, according to the New England Journal of Medicine article it says that those biopsy forceps were to be autoclaved.

A Okay. Uh-huh. Well, that's -- I don't know what to say. I mean, if you're using disposables, then, no, they're aren't autoclaved.

Q I'm talking about reusable ones.

A Well, I understand it was --

MR. STAUDAHER: Objection. There is no evidence of reusable forceps at the clinic at that time.

THE COURT: Well, maybe you should ask ones that were reused. Is that really where -- what you're getting at, Mr. Santacroce?

MR. SANTACROCE: I'm going to find it here, Your Honor, if you can give me a second.

BY MR. SANTACROCE:

Q Again, referring to 80 E-3. This is the BLC report. It said on 1/6/08 the director of nursing indicated that staff had been instructed -- that's the wrong one. Sorry. One 1/16/08 the administrative staff indicated that the facility used disposable biopsy instruments, the policy and procedures had not been updated to reflect the current practice. In other words, at this particular time in January they had stopped using reusable biopsy forceps and went to disposable ones. Now, my question to you is were you aware

that during the infection dates, September 21st or July 25th that reusable biopsy forceps were being reused.

A Forceps intended to be reused after either high -- after sterilization is what you're saying were being reused? Is that what you're saying?

Q I'm saying -- I didn't say anything about the sterilization.

A Well, you're saying --

Q I said reused.

A Well, then I don't -- but I have to know whether they --

Q I didn't say they were reusable. I said they were being reused.

A No, you said reusable biopsy forceps --

Q Okay.

A -- were being reused.

Q Okay. Biopsy forceps were being reused. Were you aware of that when you --

A I saw it stated --

Q -- came to your conclusion?

A -- in the report. I don't know whether it was occurring on those days. Now, if they -- yes.

Q Were you --

A So I saw it in the report.

Q Were you aware as to how those biopsy forceps

were being cleaned?

A I don't remember what it said in the report, but I do know that the investigation looked at that closely.

Q How do you know that?

A Because there are data to show that people who didn't get infected had the same frequency of biopsies, if not higher, than patients who did get infected.

Q Well, let's -- let's talk about that for a minute. Showing you Exhibit 157. You said you saw this chart but you didn't rely on this chart to make your conclusions.

A I actually -- no. This chart has nothing -- was generated after the investigation and it's a nice -- it's a good way to look at some things and not others, so --

Q Well, let's look at this. You see this guy on the blue line, Ziyad Sharrieff?

A Uh-huh.

Q Source patient for July 25, 2007. Do you see that?

A Uh-huh. Yes.

Q Do you then there was one, two, three, four -- three patients, and then Michael Washington gets infected genetically linked to Ziyad Sharrieff. Do you see that?

A Yes.

Q Were you aware that both Mr. Sharrieff and Michael Washington had biopsies on that day?

A It was in the report.

Q And so you were aware of that?

A Yes.

Q Okay. Were you --

A It said so in the report. I was aware of it.

Q And do you know if the biopsy forceps used on Mr. Sharrieff and Mr. Washington were ever cleaned?

A I'm not aware of what the -- what the biopsy used on the -- what happened to the biopsy forceps used on the source patient and the infected patient, no.

Q And my question before was whether or not you knew the clinic had an autoclave system.

A I don't know.

Q And you are aware that according the article you provided that biopsy -- reusable biopsy equipment needed to be autoclaved; correct?

A The article has nothing to do with my knowledge of what needs to be autoclaved and what doesn't.

Q Well, do you think that biopsy forceps need to be autoclaved --

A Biopsy --

Q -- if they're going to be reused?

A Anything --

THE COURT: What you mean is your knowledge is independent of what you read in the article, is that what you

mean?

THE WITNESS: That's correct.

THE COURT: Okay.

THE WITNESS: If someone is going to stick a needle in your liver to biopsy it, for example, you certainly want it to be sterile.

BY MR. SANTACROCE:

Q Am I talking about that, or am I talking about biopsy forceps for endoscopic procedures?

A It doesn't matter. It's still --

Q Okay.

A -- something that's going to enter your body.

Q How do they need to be cleaned?

MR. STAUDAHER: Your Honor, I'm going to object to at least the characterization that they were at least reusable at that time. I don't know that there's any evidence to that effect.

MR. SANTACROCE: Well, the jury can --

MR. STAUDAHER: I just want to be sure that this witness has at least the proper information before she makes any kind of a conclusion.

MR. SANTACROCE: He can object ten times about that, Your Honor, but you've already instructed the jury.

THE COURT: Okay. Just ask your question.

BY MR. SANTACROCE:

Q How are reusable biopsy forceps cleaned?

A Assuming that they're made of the proper material they would undergo sterilization.

Q And sterilization can only be achieved through an autoclave system; correct?

A Of some type, yes. There are other systems, but yes.

Q And it's distinguished between high level disinfectant and sterilization; correct?

A In terms of the -- yes, there is a difference.

Q And the autoclave system is a sterilization method and technique?

A Yes, it is.

Q And according to your article, not yours, but the one you provided from the New England Journal of Medicine that those items needed to be autoclaved in order to be reused.

A The article -- that's what that article said.

Q Okay.

A Technology may have changed. Do you know why scopes are not -- do you know why the scopes are -- undergo high level disinfection rather than sterilization?

Q Ma'am, I've never even seen a scope personally, except for the one when I had my procedure done, and I didn't see that either.

THE COURT: I -- and --

THE WITNESS: I won't even -- okay. I won't go there.

THE COURT: No, I was just going to say this -- you're not the first witness in this trial that I've told this to, but you don't get --

THE WITNESS: It's okay.

THE COURT: -- you don't get to ask questions.

THE WITNESS: Okay. My purpose is looking at the -- not only that information, but the epidemiological stuff.

BY MR. SANTACROCE:

Q No, I didn't ask you a question.

A Yes, of course you didn't.

THE COURT: And Mr. -- I know this is your first time testifying. Mr. Staudaher has an opportunity after Mr. Santacroce is done to come back on redirect examination. And at that point he can -- you know, if he thinks you need to clarify something, expound on an answer you've given to either Mr. Wright or Mr. Santacroce, Mr. Staudaher will, you know --

THE WITNESS: Okay.

THE COURT: -- ask you to do that at that time.

THE WITNESS: Thank you.

BY MR. SANTACROCE:

Q Now, when Dr. Fischer and Langley testified, after reviewing all of the evidence that's been -- well, I'm

not going to say she reviewed all of the evidence, but she reviewed Exhibit 156. And after reviewing this chart, her conclusion was that in order for their theory that the infection was transmitted through unsafe injection practices that the propofol bottle, the infected one, had to be moved from room to room to room. Now, what I'm going to show you, do you know what this chart represents?

A Yes, I think so.

Q Okay. Well, tell me what your understanding of this chart is.

A The line listing of the patient procedures for that day.

Q Okay. Do you know what the orange color is?

A There's a key at the top of the page.

Q I didn't notice that before.

A A legend.

Q Thank you.

A Yeah, well, it's usually helpful when reading a chart.

Q It is. Okay. What is it?

A They're known hepatitis -- they were known to be infected with hepatitis C virus before they were a patient in this procedure.

Q Okay. So -- and you testified earlier you didn't know how many rooms -- procedure rooms were at the

clinic at the time you reached your conclusion. I'll represent to you there were two. Okay? So the orange colored guy is the source patient; correct?

A He is known to be HI -- he is known to be HCD positive --

Q Okay.

A -- prior to his -- he's a potential source patient, yes.

Q Okay. And he is in Room 1. Okay?

A Uh-huh.

Q And then we go down to Room 2, it's divided by this line here, and we some more infected patients. Okay? Are you with me so far?

A Uh-huh.

Q Now, what I want to ask you is -- and we'll have to go by the color of the lines here because this machine isn't big enough to get it all in. But can you tell me, according to the nurse's log, what time the procedure started for the guy in orange?

A Well, I didn't generate this chart, and the times are, in my understanding, is inaccurate. If I could read it, I would tell you. But I also know the times overlap and they couldn't possibly be accurate because all of those times together make up more than 24 hours.

Q Okay. Can you just --

A That's the only thing --

Q -- tell me --

A -- I can answer.

Q -- the answer to the question I asked you? What time, according to the nurse's log, did the guy in orange start the procedure? Can you see it?

A I can -- I can see the screen, I just --

THE COURT: Can you read it? Is it big enough for you to read?

THE WITNESS: It's big enough for me to read. I have not focused on this chart because it wasn't --

THE COURT: I have a question. Was this chart given to you ahead of time for you to look at?

THE WITNESS: A few weeks ago.

THE COURT: A few weeks ago.

THE WITNESS: Yes, it was.

THE COURT: Okay.

THE WITNESS: It was given to me in early May.

THE COURT: Okay.

THE WITNESS: But I really didn't look at it because my expertise was really based on what had -- this is just revisiting it in a visual form.

THE COURT: In a different format.

THE WITNESS: That's right.

THE COURT: Okay.

THE WITNESS: And it was already based on the epidemiological studies that have been done. Now, the issue is, let's see, the earliest time seems to be --

BY MR. SANTACROCE:

Q The nurse's log --

A -- nurse --

Q -- what time --

A -- 9:49.

Q -- does that say.

A Is that what you're talking about?

Q And what time did the procedure end?

A 10:00.

Q And drop down to Ms. Hutchinson. What time did her procedure start?

A Is that 9:55.

Q And what time did it end?

A 10:04.

Q So at least according to the nurse's log, the source patient was undergoing a procedure in a different time in a different room at the same time an infected patient was infected in a different room by a different CRNA.

A If I -- according to that, yes.

Q Okay. Now, I want to talk about the preoperative procedures that you reviewed in coming to your conclusion. What was the preoperative procedures at the

clinic regarding the starting of heplocks?

A They usually were started by nurses in the pre-op room before the patient went to the patient bay for movement into the procedure room --

Q And were that --

A -- and --

Q I'm sorry. If you weren't done, I apologize.

A And my understanding from the report, the report stated that after they inserted the heplock, the nurses, these are not the CRNAs, but the nurses who usually put in the heplocks would flush the heplock to make sure it was clear with saline from a multi-dose vial.

Q Okay. And were you aware -- you obviously were aware because you said it was a multi-dose vial; correct?

A Yes.

Q So you were aware that they were reusing that saline on multiple patients?

A Yes.

Q Which is a practice you've already testified to is a no-no.

A We -- yes, that is correct. However, not in that vacuum.

Q Okay.

A You're doing it --

Q What's the --

A -- in a vacuum.

Q -- vacuum?

A The vacuum is they didn't reuse their needles or syringes. They only did one flush.

Q How do you know that?

A They said so and they were observed to do so. And unless you don't believe that's accurate --

Q Was Lynette Campbell observed?

A I don't know the names of anyone.

Q Well, let's show you Exhibit 166. This is the chart -- this is the Endoscopy Center of Southern Nevada hepatitis C transmission, September 21, 2007. These are the -- this is the source patient, infected patients in Room 1, and infected patients in Room 2. And this is the person that started the heplock on source patient, and Mr. Meana, Orellana, Martin, and Huynh. She also started the heplocks on Aspinwall and Grueskin. She shared the pre-opinion room on that day with Nurse Jeff Krueger who testified that they used multi-dose vials of saline in the same room. Okay?

A Uh-huh.

Q Were you aware of this information when you reached your conclusion?

A Yes, I was aware they were using multi-dose vials of saline, which is not the --

Q Are you aware of any studies that link

contaminated saline to hepatitis C outbreaks?

A Yes.

Q Can you tell me about those?

A In one case the individual responsible for administering the saline would draw blood for collection for laboratory testing from the -- from the person's IV or heplock, and then using the same syringe, maybe change the needle, I can't remember, would go into a 500 cc in this case, it was a large bag of saline, and withdraw saline to flush the heplock, and then went on. So the bag of saline was contaminated by the blood in the syringe from use on that person's heplock. So that's one instance.

Q And you --

A There's another one. I'd have to think.

Q You already testified that you don't need to actually see the blood for it to be contaminated; correct?

A That's correct.

Q Are you -- are you familiar with the CDC's report of hepatitis B and C outbreaks in 2008?

A Have I seen this particular chart?

Q No, I said are you aware of the outbreaks that they --

A Yeah. Yes.

Q Let's look at the bottom one here.

A Okay.

Q Are you aware of this study in North Carolina, or this outbreak in North Carolina?

A I'm aware that it occurred

Q 1200 people notified, 5 people contaminated, and what the CDC declared or determined was the mechanism of transmission was reuse of syringes which contaminated 30 cc saline vials -- whoops -- saline vials for IV catheter flushes.

A Uh-huh.

Q Are you aware of that study?

A It's occurred on other occasions.

Q So contaminated saline is certainly a possible mechanism for transmission?

A It certainly is. Any vial containing -- how did they infusate? Is that the word that was used in the report, infusate?

Q I'll have --

A I know it's --

Q -- to defer to --

A -- a funny word.

Q -- Mr. Wright --

A But it's liquid.

Q -- because he uses --

A Liquid in a --

Q -- those big words. I don't.

A -- vial. Liquid in a vial. That becomes contaminated, can serve as a source for transmission. It doesn't have to be propofol. It can be anything.

Q Anything.

A That's right. That's why you have to do a very good epidemiological investigation. And the problem is that when you only -- if you only have one or two infections, determining how that might have occurred can be very difficult to link a specific source because you don't have the numbers to analyze. So you have to look at all the possible ways. And the issue here is the protection of public health and not your trial.

Q Thank you.

A You're welcome.

Q When Mr. Wright asked you about the two infection dates and don't they stand alone, and I don't know what his exact question -- I don't remember the exact question, but do you remember that line of questioning where he talked about July 25th being separate and how do you link the two dates or something of that nature? Do you remember that testimony?

A That's not quite how I remember it, but I do remember the general area of questioning.

Q Okay.

A Like there were 362 other days.

Q Okay. So I believe you testified that because the clinic was using unsafe practices on the 21st of September, 2007, it can be inferred that that was the mechanism of transmission for July 25th. Is that accurate?

A Yes.

Q Finally we agree. Then you said something, and I wrote down in quotes, you can't prove it. What did you mean by that?

A I can't show you that the virus was in the vial and transmitted to the infected patient, newly infected patient because you only have the source and the patient, the one infected patient. However, we've seen that on multiple occasions. And --

Q I'm done with that. Let's move on. Let's talk about the effect that hepatitis C has on -- on the liver itself, okay. And I didn't get an answer to this question. Mr. Wright asked you -- talked to you about Mr. Perrillo. I don't think he was a medical doctor, but I think he was a neuropsychologist. And then he did 19 cases and said that there was hepatitis C caused dementia in -- in people. And I think Mr. Wright asked you do you agree with that theory, and I didn't actually get an answer to that. Can you tell me if dementia is caused --

A Well, I don't agree with it based on the information that was provided to me, and I'm unaware of any

other literature, you know, looking -- evaluating that relationship.

Q So it's your opinion that hep C doesn't cause --

A I have no data to show. I know of no data to show that hepatitis C causes dementia.

Q Does hep B cause cirrhosis of the liver?

A It can, but -- it can.

Q And I believe you testified as to the range of time the onset of cirrhosis can occur; right? I think you said the average was 20 years.

A Yes.

Q And I believe you made probably the most profound statement of the day. Bad data in, bad data out. Is that accurate?

A That is very accurate.

Q That's all I have, ma'am. Thank you.

THE COURT: All right. Mr. Staudaher, redirect.

REDIRECT EXAMINATION

BY MR. STAUDAHER:

Q Based on your review of everything, does it look like bad data in?

A No.

Q Based on all of those questions that were provided to you, the reports you've looked at, have you

changed your opinion at all?

A No.

Q Now, I want to show you the article that counsel referenced, and this is the one that you talked about the New England Journal of Medicine article. And this is back in '97; correct?

A Yes.

Q So 20 years ago?

A Yes.

Q Okay. Go ahead and look at that section that you were talking about. And this is, if I understood you correctly, a sample size of two patients.

A And one source.

Q And one source.

A Uh-huh. The possibility that HCV was transmitted because of inadequate procedures and the use of anesthesia should also be considered. To be fair, they go on to say we believe this route of transmission is less likely. Because the intravenous tubing and all the syringes containing the anesthetic drugs were changed after the first procedure. But they did not -- they don't refer to the vial of medication, only the tubing and the syringe and needles, which in most -- all of the outbreaks that were investigated, all of them -- well, not all of the outbreaks. Some were reused between patients. But in most instances the needle and

syringes are discarded, but the contamination of the vial has already occurred.

But then they go on to say, however, inadequate procedures were followed during -- inadequate procedures were followed during the other two procedures. Only the intravenous tubing and the needles were changed between the endoscopies of Patients 2 and 1. They -- so they go on for an entire paragraph about the potential of unsafe injection practices as a -- as a potential reason for this to have occurred, even though they focus and feel it's less likely, these authors, they focus on the scope as the mechanism, a poorly disinfected scope.

Q Now --

A But if you read the discussion, to me, they were unable to evaluate either of them. Both of them were bad. They had problems. There were deficiencies in both procedures, the intravenous administration of anesthetic, and the high level disinfection of the scopes.

Q Now, with regard to the article that Mr. Wright asked you about, and that was the injection practices among clinicians in the United States, that one.

A Yes.

MR. STAUDAHER: And I'm going to move for admission of this document based on doctrine of completeness at this point. Sections -- whole sections were read out of the

document.

MR. WRIGHT: Objection.

THE COURT: That's -- the document is not admitted. You certainly, Mr. Staudaher, are free to ask questions from that document as the defense did.

BY MR. STAUDAHER:

Q The sample size in this was much larger than that other study; correct?

A Well, this isn't an outbreak. This is a survey.

Q Oh.

A I didn't get the number -- isn't it? It's a survey of practices?

Q Well, let me bring it up to you.

A Sorry. I'm sorry.

Q It's okay.

A Maybe I misunderstood --

Q I want to make sure.

A -- what you were talking about.

Q It's the first time I've seen it, too.

A Oh, yeah. It's a survey, and there are several of them that have been done now, one by CMS. Those are the -- you know, it's the old -- CMS, Center for Medicare and Medicaid.

Q Services.

A Yeah, services. What did it used to be called? I can't remember. So this was a survey of -- oh, they had 8,000 respondents. That's pretty good, actually. A fairly high response rate. That's what I wasn't sure of. And they asked them, you know, the questions about how they -- about their injection practices.

Q Now, specifically on the other side here where it breaks down who responded, do you see that?

A Uh-huh. Yes.

Q How many CRNAs responded out of all those 8,000?

A 49.

Q Okay. So there -- where the sample size of CRNAs out of this was -- it says 1 percent --

A Uh-huh.

Q -- roughly.

A Yes.

Q I'm not sure how they -- they quite get that when it's only an 8,000 sample size.

A Because not 8,000 people responded.

Q Oh, okay.

A The survey they -- oh, well, no. It says 8,000 respondents. Oh, they had to have answered yes to the first item in the survey in order to be considered for the rest of the survey.

Q Okay. What was the first item?

A The first item. I knew you were going to -- that was coming next. Okay. Actually, they don't know how many people -- I don't know the denominator. So they don't know the number. It was published on the web, and individuals were -- professionals were asked to respond to the survey. It was anonymous, and so they don't know how many. It was the combined membership of ten collaborating organizations and they had a total of 8,000 responses. All respondents were asked three general questions. In your current practice do you prepare or administer parenteral medications, injectable medications. You had to answer yes to that in order to then be analyzed for the other.

Q So if I understand correctly, at least from that large --

A That's right.

Q -- 8,000, we drop it down almost in half just by that -- answer to that question; is that correct?

A I guess that's what --

Q Is it 49 out of --

A I'm surprised they don't have the n in the title.

Q If 49 nurse anesthetists responded and that's 1 percent, that means the total of respondents that actually fall in this category would be 4,900, would it not?

A Oh, don't you just love scientific articles? They have very long footnotes. Total frequencies vary. Some respondents did not answer all questions, etcetera, etcetera, etcetera. So the actual number, the total number who answered the question, like the 49 out of the number of people who answered the question and were considered eligible and answered the question.

Q And the section where Mr. Wright asked you under this -- under -- under the title for this heading in this --

A Uh-huh.

MR. STAUDAHER: And this is, for counsel, page 791.

BY MR. STAUDAHER:

Q Question, basically, did you enter a single vial more than once for the same patient? And they're talking about how many respondents reported that that had been done. In this case it was a total of 30.2 percent of 1599 respondents. When asked why they did that, they gave some examples in italics as to why they did that. Can you see that?

A Yes.

Q Okay.

A Uh-huh.

Q And was the -- what was the -- what was the reason why they responded to even just doing that?

A Cost, using multiple dose vials supplied by the healthcare entity to use up what was in there as long as the vial was only kept for a certain period of time. My understanding about heparin is it is a multi-dose. It has a bacteriostatic agent in it.

Q Now, with regard to the heading, which was entitled use of multi-dose vial for more than one patient, the very last comment on that section, what did it say, one of the respondents as an example?

A I use a new syringe for each entry and we date the vials after opening.

Q Now, does that sound like a practice that would be -- I mean, I know that it may not be optimal.

A That would be the practice. That would be the appropriate practice.

Q Okay. So somebody who answered to that in that category, that was even a quoted response by one of the people, is that correct, in this article?

A That's what they're trying -- that's the example of one of the responses.

Q Where it says practice is not considered appropriate consistent with current guidelines, one of the -- the heading there on the same page is use of single-dose vial for more than one patient. Do you see the reasoning why on that particular one was used by some of the respondents?

A As a cost saving measure.

Q Okay. So two costs involved there. Let's see if there was any others that I could see. Okay. So it varies, at least the information that was provided; correct? I mean, by these different respondents, who they responded to, which questions and the like?

A Yes.

MR. STAUDAHER: Court's indulgence, Your Honor.

BY MR. STAUDAHER:

Q Since that -- that article written 20 years ago with a subset -- a sample population in the sample -- or in the study of two people, 20 years, are you aware of a single article that's connected scopes to infection?

A No.

MR. STAUDAHER: Pass the witness, Your Honor.

THE COURT: All right. Recross, Mr. Wright.

MR. WRIGHT: Nothing.

THE COURT: Mr. Santacroce.

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q In the New England Journal of Medicine article that we were referring to, are you aware of a study that was done as to the degree of adherence to guidelines for cleaning and disinfection of gastrointestinal endoscopes?

A Can I see what you're referring to?

Q Absolutely.

A Thank you. Well, it was performed in 1988, and I can't say I'm surprised. I don't know what the percentage was, but there's been a lot of progress made. I'm not saying that people do it right all the time and it's ideal, and I'm not suggesting it's perfect. But I haven't seen an example -- an instance of transmission that could be attributed epidemiologically or otherwise to reprocessed scopes.

Q According to this survey 30 to 100 percent were inadequately using disinfectant procedures to clean gastrointestinal equipment. 30 to 100 percent were not following guidelines.

A Do you know where the survey was done?

Q Well, there's a footnote.

A I -- no, there's a reference.

Q Would you like to see the reference now?

A I saw the reference, but I still don't know where the survey was performed, in what countries.

Q Well, I can show you. Do you want to see the reference?

A Certainly. Again, that survey was done in 1988, 11 years prior to the publication of these -- of this --

Q Then why did you print it out and bring it to court?

A Excuse me?

Q Why did you print this out and bring it to -- provide it?

A I said the --

MR. STAUDAHER: Objection. She didn't bring it to Court, Your Honor. Mr. Santacroce did.

THE COURT: Well, he changed his phrasing, provide it.

BY MR. SANTACROCE:

Q If it was so old, outdated, had no relevance to transmission of disease, why did you download it three days ago, provide it to the district attorney who then, in turn, provided it to us?

A My comment about it being interpreted as being out of date was the 1988 survey of disinfection procedures, not this particular episode that was published in 1999.

Q So the conclusion about the cleaning methods of the endoscopic equipment is still relevant?

A It's relevant to the fact that they -- that they found deficiencies, yes. But it does not show -- they found other deficiencies that in my -- that they could not distinguish one from the other as causing infection.

Q After they --

A Or contributing to the transmission of infection.

Q After they cite those statistics, the 30 to 100 percent, they say failure to follow the recommended procedures can have an important role in the endoscopic transmission of microorganisms.

A That's very true, all microorganisms. This is true.

MR. SANTACROCE: Nothing further. Thank you.

THE COURT: Mr. Staudaher.

MR. STAUDAHER: No redirect, Your Honor.

THE COURT: Counsel approach.

(Off-record bench conference.)

THE COURT: Ma'am, I have a couple of juror questions up here.

THE WITNESS: Okay.

THE COURT: The juror would like to know would best practice be to use 20 cc syringes with 20 cc vials so that the entire contents of the vial are pulled up all at once?

THE WITNESS: Only if that syringe was used on a single patient. Otherwise, it would have the same -- there wouldn't be any difference in your ability to contaminate a vial by using the syringe.

THE COURT: Okay. Another juror would like to know if in this case the injection practices were bad and the cleaning of the scopes was equally bad, would that lessen your belief that the cause was the injection practices only?

THE WITNESS: No. And the reason is because the analysis of -- as I -- one of the -- the epidemiological study compares the frequency of exposures, like through the scope or a procedure or an injection in those who got infected or even a staff member, for example, those who got infected compared with those who didn't. And for these procedures, what type of procedure, when they occurred, whether or not they had biopsies, were all -- were not different between -- this is -- this is how you look at it, this is how you study it. We're not different between those who became infected and those who did not. And if you have selected your patient population to be representative of those at risk, which they did, every one they could possibly get to get tested, and they had a fairly good -- they had a high percentage of the patients tested on the days in question, then that is what speaks to be most strongly.

Also, knowing that their practices were so -- their injection practices were so deficient, faulty, and is -- is also very telling that they continue to do those even in front of the CDC investigators. So you've got two different -- you know, you've got multiple ways in which people could have been infected. But the epidemiological analysis did not show that there were no differences between infected patients and uninfected patients in those who -- in the type of procedure they had. And that, when a good study is done, is

the conclusion that they're not associated. That's how we make that conclusion. That's how you decide a drug is effective or not effective --

THE COURT: Mr. --

THE WITNESS: -- for example.

THE COURT: I'm sorry.

Mr. Wright, any follow up?

MR. WRIGHT: Yes.

RECROSS-EXAMINATION

BY MR. WRIGHT:

Q It's very -- you said it's very telling that like Mr. Mathahs --

THE COURT: Keep your voice up.

BY MR. WRIGHT:

Q Very telling -- I think you said it's very telling they continued to do this even right in front of the inspector; right?

A Yes.

Q Okay. Like -- like Mr. Mathahs knows the inspector is there watching what he is doing, he knows the purpose of the inspection, and he goes ahead and performs a -- does his thing in a manner which is not best practices; correct?

A Correct.

Q And the person who was actually there and

observed him interviewed him right at the moment and stated that she believed he was sincere in that he did not understand the risks of the procedure. So why is that telling? All that shows is that he didn't understand that he couldn't do what he was doing when he sat there and proudly put on a new needle.

A I'm not -- I know I'm not allowed to ask a question and I'm not really asking a question, it's --

Q Go ahead and try one.

A -- rhetorical. If you break the law, like driving while intoxicated or going over the speed limit and you say, oh, I didn't know I wasn't supposed to do that, isn't there some kind of --

Q No. You can ask the question. We don't have strict liability.

A -- ignorance is no excuse?

Q No, we have -- this is a criminal case, as you pointed out. This isn't --

A I'm using science.

Q Right.

A Okay.

Q I understand that.

A Right. So then --

Q But here, in order to commit an offense it must be a --

MR. STAUDAHER: Objection. Calls for a legal

conclusion.

THE WITNESS: I'm not --

MR. STAUDAHER: That's what we're doing now, so --

THE WITNESS: I'm not going there. It's so routine, whether or not this person -- this person should know, number one.

BY MR. WRIGHT:

Q Just a minute, you're going to bait me into responding.

A Oops.

Q You're not the only one who gets to preach.

A Sorry.

THE COURT: Is what you're saying it's telling because it's -- you know, that suggests to you that it's a practice, at least with respect to that person, Mr. Mathahs, that he routinely engaged in; is that what you mean?

THE WITNESS: Yes.

THE COURT: So he --

THE WITNESS: That's what I mean.

THE COURT: -- wouldn't think, oh, they're here, I'm doing something wrong and dangerous, I better not do it.

THE WITNESS: Right. And, in fact, there is --

THE COURT: Okay. Is that what you meant?

THE WITNESS: That's what I meant.

THE COURT: Mr. Wright.

BY MR. WRIGHT:

Q But normally if someone like knows they're doing something wrong and the highway patrolman is sitting there, they don't do it; correct?

A I don't know.

Q You don't?

A I don't know.

Q If you see --

A Do they step --

Q -- the highway patrolman --

A -- on their brakes and hope the radar gun didn't get them? I don't know what people do --

Q Okay.

A -- actually. I can't --

Q Well, wouldn't --

A -- attest to that, but --

Q -- you presume, as an investigator who looks at these things, that normally when a person being watched, observed, and knows it is an investigation to see how hepatitis may have transmitted --

A Did you know there's a scientific --

Q -- that --

A -- term for that?

Q -- that --

A Sorry.

Q -- that he is going to, if he knows something he is doing is wrong, he is going to change his behavior?

A Is some instances you're correct.

Q Okay.

A But --

Q And in the --

A -- not all --

Q -- in the study --

MR. STAUDAHER: Objection. If he could at least -- she could at least be allowed to finish her answer.

BY MR. WRIGHT:

Q Okay. Finish your answer.

A You're so -- you're so right in some ways that they have a name for it. It's called the Hawthorne Effect.

Q Okay.

A It's the very act of observing, someone changes their behavior because they know they're being observed. Actually, people who routinely perform a procedure, tend to routinely do it even when observed. It can be an issue in some research, but in my -- in much of -- in my experience, in healthcare related outbreaks, the procedures are not changed when the investigators come in to investigate.

Q In the studies I've read there was some type of -- it says in there bear in mind, we weren't there six months ago, and all we are doing is observing people right now

who know they are watching us, so there was an obvious bias. There is some word or --

A Well, there could be a limitation. One of the -- usually what the article says -- sorry, I interrupted. I apologize.

Q You're good at that.

A I know. I am not good at this. I apologize. Should I wait? Finish, please.

Q What is -- that is a bias that takes place because if a person normally knows they are doing something wrong, they don't do it in front of the constable; correct?

A No.

Q They do it?

A They can still -- they will still do it in some instances. I cannot tell you how often someone might change their behavior in this situation. In science it's very important to point out what limitations might exist in your study, no matter how fabulous you think it might be, or how flawed, you want to point out what the limitations could be, and that's a limitation on any study that -- particularly one that occurs well after the event.

Q Okay. But I take it you would put a great deal of credence in the testimony and observation of Dr. Fischer who actually interviewed Mr. Mathahs --

A You mean that he --

Q -- and -- and gave her opinion about whether he was genuinely surprised and had believed he was engaging in safe practices.

A She may -- she -- I'm not saying I disbelieve her. It's just not relevant to me or to my conclusions from this -- the cause of this --

Q It's not relevant --

A No.

Q -- whether -- well, see --

A To you it might --

Q -- in a criminal case -- see, we're in a criminal case.

MR. STAUDAHER: Objection, Your Honor. This is not an instruction on law.

THE COURT: Okay. So is what you're saying it's not relevant to you from an epidemiological --

MR. STAUDAHER: From the source of the cause of the outbreak.

THE COURT: Because you're not concerned with liability, civil or other -- criminal or otherwise; is that correct?

THE WITNESS: Yes, not in a hardhearted sense, but --

THE COURT: Okay.

THE WITNESS: -- from a scientific point of view.

THE COURT: You're just concerned scientifically with understanding --

THE WITNESS: That's what I've been asked to do.

THE COURT: -- the -- the genesis, if you will, of the infection and determining how to prevent future infection, is that fair?

THE WITNESS: That's right. That's right.

THE COURT: Not with respect to placing blame or anything like that in terms of civilly or criminally, is that fair?

THE WITNESS: Yes.

THE COURT: Okay.

MR. WRIGHT: The end.

THE COURT: I thought that was a preface for a question.

MR. WRIGHT: No.

THE COURT: Mr. Santacroce, do you have any follow up.

MR. SANTACROCE: Just a couple.

FURTHER RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q When the juror asked you if the injection practices were bad and cleaning practices were equally as bad would it change your opinion, you said no. What I need to ask you is you read the MMWR report from the CDC regarding this

case?

A Yes.

Q They use words in that report like the likely transmission, possible, likely, words like that. Okay? Why do scientists use words like likely and probable and possible?

A Because we cannot directly show that that event caused that infection. We can do a -- that's why.

MR. SANTACROCE: That's all I have. Thank you.

THE COURT: Mr. Staudaher?

MR. STAUDAHER: Nothing further, Your Honor.

THE COURT: Any additional juror questions for this witness?

All right. Ma'am, I see no additional questions. Thank you for your testimony.

THE WITNESS: Thank you.

THE COURT: You are excused at this time.

And the State may call its next witness.

MR. STAUDAHER: State calls Dr. Lewis, Your Honor.

THE COURT: I'm sorry?

MR. STAUDAHER: Dr. Lewis.

THE COURT: All right. Dr. Lewis.

Is everybody okay without a break?

Doctor, just right up here, please, by me. No, this one. And it's just right up those couple of stairs, and then just remain standing facing that lady right there and she'll

administer the oath to you.

DANIEL LEWIS, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Daniel Lewis; D-A-N-I-E-L L-E-W-I-S.

THE COURT: All right. Thank you.

Mr. Staudaher.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Doctor, what do you do for a living?

A I'm an internist.

Q And how long have you had that position or done that work?

A Since 2001.

Q Where did you go to school?

A University of Nevada Medical School.

Q Did you do a fellowship or training after your medical degree?

A I did my residency through the University of Nevada.

Q So all your -- all your training has been here locally?

A Up in Reno, Nevada.

Q I want to ask you about a specific patient. I mean, you know why you're here exactly; correct?

A Yes.

Q Can you tell us if you were involved with a patient by the name of Carole Grueskin at some point?

A Yes.

Q What relation did you have with her?

A I was her primary care provider.

Q Now, as far as that's concerned, I mean, go back in time. When was the first time that you came in contact with her as a patient provider sort of situation?

A February 2007.

Q What was the reason for her coming to see you at that time?

A The first visit was to establish care, but she was also complaining of kind of bronchitis symptoms.

Q Was -- was she establishing care in the sense that you were going to be her primary doctor?

A Correct.

Q So after that happens, I mean, when she comes to you for that particular problem, do you do the whole sort of first evaluation physical and lab work and the like?

A Sometimes, yes. On the first -- that -- on that visit, no, because she was sick and we just addressed the immediate problem of her being -- having bronchitis.

Q Did she return to you at a later time?

A She did.

Q Have you seen her multiple times?

A Yes.

Q Now, during the times that you saw her, were one of those at least an evaluative type of physical with lab work and the like?

A Yes, in July of 2007.

Q When you did that in July of 2007, was there any indication that she had any kind of a liver problem or liver condition based on her labs and your assessment of her?

A No.

Q Did she exhibit any symptoms of cognitive impairment, dementia, anything like that at those times?

A No.

Q Moving forward, did you continue to see her for other problems during the time?

A Yes, I did.

Q At some point down the road did you refer her for a colonoscopy?

A Yes, I did.

Q What was the reason you did that?

A She had blood in her stool. In her -- on the physical exam -- or on the -- her annual physical, she had microscopic blood on the stool test that we did on that test.

Q Okay. So what -- that was the reason to send her?

A Yes.

Q Now, what kind of a procedure or procedures did you send her for?

A I really sent her to be evaluated by the gastroenterologist for what could be causing the source of bleeding from the stool test.

Q And where did you send her?

A The referral went through Southwest Medical Gastroenterology Department, and then I think they then sent her to Gastroenterology's -- Dr. Desai's GI practice.

Q So she eventually ends up at Dr. Desai's practice?

A Yes.

Q Does she undergo procedures there?

A Yes.

Q Now, I want to back up from that point. When did that all happen?

A She thought she had a colonoscopy on September 21, 2007.

Q So prior to September 21st, I think you said the first time you came in contact with her was in February.

A Correct.

Q So you had seen her how many times between February and September of that year?

A I saw her once in February, twice in July of

2007.

Q So a total of three times?

A At that point, yes.

Q Now, during any of those times, any indication that she came in with -- with jaundice or any kind of overt liver function problem?

A No.

Q Any of the lab work you had done during any of those times came back with any problem related to her having hepatitis, anything like that?

A No.

Q Now, from a cognitive impairment, you've seen her a few times, any indications in the records you had or your direct observations that she had any kind of a mental condition or problem?

A No.

Q And when I say that, I'm talking about something like dementia, you know, Alzheimer's, anything like that.

A No, she did not.

Q Now, when she goes to the clinic, tell us what happens after that from your perspective.

A I -- at that point she saw me in November of 2007. She presented with jaundice. Her skin was yellow and she had no pain, abdominal pain. We did stat labs that day,

which then we got the results of the following day.

Q And what did they show?

A They showed her liver enzymes were extremely high. The cutoff is -- the lab values are usually around 30 or 40. Hers were in the 3,000 to 4,000 range.

Q So this is in November. Roughly, when in November?

A The -- I think the first part of November.

Q So at least at that time, was that the first time you had seen her since she had her colonoscopy procedure?

A Yes.

Q Did she have just a colonoscopy, or did she have something else also?

A As far as --

Q Endoscopic procedures at the clinic?

A An upper GI, as well.

Q So she had both?

A She had both.

Q When she gets actually to you on -- before the November date, and the window of time I'm talking about, I just want to make sure you're clear on this, is after the colonoscopy and upper endoscopy in September --

A Uh-huh.

Q -- to the November date when you see her at the beginning of November --

A Uh-huh.

Q -- were there any calls to you, any further visits, any time that you interacted with her other than time when she follows back up?

A Not that I know of.

Q When you see her at that time, is she noticeably jaundiced at the point when you see her?

A Yes, extremely.

Q Once you get that information from her and you order the lab work, I mean, do you assess her in any other way? Do you try to look her?

A I examined her.

Q Were there any other problems that you noted at that time?

A No.

Q Was she having any cognitive impairment at that point?

A No.

Q So let's move forward from the November date. You send her for the lab work. I assume you get this back?

A Uh-huh.

Q What happens next?

A I immediately sent her -- well, called her. I truly don't know if I spoke to her or if one of our staff members spoke to her and told her to go to the hospital.

Q Okay. So does that happen?

A Yes.

Q Do you follow up with her after that?

A Yes.

Q Did you see her in the hospital?

A No, I did not.

Q When was it that you saw her again after -- after the hospitalization?

A A week after she was discharged from the hospital.

Q When was that, if you know?

A I don't know the exact dates. She was in the hospital for approximately three days. It was towards -- it was in the month of November.

Q Still?

A Yes.

Q So all of this, the jaundice to the hospitalization to you seeing her afterward, the month of November?

A Right. It spanned approximately three to ten days.

Q When you saw her in follow up after that, had her mental status changed at all?

A No.

Q What do you with her or for her at that stage?

A At that point it was still unclear what caused her to have hepatitis, and so we repeated some lab work that had been done in the hospital, which included a hepatitis panel.

Q Did it come back?

A It came back positive for the antibodies for hepatitis C.

Q Now, at this point what do you do?

A At this point I told her that she needed to follow up with the gastroenterologist that saw her in the hospital.

Q To your knowledge -- I mean, do you get a report back at some point? Do you know if she did that or didn't do that?

A I did get a report back that she did.

Q So when is the next time that you actually see her?

A The next time I saw her was in December and she had seen -- she had seen the gastroenterologist who said -- well, in his reports said that he was unclear of what -- how she had hepatitis C.

Q And who was this?

A Dr. Weisz.

Q Okay. And --

A So I -- I was frustrated because the lab work

showed that she had hepatitis C, you know, that her antibody came back positive for hepatitis C. And so I told her that she, you know, she probably has hepatitis C and she needs to follow back up with the gastroenterologist.

Q Now, did you do any kind of treatment of her for her hepatitis C?

A No, that's out of the realm of internal medicine.

Q Do you know if she underwent any treatment, like interferon therapy, Ribavirin, anything like that?

A Not at that time. Not at that initial visit, no.

Q Okay. So let's -- let's move forward. What's -- and, again, at this point, what month, where are we talking about?

A We're talking about December of 2007, now probably in January of 2008.

Q Any issue with cognitive impairment at that time?

A No. No.

Q So still we don't have an issue there?

A No.

Q Move forward in time to the -- to the next visit or the next time you've interacted with her.

A I got a -- well, okay, I got a call from the

Health District stating that she had hepatitis C and that they were going to contact her. And at that point -- at that point we -- she came back in. At this point hepatitis C outbreak was, you know, on the news every day and she came back in extremely, extremely upset, distraught, angry, anxious to the point where she just was having a hard time functioning.

Q So that's after she gets the news about her condition and the news is --

A Right.

Q -- in the media.

A So she had a -- she had a test in February 2008, which did confirm that she had the virus for hepatitis C and the genotype of that virus.

Q Did you continue to see her after that?

A Yes.

Q During the times that you see her in follow up, when was the next time, if you can --

A March of 2008.

Q So now we're well in -- we're into the next year.

A Yeah, I pretty much saw her once a month throughout the entire year of 2008.

Q Do you know if she did ever undergo any kind of treatment, therapy, interferon, specifically.

A She did eventually.

Q And when was that?

A November of 2008.

Q So at least the anxiousness or at least the condition you talked about, when -- and let's talk about that initially. You say she comes back in after the results are given to her. The way that you described her just in court a moment ago, is that what we're talking about as far as anxiousness, or something else?

A She was extremely anxious and she was extremely depressed, and she -- at that point in March one of her complaints was that she was forgetting things, that she was forgetting her keys, she was forgetting to do things, meet appointments, certain things, that type of stuff.

Q Had she disclosed to you during any of the evaluations you had done as her primary, any kind of family history of dementia, Alzheimer's, anything like that?

A No, she did not.

Q Had you seen any signs or symptoms in retrospect, now that you're dealing with her later on, of those kinds of signs or symptoms?

A I saw signs of memory loss, yes. And what was confusing about it is depression can cause memory loss. You know, you can become so depressed or so anxious that you forget things. So -- so at that point that's what I felt was going on. I felt that it was due to her overall emotional

state that was causing her to forget things.

Q Related to the hepatitis infection?

A Related to having -- acquiring hepatitis C.

Q Okay. So those symptoms don't occur until after that -- that event?

A Yes.

Q Now, moving forward, you said you still saw her every month.

A Uh-huh.

Q Does -- does that cognitive issue, the depression, the things you mentioned, does it change over time?

A It -- it actually -- it -- it got worse. In March she was reluctant to go on any type of medication for depression. She refused to go see a psychiatrist or a psychologist. It was in June that we were -- that I pretty much convinced her to try an anti-depressant. We then increased the dose of that anti-depressant in August of 2008. Again, there was a lot of stress in Spring of 2008 because at that point we were trying to find another gastroenterologist to treat her, which was extremely difficult because all of the sudden no gastroenterologists were taking patients, you know, and so it became a -- it just became an ongoing thing that just wasn't moving forward as far as to get treatment.

Q Did she eventually start interferon therapy at

some point?

A She did. She started interferon therapy in November of 2008.

Q And how did she respond to that?

A She had some complications from that. The interferon caused her to -- her white blood cell count to go very low and her red blood cells to go very low.

Q Did you notice any difference in her cognitive situation once she started the interferon therapy?

A She became more confused.

Q Was it a correlation between that, I mean, before versus after?

A I don't know if it -- I mean, I don't know if it was related to the treatment. I'm not sure.

Q But after she started the interferon she got worse?

A Yes.

Q Would you classify that as mildly worse, medium, markedly?

A I would say mildly worse.

Q Now, how far did you continue with her?

A Last time I saw her was in January 2009.

Q So at that time what was her situation?

A She was -- I think they had stopped the treatment and that's about -- that's all I remember.

Q Do you know why the treatment was stopped?

A Because of the complications of her becoming so anemic from the treatment.

MR. SANTACROCE: I'm going to object as to foundation.

MR. STAUDAHER: Well, he's the -- you're the physician, you have the --

THE COURT: That's overruled.

BY MR. STAUDAHER:

Q So it was because of complications what?

A It was because of complications of -- of her unable to -- to handle or be treated by that medication because it caused her to become anemic.

Q And you mentioned red and white blood cell counts?

A Right. It required blood transfusions and -- and she still wasn't able to tolerate it.

MR. STAUDAHER: Pass the witness, Your Honor.

THE COURT: All right. Ms. Stanish.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good afternoon, Dr. Lewis.

A Hi there.

Q Let me start with Ms. Grueskin's medical history. I assume when you met with her first you collected

her medical history?

A Yes.

Q And is it the case that she was a heavy smoker, smoking one to two packs a day?

A That's correct.

Q Do you know for what duration she had done that?

A I don't know.

Q Okay. Do you recall that it was for over 20 years?

A Yes.

Q And by the way, how old was she when you first visited with her?

A She was born in 1939, so 2007 I would say that's 69, 68.

Q How old is she now since you're good at math?

A Let's see here, 39 --

THE COURT: Not to put you on the spot or anything.

MS. STANISH: No, I know he's going to get it right.

THE WITNESS: 74 -- or 72. No, 74. Sorry.

BY MS. STANISH:

Q See, that's what I thought. All right. And did she also have issues with breast cancer?

A Yes, she did.

Q And did she receive radiation for that?

A Yes, she did.

Q Were -- did she also have to have an operation in connection with that?

A I don't recall.

Q All right. Do you -- did she also suffer from diabetes?

A No, she did not.

Q Okay. Do you recall any other health issues that she was dealing with when you first visited with her?

A No, other than she was having back problems.

Q And as far as her GI issues, ultimately what was determined to be her problem with GI issues when you referred her in 2007 for the colonoscopy?

A She had -- she had black positive stools on her stool test.

Q Meaning what?

A Microscopic blood within the stool, meaning that there is possibly some sort of bleeding going on internally.

Q And as I under -- as I understand it, you had, prior to her going to the -- for the colonoscopy, you had done the -- the normal labs that you would give to a patient who is getting their annual or physical?

A That's correct.

Q And those blood tests, they test for liver

enzyme levels; is that correct?

A That's correct.

Q I assume you did not give any specific blood tests relating to the hepatitis?

A No, I did not. Not at that time.

Q And let's jump now when, as I understand it, she became symptomatic in November of 2008 and you referred her to the hospital.

A Uh-huh.

Q And the --

MR. STAUDAHER: Your Honor, to correct that, just for counsel. 2007, I think, was the year.

MS. STANISH: Oh, did I say '08?

MR. STAUDAHER: Yes.

THE COURT: Okay. 2007.

MS. STANISH: I bet you're a good proofreader.

MS. WECKERLY: I heard it, Margaret.

MR. STAUDAHER: Actually, it was my co-counsel.

BY MS. STANISH:

Q What year did -- November 2007 she becomes symptomatic and you refer her to the hospital?

A That's correct.

Q And at some point you refer her to Dr. Sood?

A Yes.

Q And do you know when that was?

A That was in 2008, March of 2008.

Q And, you know, I read your deposition, so I understood that there was an issue with whether it was yourself or Dr. Sood trying to determine if she had autoimmune hepatitis.

A Right.

Q First what was -- put that on a timeline for me relative to her becoming symptomatic in November of 2007.

A Uh-huh.

Q When were -- when were her providers struggling with this issue?

A During -- because -- Dr. Sood was. Dr. Sood ordered the test to determine whether or not she had anything that would contraindicate being on interferon therapy. If she had autoimmune hepatitis, that -- which would then probably be treated with steroids, that would make the hepatitis C worse. If the hepatitis -- if she had -- or likewise. But basically the reason why is so she -- they did a blood test. It was positive for ANA. Her ANA was positive, which kind of could point in that possible direction that she had autoimmune hepatitis.

Q So the next question is what the heck is autoimmune hepatitis?

A From what I know is it's the -- like any type of autoimmune disease it's when your body produces antibodies

that attack against itself. And in this case, your body produces antibodies that are attacking certain proteins within the liver causing inflammation of the liver.

Q It sounded like you had expressed some frustration that she wasn't getting the -- the treatment for hepatitis C, the drug regimen.

A I don't recall exactly. I mean, that was three or four years ago. But I think in general I think I was frustrated that all the hoops that we had to go through to get her treated, yes.

Q And she wasn't -- she actually didn't get the treatment until September 2008, almost a year after the colonoscopy?

A That's probably correct.

Q And can you explain -- well, you're not the one making the decision. That's Dr. Sood making the decision.

A Uh-huh.

Q Or -- or was Dr. Sood working with some other specialist that you're aware of?

A Not that I'm aware of.

Q Okay. So Dr. Sood was the one who was dealing with the hepatitis issue?

A Dr. Sood is a gastroenterologist specialist. That's what he would -- yeah, he would be the one that would do any type of treatment for hepatitis C.

Q And can you tell from your review of the medical records why there was such a long delay getting her that treatment?

A I think a couple things. One, again, there was the question of autoimmune hepatitis, and two was her mental state at the time.

THE COURT: Ms. Stanish --

I'm sorry. Were you done with your answer?

THE WITNESS: Yeah. Yes.

THE COURT: I didn't mean -- I have a bad habit of interrupting people.

Ms. Stanish, we're going to take a quick break.

MS. STANISH: Okay.

THE COURT: So I am going to interrupt you.

MS. STANISH: All right.

THE COURT: Ladies and gentlemen, during the quick break you're reminded you're not to discuss the case or anything relating to the case with each other or anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case, or do any independent research. Please don't form or express an opinion on the trial.

Notepads in your chairs and follow the bailiff through the rear door.

And, Doctor, during the break, please don't discuss

your testimony with anyone.

THE WITNESS: No problem.

THE COURT: All right. Thanks. And you're free to sit there, or if you want to take a break you can exit through the double doors.

THE WITNESS: Thanks a lot.

(Court recessed at 4:26 p.m., until 4:34 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session.

And Ms, Stanish, you may resume your cross-examination.

MS. STANISH: Thank you, Judge.

BY MS. STANISH:

Q Going back to the autoimmune deficiency, you noticed that at one time period?

A At what time period what?

Q On the timeline.

A In the summer of 2008.

Q And is that suggestive of the beginning stages of lupus? Did she --

A I truly don't know if -- the reason why she -- I was involved with the whole scenario of possible autoimmune hepatitis is because of the way her insurance was set up she had to go back to her primary doctor for referrals. And it

was recommended by the gastroenterologist that she be referred to the rheumatologist. And so she came back and saw me for a referral to go see the rheumatologist.

Q And what exactly is a rheumatologist?

A A rheumatologist is a specialist in conditions like rheumatoid arthritis, lupus, autoimmune diseases of that nature.

Q Do you know if memory problems are associated with lupus or other autoimmune diseases?

A Not that I -- I don't know.

Q You don't know. And your -- from the time you -- you're seeing her, November of 2007 when she's diagnosed with hepatitis C to mid-September 2008 when she's not getting the hepatitis treatment, the drug regiment, during that time frame are -- are her -- are her viral loads stable or what's going on there?

A I do not know.

Q You don't know. Do you even know as -- today if -- if the -- if the hepatitis C has cleared her system?

A The last time I was in contact with her was in January of 2009.

Q Okay. So you don't know. All right.

A I know nothing after that visit.

Q Well, then I guess I can't ask you much more, so thank you.

THE COURT: All right. Mr. Santacroce, any cross?

MR. SANTACROCE: Yes, thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Doctor, you said that you noticed some cognitive impairment after the procedure or after the diagnosis of hepatitis C?

A She came in with the initial complaint of having memory loss in March of 2008.

Q Okay. And is that when you noticed some cognitive impairment?

A Yes. I ordered an MRI of the brain at that time and it was normal. And I thought that it was probably due to the amount of anxiety, depression that she was undergoing at that -- having at that point.

Q Do you have an opinion as to whether or not hep C causes dementia or Alzheimer's?

A I don't have an opinion. I leave that up to the gastroenterologist.

Q Okay. So you can't say to a reasonable degree of medical certainty what, if anything, caused dementia or Alzheimer's?

A What causes Alzheimer's dementia?

Q In her.

A No, I do not know.

Q Did she have a -- is there a formal diagnosis for dementia? I mean, who do you go see to be diagnosed with dementia?

A A neurologist.

Q Do you know if she saw a neurologist?

A I do not know if she saw a neurologist.

Q Could memory loss or dementia be caused by treatment, chemotherapy, radiation, things of that nature?

A Yes, it can.

Q And your testimony was that she had undergone radiation prior to her procedure at the clinic?

A That is correct. She did have radiation treatment for breast cancer, yes.

MR. SANTACROCE: I have nothing further. Thank you.

THE COURT: Redirect?

MR. STAUDAHER: No, Your Honor.

THE COURT: Any juror questions for this witness? No juror questions?

Doctor, thank you for your testimony. Please don't discuss your testimony with any other witnesses, and you are excused at this time.

And the State may call its next witness.

MS. WECKERLY: Yereny Duenas.

THE COURT: Ma'am, just right up here, please, next to me. And then face this lady right there and she will

administer the oath to you.

YERENY DUENAS, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: My name is Yereny, Y-E-R-E-N-Y, last name Duenas, D-U-E-N-A-S.

THE COURT: All right. Thank you.

Ms. Weckerly.

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Ms. Duenas, how are you employed?

A I'm employed.

Q How?

A Through my employer. No. I'm employed through Zenith American Solutions. I'm a participant service coordinator.

Q And what does that mean you do?

A We are the third party administrator for a bunch of the unions in town. For example, Culinary, we pay their claims, we handle their eligibility, we handle self-pays and things like that.

Q And how --

A On the insurance side, medical insurance side.

Q How long have you done that type of work.

A 18 and a half years.

Q And was the company that you work for always known as Zenith American?

A No, we've had different name changes through the years. It was previously ABPA, and then we had a merger with Zenith, so we're now Zenith American Solutions.

Q Okay. And were you someone who was specifically involved in handling claims for under Culinary insurance back in 2007?

A Yes, I was a claims team leader.

Q And as a team leader do you handle claims personally and do you supervise or how does that work?

A I distribute the work, if there's any questions, I help the examiners, any provider calls, customer -- escalated customer calls, I handle all those type of issues, go to contract meetings, and so on.

MS. WECKERLY: Your Honor, may I approach the witness?

THE COURT: You may.

MS. WECKERLY: And I've shown these to counsel.

BY MS. WECKERLY:

Q Ms. Duenas, I'm showing you what's been marked as State's 209, and there's actually several documents. And there's 209A, B, and C. And if you could just look through all those --

A Okay.

Q -- and then let me know when you're done.

A Okay. Okay.

Q Are all of those documents related or all they all business documents related to an insurance claim that was processed by your company, I guess, based on Culinary insurance back in 2007?

A Yes, but it looks like there's statements in there that the patient received from the actual doctor's office.

Q Okay.

A Like the explanation of benefits, that has our name on it as ours, but like these invoices --

Q Uh-huh.

A -- they look like they are from the doctor's office. Those are not from our office.

Q Okay. You didn't generate these --

A No, we did not --

Q -- at the insurance company --

A -- generate those.

Q -- but you're familiar with this type of --

A Yes.

Q -- document being submitted?

A Yes.

Q Is that fair?

A Yes.

Q Okay. Are all of the documents in here something that you would be familiar with from working --

A Yes.

Q -- for 17 years?

A Yes.

Q Okay.

MS. WECKERLY: Your Honor, the State moves to admit 209, and then 209A, B, and C.

THE COURT: Any objection?

MS. STANISH: No, Your Honor.

THE COURT: All right. Those are all admitted.

(State's Exhibit 209, 209A, 209B and 209C admitted.)

BY MS. WECKERLY:

Q Okay. Can you -- is your screen on up there?

A Yes, it is.

Q Okay. Perfect. I am showing you -- this is 209C, and it looks like -- well, you tell me. What are we looking at here?

A Okay. These are our internal processing guidelines based as how the claim was processed in 2007.

Q Okay.

A It's just an internal document that we have that we provide for the examiners so they know when they receive their certain claim type how -- kind of like what is loaded in the system and what the background information is.

Q Okay. And in 2007 through Culinary insurance for a -- for a claim for the anesthesia associated with the colonoscopy, how is that measured or how is it determined?

A Our anesthesia claims are based on base units plus time, times the RVU units.

Q Okay. And it looks like on here there's an RVU unit price.

A Correct.

Q And was that the price in 2007?

A Yes, for a CRNA. Yes, it was.

Q Okay. So this is the price. Sorry. This $34 is the price that you pay per unit for the procedure?

A Correct.

Q And you said the price is determined by calculating the number of units associated with the procedure?

A Yes.

Q And then just timing it by this 34?

A Yes.

Q Okay. And the other kind of information on this document, I guess, defines the -- sort of the conditions of what can be billed or what counts or what doesn't?

A That is correct.

Q I'm going to flip to -- well, it's the second to the last page. Okay. And this -- this box right here, which is the -- the second box on the page, can you explain to

us what information is contained in that box?

A Okay. In this box it's basically how the system calculates anesthesia time. For example, if the anesthesia time billed is, for example, 45 minutes, the system looks at that. The system is programmed to look at it every 15 -- every -- every unit, every 15 minutes equals one unit.

Q Okay.

A So anything over 15 minutes gets rounded up to the next unit. So, for example, if 16 units were billed, that rounds up to two units.

Q Okay. And if it's 12 minutes, how many is that?

A That's one unit.

Q And if it's 32 minutes, how many units is that?

A That's -- 32 units is three units.

Q I'm sorry. 32 minutes.

A Oh. 32 minutes is three units.

Q Okay. So if you go at all into --

A Round up. Anything above 15 increments is -- rounds up to two units.

Q Okay. And I think you said that you have a base number of units associated with a procedure and then you add on those 15 minutes depending on how long the procedure is?

A Correct.

Q And in 2007, what was the base unit assignment to a colonoscopy?

A It was six units.

Q Six units. So it would be six plus whatever 15 minute increments?

A Correct.

Q Times the 34?

A Correct.

Q Okay. So let's look at her claim detail. And maybe I'll zoom in just a little. Can you see that?

A Yes.

Q Okay. So this -- this page of the document shows the claim is for anesthesia; correct?

A Correct.

Q And this would be -- this 560, would that be the charges --

A Submitted. Those are the bill charges.

Q By the provider?

A Yes.

Q Okay. And it looks like there was -- is that like a discounted rate?

A That's considered a PPO discount where we don't pay for it and the patient is not liable for it.

Q Okay. So that's because of the agreement that

you had, you discount the 560 by 254?

A Correct.

Q Just off the top?

A And that would be the allowable.

Q Okay. And then it looks like this was the eligible amount on the claim, which is 306?

A Correct.

Q And was there -- can you tell on this document whether the patient had to pay a copay or whether you paid the whole thing?

A We pay the -- we paid the whole thing. Over here where it has a percentage co-insurance.

Q You can actually write on the screen with your fingernail.

A Oh.

Q Yeah.

A Okay.

Q If you want to just show us where that is. Okay.

A Right there, that is -- shows that the allowable, what's considered at 100 percent, so the patient had no out of pocket.

Q Okay. And so this is how much Culinary and the insurance company paid for her procedure?

A Correct.

Q And so this was $306

A Yes.

Q Now, are you able to tell -- I'm showing now the last page of -- can you tap the bottom right of that with your finger there. Thank you. This is the last page of 209, and it looks like there is time entered on this document; is that fair?

A Yes.

Q And what -- what is the time that's entered?

A This is the time that the -- that the provider submitted that the patient was under anesthesia, and it's 11:45 to 12:18.

Q And how many units would that be?

A That would be three units.

Q Okay. And so with a base unit of six that's associated with the procedure, and then you add three more units, so it was nine.

A Uh-huh. Times the 34 -- $34 per RVU.

Q Okay. And then we times that by this 34 RVU?

A Is a 306.

Q And that's the 306 that was paid on the claim?

A That's correct.

Q So let me ask you. If this time were lower, like one less unit, would less have been paid on this claim?

A Yes.

Q How much less?

A $37 less.

Q Or 34?

A 34. I'm sorry. 34.

Q 34.

A Yes.

Q And if it was one -- if it was a procedure that lasted under 15 minutes, how many units could have been billed?

A Just the one.

Q Okay. So it would have been seven times the 34?

A Correct.

Q So each unit that was added on in terms of anesthesia time increased how much was paid by the insurance company by $34, is that fair?

A That is correct.

Q And in this particular claim, $306 was paid, meaning nine units were billed?

A Yes.

MS. WECKERLY: I think that's all I have.

THE COURT: Thank you.

Cross.

CROSS-EXAMINATION

BY MS. STANISH:

Q Good afternoon.

A Hi.

Q Just a few clarifying points, and I mean just a few because you're really an expert. You know how this works. And I did have this nice chart prepared, and I think that given what you've already testified you can click right through this. This column right here, as I understand your testimony, a total of nine units were paid and do you multiple that by 34?

A Yes.

Q Did that work?

A It's exactly how you have it, plus, plus, and then times.

Q So I got it right?

A [Nods head yes]

Q Okay. And so if we wanted to, all we had to do is subtract $34 from this and it'll be the amount that would be $34. I won't even go through the math, even though I have my calculator. But from 16 to 30, all we have to do is subtract 34 from -- well, I guess I will do it. What the heck. 306 minus 34, you say? Oh, what did I do?

MS. WECKERLY: You had an error message. I saw it on your -- you did.

MS. STANISH: Yeah, it's hard to use a calculator often, I know, but you can see why I have this problem.

MS. WECKERLY: That's all right.

BY MS. STANISH:

Q So 306 minus 34 equals 272. So if the anesthesia services was between 16 minutes and 30 minutes, the insurance company would have paid 272 and the patient would not have to pay anything?

A Correct.

Q And then minus another -- by the way, if it's zero to 15, if there's -- if I'm at zero, I still get -- do I still get the one unit?

A Yes.

Q So if there was no time --

A Well, if there was no time the claim wouldn't have been submitted.

Q Well, no, I mean, you get the base; right?

A Right.

Q You automatically get --

A Right.

Q -- the base.

A Right.

Q And so -- and by the way, your competitors are only giving five units. But just to clarify, it's automatic that they get six for having the colonoscopy procedure. I guess my question is, as I understand the timing permits, if it's zero to 15 you're going to get one point?

A Correct.

Q So just meaning if there was -- if they just didn't report any time, left the time unit blank, they would get seven?

A Right.

Q All right.

A If they left time blank, we would always send for the medical records to see actually what time was used.

Q Sure. And so to -- so if we minus 34 from -- if we were at the zero to 15, the amount paid would be $238; correct?

A [Nods head yes].

Q All right. That's all I have.

THE COURT: All right. Thank you, Ms. Stanish.

Mr. Santacroce.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon. Can you tell from the documents you have who the provider is that you pay?

A Yes.

Q Who is that?

A Do you want to bring it back up?

MS. WECKERLY: It's -- it's right there.

MR. SANTACROCE: Why don't you just hand her those, Margaret?

MS. STANISH: Anything for you.

THE WITNESS: Oh. Thank you. Based on the explanation of benefits, the provider was Keith H. Mathahs.

BY MR. SANTACROCE:

Q And who was the patient?

A The patient is Sonia E. Alfaro Orellana.

Q And who did you make the check out payable to?

A Check payable to -- there's no copy of the check in here, but based on the provider that's on the explanation of benefits it would have been made to Keith Mathahs.

Q Are you sure about that?

A No, I'm not 100 percent sure without the copy of the check.

Q Okay. So you're not sure. It might have been made to Gastroenterology Center of Nevada?

A I don't -- it probably would have -- it should have been made to Keith Mathahs based on Box, probably, 31 of the HCFA.

Q But as you sit here today you can't testify as to who the check went to?

A Let me look at the image in here to see what was billed in Box 31. The check was made to Keith Mathahs based on the information on 209B.

Q Okay. So we're starting -- the check wasn't

made out to Ronald Lakeman; correct?

A Correct.

Q Now, you -- you testified that the allowable amount was $306?

A Correct.

Q Do you administer a lot of these claims for anesthesia?

A We process --

Q For your company.

A We process a lot of anesthesia claims, yes.

Q Okay. And other than the Gastro Center of Nevada or Endoscopy Center of Nevada, other -- other providers?

A Yes.

Q And is this amount a customary amount in the industry about, roughly?

A Yes. I mean, the base units are always the same for that procedure for CPT Code 00810.

Q And what is that code for?

A That is for anesthesia for gastrointestinal issues.

Q Okay. So --

A So the base units for that on our plan, no matter who the provider is, is always six units. So that stays the same. The only thing that would change is how the

provider bills the time that the patient was under anesthesia.

Q Okay.

A So it all depends on how we receive the claim.

Q So no matter what they're getting six base units.

A Correct.

Q And the only thing that varies is the minutes?

A Correct, depending on what the patient was under.

Q And I want to know from your experience is a $306 payment for that provider code customary in your business for that type of procedure?

A It depends on what -- how we get the claim. I -- the examiners don't look at a claim and be like, oh, this seems -- these minutes don't seem appropriate. We process the claim based on good faith. I mean, it could have said five -- it could have said five units and we would have paid it because we process based on good faith that the claim we're getting is correct with the information. And we have the screen that shows the to and from time.

Q Okay. And from -- from the provider code, if I had billed $1,000 for a procedure that was for this provider code, would your machine kick it out?

A No, it would not kick it out.

Q You would pay $1,000?

A We would not pay $1,000. The system is set up according to that base plus time, times the RVU. So depending on how many units were in there, then we would have -- we pay according to that.

Q Okay. So there was nothing out of the ordinary about paying $306 for that procedure code?

A Not to -- to a normal processing claims examiner, no.

Q Okay.

MR. SANTACROCE: Nothing further.

THE COURT: Redirect.

MS. WECKERLY: Nothing else. Thank you.

THE COURT: Any juror questions for this witness? I see no juror questions.

Thank you for your testimony. Please don't discuss your testimony with anyone else who may be called as a witness in this case, and you are excused.

THE WITNESS: Okay. Thank you.

THE COURT: Thank you.

THE WITNESS: Do I just leave these up here?

THE COURT: You can just hand them to me.

THE WITNESS: Okay.

THE COURT: All right. I believe that's the last witness for today; is that correct?

MS. WECKERLY: That's correct.

THE COURT: May I see counsel at the bench, please?

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to take our evening recess. We will reconvene tomorrow morning at 9:15.

During the evening recess you're reminded that you're not to discuss this case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries regarding this case, any person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 5:08 p.m.)

THE COURT: We got -- while I think of it, we got -- I got from Ms. Killebrew the disclosure on the Meana, and the global net settlement amount was two million -- anybody writing this down?

MR. WRIGHT: Yep.

MS. WECKERLY: No.

THE COURT: Okay. Well, Ms. Stanish has such a head for numbers. It's $2,349,268.18.

MS. STANISH: I would never remember that.

THE COURT: I know you wouldn't, but I'm telling you so in case I forget to tell you tomorrow you now know that I have this amount.

MR. WRIGHT: Say it again.

THE COURT: Well, you can ask me tomorrow. I just didn't want to forget that I had this envelope sitting up here and not say anything. It's $2,349,268.18.

MR. WRIGHT: Thank you.

(Court recessed for the evening at 5:09 p.m.)

CERTIFICATION

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

AFFIRMATION

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

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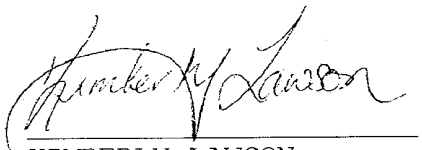

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 43

TUESDAY, JUNE 25, 2013

APPEARANCES:

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

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

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I N D E X

WITNESSES FOR THE DEFENDANT:

E X H I B I T S

LAS VEGAS, NEVADA, TUESDAY, JUNE 25, 2013, 9:30 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: Did anyone need me for anything before we start?

MR. WRIGHT: I was going to mark that as an exhibit. It's simply the Meana family proceeds received from the civil litigation.

THE COURT: Oh. Okay.

MR. WRIGHT: That's the number we got from you.

THE COURT: Right. Which --

THE CLERK: It's a Court's exhibit.

THE COURT: All right. So are we just going to read that as a stipulation, or do you want it to be an exhibit exhibit or what?

MR. WRIGHT: I'll just make it a defense exhibit.

THE COURT: Okay. So make it BB-1 or whatever is next.

MR. WRIGHT: And then I was going to read in a portion of Meana deposition.

THE COURT: Okay.

MR. STAUDAHER: Which we don't necessarily have an issue with, but the issue that's concerning that area that counsel gave us a head's up on was related to interferon. And if he wants to read it in, I want the entirety of that section

dealing with interferon read, which is pages 31 through 45.

MR. WRIGHT: Well, I -- I object to it.

THE COURT: Basis?

MR. WRIGHT: I never got the right to cross-examine him. I am -- at all. This was already offered by the State, denied confrontation, then over our objections you introduced the -- his deposition.

THE COURT: Yeah, I mean, that would be the point of them introducing the deposition testimony that they didn't get to complete their cross-examination. I mean, it's not fair to say you didn't get to cross-examine him. You didn't complete your cross-examination.

MR. STAUDAHER: I don't have a problem with him introducing it. I just don't want it to be piecemeal. I think that that whole section should --

THE COURT: Well, what's the whole section say?

MR. STAUDAHER: It's all about -- it's the exchange back and forth about his understanding about his interferon therapy, why he didn't do it, what his symptoms were, things like that. I think it's fair if --

THE RECORDER: I'm not picking you up, Mr. Staudaher.

MR. STAUDAHER: Oh. I think it's fair that if we bring that in, which I don't have an objection to, that we do the complete section of that to get context so it's not just

parsed out. That's what would have happened at a deposition.

MR. WRIGHT: Well, let's -- let's read the entire thing because it is the entire thing. I selected the portions that were relevant because he was confused between Dr. Lipman and Dr. Sood and who gave him the -- or the questioners were, or the lawyers or he were confused and mixing up Lipman and Sood.

Lipman was only in the case from like April -- no, February, March, April 2008. And Sood and the interferon treatments were in the spring of 2009. And so if you read that part, Lipman's name hasn't even been introduced here in evidence as to who Dr. Lipman is.

MR. STAUDAHER: But that's what he's saying. He got advice, at least, from Dr. Lipman in this part of the deposition. So, I mean, that's what I mean. It's a collective whether it was --

THE COURT: Well, my other concern is now you're introducing this purported hearsay from Dr. Lipman that Dr. Lipman gave him advice that he wasn't supposed to do or could -- what's the advice? I don't even know.

MR. STAUDAHER: That he didn't need to continue it if he had -- if he had problems.

THE COURT: That's kind of big stuff, that he didn't need to continue it. So to me, now to introduce something with this Dr. Lipman, do you see what I'm saying? I mean,

then that's putting that out there that it's true that Dr. Lipman told him he didn't need to continue it. Is that basically --

MR. STAUDAHER: But it's in the context of the exact -- I mean, it's not -- I mean, you just can't take a little piece out and out of context. That's the whole discourse back and forth about interferon therapy, what he was -- that it was offered to him, who offered to him, when did they offer it, what were the -- what -- what did he know about side effects or lack thereof, why he stopped it, why he didn't start it. That's the questioning that goes on.

So to take an individual question out of it and put that out there I don't think is fair. I think if that's the case, read it in context, and then he can argue to his heart's content.

MR. WRIGHT: You know it's misleading deposition testimony when they say it was Lipman who told him to discontinue it when he is wrong by a year as to what doctor he is talking about. And you're trying to interject information you know is not accurate. That's why I edited it to make it comport with the truth, which is what we're supposed to be looking here --

MR. STAUDAHER: Again --

MR. WRIGHT: -- for here.

MR. STAUDAHER: -- I would ask him --

MR. WRIGHT: There is no --

MR. STAUDAHER: -- to address the Court --

MR. WRIGHT: -- question --

MR. STAUDAHER: -- instead of counsel.

THE COURT: Okay. First of all, address the Court.

MR. WRIGHT: Yes.

THE COURT: Second of all, don't interrupt each other. And third of all, and most significantly, don't interrupt me. You may speak.

MR. WRIGHT: There -- there is no question in the evidence if you go through all of the medical records of Mr. Meana that starting in February -- January and February of 2007 Dr. Carrera and Dr. Clifford Carrol told him to start interferon treatment. That's in evidence by the documents AA-1.

And then it's -- there is no question that he learned of the outbreak and obviously I'm not going back to Gastro Center, terminated his relationship. Then there's no question Dr. Jurani told him you need to start interferon, go see another gastroenterologist. Instead, there's no question Mr. Meana hired a lawyer and the lawyer said I want you to go to Infectious Diseases Specialist Lipman.

And so he went from March, April, into May to Infectious Control Dr. Lipman. And finally Lipman said I'm not going to treat you for hepatitis C. You need to go to a

gastroenterologist. Dr. Jurani then referred him to Dr. Sood like in May or June of 2008. From May or June of 2008, Dr. Sood raised various questions. You need a cardiologist clearance, you need an ophthalmologist clearance because of your blood pressure. Those took -- took from -- took six months because of foot dragging or problems with medical -- with --

THE COURT: Getting --

MR. WRIGHT: -- insurance.

THE COURT: -- appointments, whatever.

MR. WRIGHT: Right. Then into 2009, spring, Dr. Sood, records are in evidence in AA-1, told him you need to start this. No more foot dragging. No more excuses. And he then started it and next treatment by Dr. Sood in evidence, he said I'm not taking it anymore. I took it once and I can't tolerate the side effects.

And so the testimony I am offering is solely about Dr. -- Mr. Meana's testimony about his relationship with Dr. Sood and why he stopped doing it. And significantly did Dr. Sood tell you the consequences it could flow? Yes, he told me I could get cirrhosis, but he said I could beat it on my own if I have a strong immune system, and I do have a strong immune system, so I elected not to take it.

THE COURT: All right. Two questions. Number one, you, I'm assuming, have the Lipman records that you're

referring to and you reviewed them and that's what the Lipman records indicate, that Lipman said to him, said I can't treat you, you need to go to a gastroenterologist?

MR. WRIGHT: I have Lipman's records that Dr. Jurani -- I'm unclear where I acquired them, but I have Lipman's records, Sood's records, and Jurani's records.

THE COURT: Okay. So do you have -- the question is do you have records from Dr. Lipman showing from Dr. Lipman, yes, I can't treat him here anymore, he needs to see a gastro specialist? Are those in the records that you have?

MR. WRIGHT: I -- I --

MR. STAUDAHER: Because I don't have Dr. Lipman's records, so --

THE COURT: Yeah, I'm just wondering where that's coming from. Is that coming from Jurani's records, is that --

MR. WRIGHT: Jurani's records.

THE COURT: Okay.

MR. STAUDAHER: Those aren't Lipman's records, then.

MR. WRIGHT: Well, it's -- it's -- I don't know.

THE COURT: Okay. Then the second question I've now forgotten. What does he say, then, in the deposition about Dr. Lipman that you think is not true that Mr. Staudaher wants to read?

MR. STAUDAHER: No, I just want it to be complete.

THE COURT: Well, and it's the part you want to read

or have read or present to the jury.

MR. WRIGHT: Well, where I stop is, question -- I mean, this is part of what I left out.

Do you remember seeing Dr. Lipman in November 2008?

Answer, I cannot remember.

Do you remember Dr. Lipman offering to set up the interferon treatment plan for you?

I mean, I just know these questions are wrong.

THE COURT: Who is asking the questions in the deposition? Is it the --

MR. WRIGHT: Civil attorney.

THE COURT: I know. Is it the defendants that are asking those questions or his own lawyer?

MR. WRIGHT: Stoberski.

THE COURT: Oh, yeah, Mr. Stoberski. Okay. He was on the defense side. I don't remember who he represented, but --

MR. STAUDAHER: It says right in the deposition, and I'm referring to page 34.

It says, question, You first saw Dr. Lipman in March of 2008?

His answer, I don't remember.

Do you recall discussing with Dr. Lipman whether you should go on interferon treatment? Yes. Dr. Lipman told me I don't have to take the treatment because I'm too old

for the supposed treatment and I may not be able to -- to be the side effects.

Did you start treatment despite his warning?

Yes, only once.

Then there's an objection.

Did Dr. Lipman advise you start interferon treatment?

No.

Did he want you to start interferon treatment?

The what?

He didn't want you to do interferon treatment?

Yes.

And you tried interferon treatment once?

Yeah. Not Dr. Lipman, but another gastro specialist.

So he's telling -- he's saying that's not who he did it with. He's saying it was with another one.

Later on after Dr. Lipman?

Yes.

Do you remember the other specialist that you went to, what his name was?

Dr. Rajat Sood. I'm not sure about the first name.

I think you're correct, it's Dr. Sood. What is your understanding of what kind of specialist Dr. Sood is? And then he goes on. But that's clearly a conversation he had

with Dr. Lipman beforehand. He knows that there's a difference, that he actually treated with interferon with -- with Dr. Sood. So I don't necessarily think based on that that it appears as though it's false or inaccurate. He went to Dr. Lipman in the time frame in question, he got advice from him, and then he went to Dr. Sood for the actual treatment.

THE COURT: Here's the deal. Because the limitations with cross-examination and the fact -- I mean, we've heard abundant evidence of Mr. Meana's sort of weakened mental state and everything like that, I'm not going to allow either side to introduce something that's inconsistent with the medical records. Because I think we can assume that that would be the truth. So do we -- that's why I ask. Do we have anything from either Dr. Jurani or from Dr. Lipman showing that he was told he wasn't a good candidate for interferon or --

MR. STAUDAHER: I don't have --

THE COURT: -- that that was --

MR. STAUDAHER: -- Dr. Lipman's records.

THE COURT: Okay.

-- or that was discussed or if they're in Dr. Jurani's records? Because at some point he came back from Dr. Lipman to Dr. Jurani; is that correct?

MR. STAUDAHER: I don't know the answer to that.

THE COURT: You see what I'm saying? So if the medical records don't comport with that, then I'm reluctant to let you get into it because I would defer to the medical records. If the medical records are consistent with that or -- then I would say certainly I think you're -- you can introduce the whole thing or that portion.

MR. STAUDAHER: Right. I mean, then that's just what we're talking about. The State's position is that if you piecemeal put in between those two pages, which is 31 to 45, it's incomplete and misrepresents what the questions and answers were about that very issue. So that's why I'm just asking for completeness --

THE COURT: Okay.

MR. STAUDAHER: -- if he's going to put it in.

THE COURT: Does someone have Dr. Jurani's medical records --

MR. WRIGHT: Yes.

THE COURT: -- that show when he came back and was referred to Dr. Sood?

MR. WRIGHT: Yes.

THE COURT: Can I see that, please?

Are the jurors all here, Kenny?

THE MARSHAL: Yes, Judge.

(Pause in the proceedings.)

THE COURT: So am I correct that neither side

requested the medical records from Dr. Lipman?

MR. STAUDAHER: The State did not, Your Honor.

MR. WRIGHT: Yeah, I --

THE COURT: Okay. No, I'm just -- just trying to get to the bottom of things. I'm not --

MS. STANISH: I can tell you when we arranged for the deposition we requested complete records so we could be prepared for the deposition and the State provided us with what it had and it did not include that.

THE COURT: Okay.

MR. STAUDAHER: Your Honor, while --

THE COURT: Like I said, with all of the limitations that have been imposed with the -- on the defense, I'm going to go with whatever the medical records say.

MR. STAUDAHER: Your Honor, while Mr. Wright is looking that up, I just wanted to -- I went through the -- I went up and went through the exhibits today. There are a couple of issues with some things related to the -- I know there was all this stuff that was going on with the billing records. There were some things related to that that appear as though they're not marked as being admitted. It's my understanding that they were. I'm willing to go through it with counsel to go through that, but as far as our resting, I would rest with the caveat that we have to get that straightened out.

THE COURT: Okay. That's fine.

MR. STAUDAHER: And I believe that there is -- those are the only -- I've marked the areas and I'll go over that with counsel if we -- if we have some time to do that. But I just wanted to make sure that that was on the record that we're resting kind of --

THE COURT: Okay.

MR. STAUDAHER: -- with that.

THE COURT: And then, defense, you have your witness here?

MS. STANISH: Yes, she's here, Your Honor. And then we, basically just for scheduling purposes, should be done today.

THE COURT: Okay. So we're going to do her -- is she a full day witness?

MS. STANISH: She's a half day witness, and then we have our expert, and he'll be -- we figured he probably wouldn't get on until the afternoon.

THE COURT: Okay.

MS. STANISH: I don't imagine he'll be very long.

MR. STAUDAHER: And we do need to talk about him before he gets on the stand.

THE COURT: Okay. And then I'll do the -- probably then at the lunch break or so I'll do the Fifth Amendment admonishment with the defendants.

MS. STANISH: Correct.

THE COURT: I still have to do that.

MS. STANISH: And, Your Honor, just kind of long term if you could bear with us, we -- both sides, I believe, would like to have tomorrow off to address with you the jury instructions, as well as prepare for closing arguments.

THE COURT: That's fine. I think -- I don't know. I mean, my guess would be jury -- there might be a lot of argument on the instructions. That would be my guess, but I -- I don't know.

MS. WECKERLY: We haven't received any yet, so I think we're going to get those tonight. And so that -- you know, I mean, we can maybe --

THE COURT: Right.

MS. WECKERLY: -- shorten some of it.

THE COURT: What I like to make the lawyers do, I mean, if it's clear that there's just, you know, you're not going to agree on some of them, I like the lawyers to meet themselves. Sometimes it's just rewriting one. For example, you may find the defendant guilty or innocent. You know, if they want it changed to not guilty, I normally make that change.

Little things like that you may be able to just agree on and make those changes together. Or let's say you want to add a paragraph to one of theirs and if you agree to

that or -- you know, things like that if you can agree. On the ones you can't agree on, then, obviously, we just -- we'll settle them in here in front of me. And then I just ask that you just do the special ones that you want either alternatively or in addition to whatever specials they have.

And then is this a concerted effort between Mr. Santacroce and Ms. Stanish on the jury instructions?

MS. STANISH: It will be. I have --

THE COURT: Okay.

MS. STANISH: I have my --

THE COURT: So there's just --

MS. STANISH: -- first draft done.

THE COURT: -- going to be, in other words, one defense packet for both defendants; is that correct?

MR. SANTACROCE: Yes.

THE COURT: Okay. And then I want you to then, of the ones that can't be agreed on that you are submitting, I want those to come to the Court to be made a Court's exhibit in their original form as well. I don't really care about annotations if you want to also submit an annotated form. That's fine. So a copy, two copies, one for me to work off of and one that's a clean copy that won't have my notes on it to be the original Court's exhibit.

MS. WECKERLY: Right.

THE COURT: Okay.

MS. STANISH: Well, we're giving you an annotated one because that fan man statute is -- you know, there's nothing published on it.

THE COURT: Okay. That's fine. I'm just saying, you know, I definitely want a clean copy and an annotated copy --

MS. STANISH: Absolutely.

THE COURT: -- if you're going to do the annotated. And then, like I said, clean to go to the clerk so that anything that we don't use then is definitely part of the record for potential appellate purposes.

MS. STANISH: Okey-doke.

MR. WRIGHT: May I -- I'm going to read six pages of deposition of Dr. Jurani, and the reason I'm doing it is that's his records.

THE COURT: Okay. May I see that, please?

MR. WRIGHT: Okay. And so you can't tell anything from his records, but he testifies to those records.

THE COURT: Okay. Would you just show this to the State so they can see what page you're talking about?

MR. WRIGHT: Right. I'll just --

THE COURT: His writing is pretty impossible to read, I will say.

MR. WRIGHT: Right. The -- the portion I'm going to read, 67 to 73, is his reading of the documents --

THE COURT: Okay.

MR. WRIGHT: -- for March and April regarding Lipman and why it's being switched to Dr. Sood. Page 67 of his May 14, 2009, deposition of Dr. Jurani.

March 6, 2008, can you go over the clinical history with me, please?

Okay. It states he's hired an attorney to sue Endoscopy Center. GI Center was closed. He needs a new referral. He is referring to a gastroenterologist.

What does it say under that?

It says he knows that it's out of plan, his insurance will not pay if you refer him to a gastroenterologist that's not -- that's out of plan.

Okay.

Answer, The insurance will not pay. It states Dr. Lipman-- he's referring to his notes. It states Dr. Lipman and attorney will manage the payment. He was very specific about getting referred to a specific person.

And that specific person was Dr. Brian Lipman?

Answer, Well, that's -- initially that was, you know, Dr. Lipman, infectious disease specialist.

Did you refer him to another GI?

Well, at that particular time he was insisting on going to -- we have like a healthy discussion of -- because I don't really feel like he should go there, but he insisted on

going there.

Going where?

To see Dr. Lipman. I said patient will go on his own to Dr. Lipman.

Why? Did you want him not to go to Dr. Lipman?

No, because the appropriate consult would be a gastroenterologist, the one who deals with hepatitis more than infectious diseases.

Is that why you wrote in the clinical history needs referral?

When he insisted on seeing Dr. Lipman, I crossed it.

Do you know if he's still seeing Dr. Lipman?

No.

Under this note under the test results and medication notes, are you saying that Dr. Lipman -- the note here says -- does that say Dr. Lipman will take care of payments? Can you read that? Can you read it again, please?

Okay. GI referral is crossed out, and it says Dr. Brian Lipman, infectious disease, and then the note, it says patient will go on his own.

THE COURT: Okay. I'm assuming -- I'm just -- my comment would be, my assumption would be Dr. Lipman would have been treating him on a lien if he was referred by the plaintiff's attorney. That's what that sounds like to me.

MR. WRIGHT: Right.

Under test results, medication notes, his insurance will not pay. That's under clinical history. Then it continues into test results. He states Dr. Lipman and attorney will manage payment. And is the payment for you or for Dr. --

Objections.

Okay. I was not involved because he knows insurance will not pay, so they will take care of payment.

When did you next see Mr. Meana?

April 3, 2008.

Can you read the clinical history for me?

Saw Dr. Lipman, has more blood tests, no fever, no further treatment. No further treatment was given. He was given a hepatitis B shot, and then below that is the hepatitis RNA report, 12/27/07, $5,980,000.

Going back on something. Brian Lipman.

Yes?

Have you ever referred to an infectious disease specialist? Why did you have a problem with Dr. Lipman?

Well, my concern is treating hepatitis C, an infectious disease, while they deal with that, apparently that's not the normal course that we take when we are dealing with hepatitis C. It has to be either a gastroenterologist, or even a hepatologist. So you're granting, as primary care physician, you're told hep C to refer to a gastroenterologist

or a hepatologist.

THE COURT: All right. I've heard enough. Balancing everything, you know, like I said the constraints placed upon the defense, the fact that we don't have the Lipman records, the fact that he went to this doctor against the advice of his primary care physician, apparently on an attorney's lien or a personal injury lien it sounds like, it was a separate arrangement, that he ultimately comes back to Dr. Jurani, his primary care physician who has been sort of managing his care this entire time, who then sends him to -- I'm sorry --

MR. WRIGHT: Dr. Sood.

THE COURT: -- Dr. Sood. The fact that the defense is limited in their ability to cross-examine, clearly, Mr. Meana on all of these things, including the incredibly important question of, well, why would you go against the advice of your primary care physician, Dr. Jurani, who you presumably trusted, to go to this other specialist who is not the recommended kind of specialist at the advice of your lawyer I think is opening up a huge Pandora's box of questions.

So balancing everything out, the constraints that have been placed due to the, you know, death of Mr. Meana, the fact that he left the country, you know, to die in his homeland, you know, that -- obviously, he had the right to do

that, but that placed further constraints on the ability to depose him.

The unfortunate timing in the matter and everything else, I'm going to have Mr. Wright just read the portion of the deposition that he selected because, as I just said, looking at the records of Dr. Jurani, which really we can't make out, but Dr. Jurani's testimony, what we understand from that, I think that that creates more questions that then would open more doors for cross-examination that would need to be pursued.

Because, like I said, you know, the question is, well, why on earth would he disregard the advice of his primary care physician, Dr. Jurani, and go to a lawyer who was suggested apparently by his attorney when he had insurance in place which would have covered initially a gastroenterologist, presumably. So reading the rest of it along -- and then, you know, if you're going to read that, then we have to read the testimony of Dr. Jurani. I mean, it just opens up a whole new kettle of worms, if you will.

So I'm going to have Mr. Wright just read the -- you know, balancing everything, the limitations that were place, the fact that the deposition was played, I'm going to let Mr. Wright just read that portion. Because, again, I think that the testimony, the independent testimony of the primary care physician, who I'm assuming testified as not an expert, but as

a treating -- he may have also been an expert, but certainly he was testifying as a treating physician in the civil cases -- I think suggests that the recommended course of treatment was a GI specialist, was Dr. Sood, and there was this sort of deviation that ultimately resulted in him going back to Dr. Jurani and pursuing the course of action that Dr. Jurani had recommended in the first place. So for those reasons I'm going to deny the State's request.

Are they ready?

MR. STAUDAHER: Your Honor?

THE COURT: Yes.

MR. STAUDAHER: I understand the Court's ruling, I just want to make a record on it --

THE COURT: That's fine.

MR. STAUDAHER: -- because of the accusation that was proffered. I did not hear in any of the discourse that counsel read regarding the deposition or any reference to any medical record that what was contained at least in the deposition transcript of Mr. Meana was false, as was implied. We're talking about a date of March of 2008. The dates that counsel referenced were March of 2008, and then in April 2008 also when he followed back up after seeing Dr. Lipman. So I think that that was consistent.

THE COURT: I think it is consistent with what Mr. Meana said. All I'm saying is I think it opens up --

MR. STAUDAHER: I have no problem with that.

THE COURT: -- a whole array of other questions and more cross-examination, which obviously he would want to know, well, why are you disregarding Dr. Jurani's suggestion? Why is your lawyer telling you who to treat with that ultimately could have contributed to, you know, a misunder -- I don't want to say contributed to his death, but certainly could have contributed to a misunderstanding in his own mind that led him to refuse treatment?

Now, we -- we don't know the answer to that question, but that's certainly a question that pops into my mind hearing the deposition of Dr. Jurani. The reason I said he's certainly a treating physician is because if he testified solely as a treating physician, then he has no dog in the fight. He's not a retained expert. He's just there to say these are my notes, this is what happened as opposed to, as you know, a retained expert that's been paid by either side.

So certainly he's testifying as a treating, possibly as an expert, but I don't -- I don't know. But I think, you know, his records as -- my point being I think the records of a treating are more inherently reliable than something that's done by an expert who has been retained by one side or the other and is being paid to form, essentially, a particular opinion.

You know, Dr. Jurani's records, he was strictly

treating at that point in time, had been his primary care physician. So I think there is a great deal of reliability in those records and the testimony that was based on the records. So if anyone needs to take a quick restroom break, let's -- oh, we're not done.

MR. WRIGHT: He was a treating physician.

THE COURT: No, he was a treating, but I'm saying he could have also then been brought in as an expert. I suspect he wasn't, but that's what I meant.

MR. WRIGHT: He was not.

THE COURT: Clearly he was a treating. And like I said, all of his records and the testimony was based on his role as a treating physician, which I think is more accurate or is more likely to be accurate because there is no dog in the fight at that point. And he wasn't -- it doesn't sound like he's working on a medical lien, either. He was paid by insurance.

MR. WRIGHT: Correct.

THE COURT: So in any event --

(Court recessed at 10:00 a.m., until 10:03 a.m.)

(Outside the presence of the jury.)

MR. STAUDAHER: Your Honor, we're going to -- we will be resting with the reservation about the exhibits.

THE COURT: Okay.

MR. STAUDAHER: And also with the reservation that

there's just a couple of cleanup things we want to put on the record in our case in chief, outside the presence, obviously, later on. It doesn't have to be done now, but we just want to make sure that that's reserved, as well.

THE COURT: Okay. Like what?

MR. STAUDAHER: Well, things that were brought up initially about records with Tom Pitaro involved with attorney-client privilege stuff, things like that.

THE COURT: Oh.

MR. STAUDAHER: We ferreted out some of that and want to make sure --

THE COURT: Okay. So you just --

MR. STAUDAHER: -- we put it on the record.

THE COURT: -- want to correct some representations --

MR. STAUDAHER: I just want to put --

THE COURT: -- that were made --

MR. STAUDAHER: -- it on the record, yes.

THE COURT: -- that maybe weren't correct? That's fine.

MR. STAUDAHER: And also that we made a disclosure to the defense as to who the CI was listed in the search warrant so that that's on the record, too.

MR. WRIGHT: And -- and at the same time I -- I want to reserve arguing about Exhibit 87. That's the affidavit

prepared for CRNAs that I had stipulated to, then withdrew my stipulation because I didn't know where it came from.

THE COURT: Oh, this was from the search warrant that they found?

MR. WRIGHT: Right. I want to -- and we reserved on that, and so I want to -- and we don't have to do it now.

THE COURT: Okay.

MR. WRIGHT: I mean, but at the same time I want to argue about --

THE COURT: Yeah, we never had any testimony on that anyway about where that came from --

MR. WRIGHT: Right.

THE COURT: -- as a result of the search warrant, if it was in a box, if it was --

MR. STAUDAHER: Well, it's because it was a stipulated --

THE COURT: -- on a computer. Right. It was stipulated.

MR. STAUDAHER: He can get back up on the stand if we need to deal with that.

THE COURT: I don't know if -- I mean --

MR. WRIGHT: Well, I -- I stipulated to it not knowing that it was -- what I stipulated to was when I went over there on that Friday afternoon and looked at everything and I understood it had all come from, and then this appeared

and I didn't stipulate to that. I agree I --

THE COURT: What do you mean this appeared? Was it there when you looked at the exhibits in their office --

MR. WRIGHT: No.

THE COURT: -- or wasn't it?

MR. STAUDAHER: I don't believe that -- at least at court beforehand, the two weeks before or whatever, or the week before we started trial, it was not part of that. It was part of the exhibits that I brought over to show --

THE COURT: That particular day.

MR. STAUDAHER: -- before we started, then they stipulated in court that day as to them, but I don't believe that he realized, afterward, at least that was what he said, that he didn't realize what it was until later. So --

MR. WRIGHT: Right.

MR. STAUDAHER: But -- but we did, then, disclose where that information came from one of the computers, and I think that --

THE COURT: Right. Well, here's the deal. Where did that -- does --

Detective Whitely, do you know where that particular exhibit even came from?

MR. STAUDAHER: He does.

MR. WHITELY: I'll find it.

THE COURT: Okay.

MS. STANISH: Well, he didn't know where the other exhibits came from yesterday.

MR. STAUDAHER: He knows. He said that he needed a cover sheet. And he can actually do that, it's just that you didn't provide the cover sheet for him.

MR. WHITELY: Where's the cover sheet?

MS. STANISH: I didn't provide the cover sheet?

MR. WRIGHT: We can do this --

THE COURT: All right. We can do it later. I'm just -- just making sure that we have a witness who even knows where it comes from as opposed to --

MR. STAUDAHER: He does.

THE COURT: -- oh, here's just this exhibit that came out of the search warrant, but we don't know if it's from a computer or if it was in a file or, you know, who downloaded it or where it was, if it was an email. Because that was the attorney-client issue --

MR. WRIGHT: Right.

THE COURT: -- that I had raised that I was concerned about that this better not have been an attachment to an email or in a file or something like that because it could also be -- I mean, it's clearly written by a lawyer or appears to be. Clearly, I'm pretty sure it wasn't written by Dr. Desai based on the other things he's written. There is no way he wrote that. Nothing against --

MR. STAUDAHER: Just so the Court would be aware that if we -- if there was an issue on that and we had to then bring it in through the detective --

THE COURT: Okay.

MR. STAUDAHER: -- we would have to reopen --

THE COURT: That's fine.

MR. STAUDAHER: -- our case.

THE COURT: That's fine. All right. Bring them in.

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the deputy district attorneys, the presence of the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

Mr. Staudaher.

MR. STAUDAHER: Your Honor, at this time with the reservations that we have discussed previously related to exhibits and other things, the State would rest at this time.

THE COURT: All right. Mr. Wright.

MR. WRIGHT: Yes, before calling a witness I'm going to offer two items.

THE COURT: All right.

MR. WRIGHT: One is Exhibit BB-1.

THE COURT: All right. And that's stipulated to; is that correct?

MS. WECKERLY: Is that this one?

THE COURT: Yes.

MS. WECKERLY: Yes.

MR. STAUDAHER: Yes.

THE COURT: Thank you.

MR. STAUDAHER: Oh, yes. I'm sorry.

THE COURT: All right. And would you just present that? You can publish that to the jury, if you'd like.

MR. WRIGHT: Thank you. Exhibit BB-1 deals with resolution of the civil cases with the Meana family by the Meana family's civil litigation against various individuals. And the Meana family total proceeds received from civil litigation, $2,349,268.18.

THE COURT: All right. Thank you.

MR. WRIGHT: And I'm going to read, Your Honor, a portion of a deposition of Mr. Meana taken on November 22, 2011, in civil litigation.

THE COURT: All right. Thank you.

And, ladies and gentlemen, this deposition, as Mr. Wright just told you, was taken in connection with one of the civil lawsuits that Mr. Meana was involved with.

MR. WRIGHT: And I will read the questions and answers, Your Honor.

THE COURT: All right.

MR. WRIGHT: Question, Did Dr. Sood recommend that

you start the interferon treatment?

Answer, Dr. Sood actually was the one who told me to undergo the tests, the treatment of the interferon.

Question, Did you start the interferon based on Dr. Sood?

Answer, And Dr. Sood.

Question, And how many times did you take interferon?

Answer, Only once.

Question, Did you give yourself a shot?

Answer, Yes.

Where did you take the shot?

Answer, On my thigh.

Question, And what type of side effects did you have from the shot?

Answer, I have a flu-like symptom. I have diarrhea, jaundice, and some sort of slight depression.

Question, Did Dr. Sood explain to you what might happen if you didn't continue with the treatment?

Answer, Yes.

What do you remember him telling you?

Answer, Telling me that I might not -- telling me that I might have some scar -- scar in my -- and that I might also possibly will have later on cirrhosis and it will actually try to destroy some cells in my liver.

Question, Did Dr. Sood tell you how long the cirrhosis might take to develop?

Answer, No.

Question, Was it your decision to not stay with the interferon, to not keep going with the interferon?

Answer, Yes, I have decided not to take it.

Question, And was that because of the side effects only?

Answer, Yes.

Did Dr. Sood tell you that the interferon treatment could cure you?

Answer, Yes.

But the side effects were too much, so you decided not to stay on the interferon?

Answer, Yes.

Did you understand that there was a risk that you would develop cirrhosis of the liver if you did not continue with interferon treatment?

Answer, Yes, I understand that, but I was told that it depends on how strong is your immune system. Sometimes the immune system might be able to cure you.

Question, Did you feel that you had a strong immune system that would be cured without the interferon?

Answer, Yes.

THE COURT: All right.

MR. WRIGHT: Thank you, Your Honor.

THE COURT: Thank you, Mr. Wright. And the defense may call its first witness.

MR. WRIGHT: We call Dorothy Sims.

THE COURT: Ma'am, just right up here, please, up those couple of stairs. And then just remain standing facing that lady right there who will administer the oath to you.

DOROTHY SIMS, DEFENDANT'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your first and last name for the record.

THE WITNESS: Dorothy, D-O-R-O-T-H-Y, Sims, S-I-M-S.

THE COURT: All right. Thank you.

Mr. Wright, you may proceed.

DIRECT EXAMINATION

BY MR. WRIGHT:

Q Dorothy Sims, is it Nurse Sims or what's your title?

A I am a registered nurse, yes.

Q Okay. And tell the jury a little bit about your education.

A I attended the University of Nevada at Las Vegas. I have a bachelor's degree in nursing. I have five years experience in neonatal intensive care nursing, I did two years of case management, and for the last eight years I've

been with the Bureau of Healthcare Quality and Compliance.

Q Okay. The Bureau of Healthcare Quality and Compliance was previously known as what?

A The Bureau of Licensure and Certification.

Q Okay. In the courtroom here for the period in 2007 and 2008 we've been referring to a state agency as the BLC. Is that where you work?

A Yes.

Q Okay. And it's now changed its name?

A Yes.

Q Okay. Just for continuity and what we've been doing here in the courtroom I'm going to call it the BLC, okay?

A Okay.

Q And so you were employed by the BLC in January 2008, five and a half years ago?

A Yes.

Q And you're still so employed?

A Yes.

Q And what is your current position?

A I'm a Health Facilities Inspector III, supervisor position.

Q Okay. And in January 2008 what was your position?

A I was a Health Facilities Inspector II as a

surveyor, and then I got promoted to a Health Facilities -- or at the time it was a Health Facilities Surveyor III, supervisor position.

Q Okay. And so did you participate in January 2008 for the BLC with an inspection at the endoscopy clinic on Shadow Lane here in Las Vegas?

A Yes.

Q Now --

THE COURT: Keep your voice up.

MR. WRIGHT: Okay.

BY MR. WRIGHT:

Q Do -- do you recall your first involvement? When did you first go to the clinic?

A That I can't recall.

Q Okay.

A Can --

Q I'm going to show you some documents. It's been five and a half years; correct?

A Yes, it has.

Q Okay. And we have not met until I just saw you in the anteroom; correct?

A Yes.

Q So I have not interviewed you or had meetings to prepare your testimony; correct?

A Yes.

MR. WRIGHT: May I approach, Your Honor?

THE COURT: You may.

BY MR. WRIGHT:

Q I'm going to show you something called a ACPS complaint incident investigation report.

A Okay.

Q Look at that to yourself and tell me if you recognize what that is.

A Yes, I do recognize it.

Q Okay. Is that the incident investigation report pertaining to the Shadow Lane clinic for January 2008?

A Yes, it is.

Q Okay. And was this report produced based upon BLC's investigation at the Shadow Lane clinic?

A Yes, it is.

Q Okay. You -- you may utilize that to refresh your recollection as to dates, times, meetings.

A Okay.

Q And the -- what I'm -- what I'm initially looking for is do you recall a first entry meeting when it was the first time you went to the clinic?

A Yes.

Q Okay. And can you tell when that was by refreshing your recollection?

A January 9, 2008.

Q Okay. And do you -- using that date, do you recall the meeting and who you went with?

A Yes.

Q Okay. And who was that?

A There was another member of the Bureau of Licensure and Certification, there were two members from the CDC or Center for Disease Control, and one member from the Southern Nevada Health District.

Q Okay. And would that have been Brian Labus?

A Yes.

Q Okay. And do you -- you -- you went to the clinic to participate in an investigation because there had been a hepatitis C outbreak; is that correct?

A Yes.

Q Okay. Do you recall that independently?

A No, I read it from the --

Q Okay.

A -- report.

Q The -- okay. Well, I'm just trying to figure -- do you recall going to the clinic and participating in the investigation? Forget in the time frame and day of the week. Just tell me if you remember that.

A I do remember going to the clinic to participate in an investigation.

Q Okay. And do you remember that it was a

hepatitis C -- outbreak was my word, but there had been several cases of hepatitis C identified for patients from the clinic?

A That's correct.

Q Okay. And do you recall that they had been patients, the victims had been patients at the clinic on a couple of specific days?

A I'm not -- I'm not understanding the question.

Q Okay. Do you recall that they -- the -- the patients who contracted hepatitis C had been patients at the clinic on Shadow Lane on a couple, two specific dates in 2007?

A Yes.

Q Okay. Now, your -- your purpose in going -- you -- you went with -- who did you go with from BLC?

A On the first day of the survey, so on Sep -- no, on January 9th it was Nadine Howard.

Q Okay. And the first meeting you had at the clinic, do you recall who was present on behalf of the clinic?

A Can I refer to my --

Q Yeah. Do you --

A -- notes?

Q Do you recall was a -- well, you can go ahead. I don't want to lead you.

A According to the report we met with the chief operating officer, a physician, the charge nurse, and the

director of nursing.

Q Okay. And would the -- would the -- do you recall the name Tonya Rushing?

A Yes.

Q Okay. Would she be like the chief operating officer?

A Yes.

Q Okay. And Dr. Clifford Carrol?

A Was the physician.

Q Okay. And Jeffery Krueger?

A Was the charge nurse.

Q Okay. And the director of nursing, Katie Maley?

A Yes.

Q Okay. And at -- at this initial meeting, tell the jury what the purpose of the initial meeting was.

A The initial meeting was to inform the -- the facility that we were there to investigate a complaint allegation regarding infection control.

Q Okay. And did you tell them what the issue was?

A The Southern Nevada Health District informed them of the issue.

Q Okay. And was the issue the outbreak of hepatitis C connected to that clinic?

A Yes.

Q Okay. And did -- at that meeting did the clinic representatives cooperate?

A Yes.

Q Okay. And did the clinic representatives explain their procedures and what they do there?

A Can you clarify the procedures?

Q Okay.

A Like as to what you're asking.

Q Okay. Like what type of anesthesia they use for the procedure.

A Yes.

Q Okay. And do -- do you recall what -- what they -- what you learned?

A And I can go by my notes here?

Q Sure, if you need to refresh your recollection.

A Okay. Okay.

Q Do you recall what they said about the anesthesia used at the clinic?

A Yes.

Q And what did they say?

A They use propofol and lidocaine to sedate the patient.

Q Okay. And did they use multi-dose vials?

A Yes.

Q Okay. And you were -- you were -- you and everyone at the meeting were told that at the initial entry meeting; correct?

A Yes.

Q Did you have familiarity with propofol?

A No.

Q Okay. Did -- did you know if propofol is single-dose or multi-dose vials on Wednesday, January 9th at the first meeting?

A No, I did not.

Q Okay. Did -- is -- is it fair to say that at that meeting the -- do you recall specifically who of the individuals, who explained that they use multi-dose propofol and multi-dose lidocaine to sedate?

A No, I don't.

Q Okay. The -- did anyone at that meeting, the CDC or the -- you're the BLC, but your other BLC member there with you, or the Southern Nevada Health District, did anyone at that meeting say stop, you can't multi-dose propofol at that initial meeting?

A No.

Q Okay. At that initial meeting it -- it was not known by the -- by yourself that propofol could not be used multi-dose, is that fair?

A Yes.

Q Okay. You learned differently, correct, after the initial meeting?

A Yes.

Q Okay. I mean, I saw some hesitancy on your face. I want to be clear. That initial meeting Wednesday the 9th we multi-dose propofol and no one -- no representative of the government said anything about stopping that practice; correct?

A That's correct.

Q Okay. And did you -- did you all return the next day?

A Yes.

MS. WECKERLY: I just want to -- if we could just clarify who it is that's returning.

BY MR. WRIGHT:

Q Okay. Who -- who is returning on January 10th?

A The BLC returned with -- Nadine returned, I returned, and we had another surveyor from the BLC, Leslee Kosloy joined us. There were representatives from the CDC and representatives from the Southern Nevada Health District.

Q Okay. And on that next day, Thursday, January 10th, did -- did you -- were you there all day, the three of you, from BLC?

A Yes, we were.

Q Okay. And did you participate in chart reviews and observations in the clinic?

A Yes.

Q Okay. And were you observing procedures and cleaning of scopes and everything that goes on in the clinic?

A Yes.

Q And you were looking to see if, in layman's terms, they were doing everything right?

A Yes.

Q Is that -- is that fair?

A Yes.

Q Okay. Because there -- there had been an outbreak of hepatitis C tied to the clinic, and you all were investigating to determine if you could figure out how the hepatitis C spread and any wrongdoing in any of the procedures or processes in the clinic; correct?

MS. WECKERLY: I'm going to object to leading.

THE COURT: Overruled.

You can answer.

THE WITNESS: We were looking at whether they were following infection control practices. Whether they were -- the cleaning of the scopes was done properly, so that's what we were looking -- looking at.

BY MR. WRIGHT:

Q Okay.

A So we were looking at infection control practices in the facility.

Q Okay. And so in doing that you would observe procedures?

A Yes.

Q Okay. And follow a patient through -- a patient is done and following to the cleaning of the scopes and all that takes place?

A Yes.

Q Okay.

THE COURT: You are leading.

MR. WRIGHT: Okay. Correct.

BY MR. WRIGHT:

Q Tell me, who did -- do you recall who you observed on Thursday, January 10th? And I'm going to give you some more notes.

A Okay.

Q Okay?

A Okay.

Q Because it's been five and a half years.

MR. WRIGHT: I'm going to ask her to identify --

MS. WECKERLY: Okay.

MR. WRIGHT: -- what they are.

MS. WECKERLY: Yeah, would you, please.

BY MR. WRIGHT:

Q I have one stack here. Can you -- do you -- can you tell me what those represent?

A These are my handwritten notes.

Q Okay. And so the -- your handwritten notes, you write well, I can read it. And the -- to your right, you were actually looking at the typed report; correct?

A That's correct.

Q And so this -- your handwritten notes were made simultaneously while you were at the clinic?

A Yes.

Q Okay. And I have another package of notes. Can you tell me what those represent?

A These are notes that were taken during telephone calls after the investigation was completed.

Q Okay. And are those your notes?

A Yes, they are.

Q Okay. You can just hang on to those three things as I go through because the first question I have is on January 10th did you observe an endoscopic procedure in which a CRNA participated? Looking at your handwritten notes, look at the second to the last page.

A Okay. Okay.

Q Is that a 1/10/08 observation?

A Yes.

Q Okay. And is -- and these are your notes, and is this your observation?

A Yes.

Q Okay. And do you recall who is the CRNA you were observing?

A Linda Hubbard.

Q Okay. And it's -- the date is January 10, 2008. That's a Thursday. I'll tell you that. We know it because we've been dealing with it here. Okay?

A Okay.

Q And what time?

A 3:35 p.m.

Q And the -- the administration of anesthesia, did the CRNA administer propofol?

A Yes.

Q Okay. And is it -- is she using the propofol -- Linda Hubbard using the propofol vial as a multi-dose vial on Thursday afternoon?

A Yes.

Q And if -- do you recall watching her like administer propofol?

A I watched her administer the propofol to the patient.

Q Okay. And if the patient needed additional propofol, another dose, she was utilizing the same vial of

propofol; is that correct?

A Yes.

Q And when -- when she would redose, did she use same needle and syringe or new needle and syringe?

A New syringe.

Q Okay. So the -- she -- she -- she would -- and we're talking about giving a second injection to the patient; correct?

A Yes.

Q Okay. And she would utilize a new needle and syringe to give an additional dose to the patient?

A I have written down just that new syringe.

Q Okay. I see written there separate syringes for additional doses propofol.

A Yes.

Q Okay. Is that what you're referring to?

A Yes.

Q And at the time they were still utilizing propofol as multi-dose vial; correct?

A Yes.

Q Meaning if -- if a new patient, if there's still propofol available and a new patient comes in, they would use the same vial on the new patient, but with a new needle and syringe --

MS. WECKERLY: Objection.

BY MR. WRIGHT:

Q -- is that correct?

THE COURT: Basis?

MS. WECKERLY: Well, he said they, and I think she's only observing Ms. Hubbard.

THE COURT: All right. So be more specific in your question.

BY MR. WRIGHT:

Q Ms. Hubbard.

A I'm sorry. Can you ask that again?

Q Yes. Now, tell me the propofol was being used multi-dose; correct?

A Yes.

Q Okay. And so one vial could be used on more than one patient; correct?

A Yes.

Q Okay. And so if one patient is done and a new patient comes in and the remainder of the propofol is to be used, what would Linda Hubbard do?

A She indicated she would get a new syringe.

Q Okay. And is -- is all of that safe and aseptic as you understand it?

A Yes.

Q Okay. Because she is utilizing a new -- is it because she is utilizing a new needle and syringe each time

she goes into the vial?

A Yes.

Q Now, did anyone at that time, Thursday, okay, you three representatives from BLC are there, CDC is there, Southern Nevada Health District is there; correct?

A Yes.

Q Okay. Did anyone on Thursday step in and stop the clinic and say propofol is single-use, you shouldn't be multi-dosing?

A No.

Q Okay. I want to go -- you -- you made additional visits to the clinic; correct?

A Yes.

Q Okay. And did you make additional observations at the clinic?

A Yes.

Q Okay. And do you recall observations on January 16, 2008?

MR. WRIGHT: If I can approach?

THE COURT: That's fine.

BY MR. WRIGHT:

Q I'll direct you to the way I read your notes. Did you again see -- observe Linda Hubbard on the 16th?

A This was just an interview.

Q Okay. An interview with Linda Hubbard on

January 16, 2008?

A Yes.

Q Okay. And that's you interviewing her?

A Yes.

Q Okay. And she is the CRNA you had previously observed?

A Yes.

Q Okay. And why don't -- why don't you run through your interview with her?

MS. WECKERLY: Objection. Hearsay.

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

THE COURT: All right. That's overruled.

Ladies and gentlemen, the statements made by Ms. Hubbard that are testified to may only be considered by you as to their effect on the listener, the person hearing the statements and what knowledge and what information they had in the course of their investigation.

So go on, Mr. Wright.

BY MR. WRIGHT:

Q Go ahead and explain what Linda Hubbard told you on January 16th.

A The registered nurse would give the propofol vials to the CRNA. The propofol vials were to remain in the room. A syringe and needle, both new, and 20 milligrams of

lidocaine and 110 milligrams of propofol would be drawn up. They would refill same syringe, same vial, and toss the propofol after each patient.

Q Okay. And -- and what did she tell you had been the practice in the past?

A In the past did not use the propofol as a single-use vial. Used a clean syringe for each patient, may use the propofol for two patients, clean draw.

Q Okay. Now, it -- interpret what her practice on January 16th was as you understood it. At that time were they using propofol as a single patient -- a single-use vial as opposed to multi-use?

A Yes. On January 16th Linda Hubbard indicated that the propofol was used for one patient only.

Q Okay. And so no more multi-use, single-use propofol; correct?

A Yes.

Q Okay. And if the patient needed additional dose of propofol, Linda Hubbard was refilling same syringe, same vial; is that correct?

A Yes.

Q Okay. And does that -- rather than using a new needle and syringe, she was reusing same needle and syringe, go back into the vial, redose the patient, and at the conclusion toss needle, syringe, and remnants of propofol; is

that correct?

A Yes.

Q Okay. And is all of that safe injection practices and aseptic technique?

A It would not be the best practice, but if she tossed the propofol vial after each patient, my opinion it would be safe, but not best practice.

Q Okay. What -- what would you view as best practice?

A New syringe, new needle to reenter the vial.

Q Okay. At -- at the time did you or BLC tell Linda Hubbard on the 16th you can't do that?

A No, we did not. I did not.

Q Okay. At -- at that time -- I'm taking this chronologically.

A Okay.

Q At that time you were aware of the fact that the clinic historically had been using propofol as multi-use vials; correct?

A Yes.

Q Okay. You were aware of reuse of syringes on same patient; correct?

A Yes.

Q Okay. And at that time you and the BLC did not recognize those two components as creating a health

hazard; correct?

A From what they told us, that's correct.

Q Okay. And ultimately BLC issued a -- what do you call that document where -- where the clinic then gives you a plan of correction?

A A statement of deficiencies.

Q Okay. Statement of deficiencies. That's what I was looking for. The BLC, your agency, issued a statement of deficiencies to the clinic on Shadow Lane; correct?

A Yes.

Q And that statement of deficiencies identified what deficiencies, do you recall?

A No, I would -- I would need to see the statement of deficiencies.

Q Okay. Does that look like it?

A Yes.

Q Okay. And what -- what were the deficiencies -- when did your investigation end?

A January 17, 2008.

Q Okay. So it went from January 9th through January 17th; correct?

A Yes.

Q Okay. And then a -- a report or a statement of deficiencies is issued to the clinic; correct?

A Yes.

Q And it's pointing out any deficiencies that have been identified by inspection, observation, or interviews?

A Yes.

Q Okay. And then once the clinic receives that, just like any other clinic here in Nevada or hospital or doctor's office now, they -- they get to respond; correct?

A Yes.

Q And that response is called what?

A A plan of correction.

Q Okay. And is that -- that document there, does that have the statement of deficiencies and the plan of correction?

A Yes, it does.

Q Okay. And so the statement of deficiencies was authored -- was authored or delivered to them, the clinic, about when?

A It was provided to the clinic on -- around February 4, 2008.

Q Okay. And -- and did they -- and you indicated that there is a plan of correction. Is that where they essentially -- the clinic answers and states what they will do to correct each deficiency right in on the same report?

A Yes.

Q Okay. And did the clinic provide a plan of correction?

A Yes, they did.

Q Okay. Now, explain what the deficiencies were that were that were identified for the clinic.

A The first deficiency was the facility failed to ensure the center adopted and reviewed written policies and procedures for the use of single dose of propofol vials, and for the first step of the cleaning process for the upper gastrointestinal endoscopy and colonoscopy scopes, and the use of disposable biopsy instruments.

Q Okay. So three different deficiencies?

A For the first tag, yes.

Q First tag?

A Yes.

Q What's that mean?

A In our regulations we have tag numbers to identify specific regulation sets. So when we find a deficient practice we would cite it at the most appropriate tag.

Q Okay. So you -- to a layman it sounds like you found three things wrong.

A Under the administration tag, so it's the governing body, the regulation is the governing body shall ensure that that the center adopts and enforces and annually

reviews written policies and procedures required by the NAC, inclusive and including an organizational chart, and these policies and procedures must be approved by the governing body annually. So that --

Q Okay.

A -- was the regulation, and we found three areas of deficient practice under that regulation.

Q Okay. And what were the three deficient practices? Number one was propofol?

A Failure to adopt and review written policies and procedures. The first one was the use of single-dose propofol vials.

Q Okay. And -- and the deficiency was what? Using single-dose as multi-dose?

A That's correct.

Q Okay. And it had -- when we went through it chronologically you all had been there on Wednesday and they explained that they used propofol multi-dose.

A Uh-huh.

Q It was observed on Thursday, multi-dosing propofol. And then by the 16th of January, the practice had changed; correct?

A Yes.

Q Okay. And during the interim was it brought to the clinic's attention? Between January 10th and 16th when

they changed their practices, was that because they were told use this single-dose, not multi-dose?

A Yes.

Q Okay. And that was why?

A We did not -- the BLC did not inform them to use it as a single-dose. That was done by either the CDC or Southern Nevada --

Q Okay.

A -- Health District.

Q All right. So you -- you were aware -- this investigation you were participating in, there were other agencies there at the same time?

A Yes, during the investigation.

Q Okay. And so you were aware that that was brought to the clinic's attention that propofol should be used single-dose rather than multi-dose?

A Yes.

Q Okay. And did -- did you independently learn that yourself, like by researching?

A That I have to review to my notes.

Q Okay. You don't recall?

A The -- the question -- can you repeat the question?

Q Did you like go online to AstraZeneca and look up propofol and determine whether it should be used single-use

or multi-use?

A Yes, we did do that.

Q Okay. I mean, does that refresh your recollection --

A Yes, that does.

Q -- when I told you?

A Yes.

Q Okay. And the -- do you -- do you recall from your investigation that it -- it should be single-use rather than multi-patient use because of the lack of preservatives in the propofol?

A Yes.

Q Okay. Now, what was the -- the deficiency pointed out to the clinic -- I'm just taking them one at a time.

A Okay.

Q But regarding propofol, what was the plan of correction?

A The facility implemented a policy which was approved by the governing body outlining the strict adherence to the administration of propofol. The policy states that all propofol vials are to be utilized as single-dose only, one vial per patient. The policy also states that needles and syringes are to be utilized as single-use only and are to be discarded intact in an appropriate Sharps container

immediately after use.

The nurse anesthetists and staff nurses have been informed and reeducated regarding the newly implemented policy and proper protocols for single-dose vial medications, and needle and syringe utilizations. The facility no longer uses any multi-dose medication vials.

The 50 milliliter 2 percent lidocaine and the .9 percent normal saline vials have been discontinued and removed from the facility. The 0.9 percent vial, normal saline, now comes in a prefilled single-use 3 cc syringe, 2.5 percent lidocaine injectable for use with propofol has been stopped until further notice. If the 2 percent lidocaine is reimplemented for use with propofol at a later date, 5 milliliter single-dose vials will be utilized

Q Okay. And when a clinic responds like -- you -- the deficiencies are served on them, and then a plan of correction is returned to the agency, BLC. What -- what then happens? Is it -- is it approved? Is it disapproved? What's the agency do? Like okay, or not good enough? How does this work?

A We would review the plan of correction to see if they have addressed the deficient processes that were identified. If they have, we can accept the plan of correction. If they have not addressed the deficiencies practice, then we cannot accept it and we would inform the

facility that the plan of correction was unacceptable and identify why it was unacceptable.

Q Okay. And what happened here?

A I don't know because when we accept a plan of correction we usually identify at the top of the statement of deficiencies that the plan of correction was acceptable. It's not identified on this here, so I'm not sure if this was accepted or not.

Q Okay. Do you have any recollection at all? That's the only copy I've got.

A No, I don't. We would usually, like I said, whoever reviews it will identify if it was acceptable or not.

Q Okay. Who would have reviewed that?

A It would have been either the Health Facility Surveyor III, the supervisor, myself, or any other surveyor who was available to review it.

Q Okay. And to jump back -- what were -- what were the other two deficiencies?

A In regards to this tag, the first step of the cleaning process for the upper GI endoscopy and colonoscopy scopes, the facility failed to ensure the center adopted and reviewed written policies and procedures. Again, for the first step of the cleaning process and for the upper GI endoscopy and colonoscopy scopes and the use of disposable biopsy instruments.

Q Okay. Sounds like two different things there. One is biopsy instruments, one is scope cleaning.

A That's correct.

Q Okay. There was a scope cleaning deficiency.

A Yes.

Q Okay. When you keep talking tags, you throw me for a loop. Were there additional tags in there, additional things found wrong?

A Let's see. There was another tag, again, related to the center failed to ensure the administrator evaluated and revised the policy and procedure for the use of propofol, for the cleaning of the scopes.

Q Okay. The way I read that, tell me if I'm wrong. I'm just a layman. Without tags and everything, just tell me how many things were found wrong.

A Okay. Let me see.

Q The way I read it there's three things.

A That's correct.

Q Okay.

A There are three areas of deficient practice.

Q Okay. And it impacts various ways because they didn't have written policies or else they were not following them or something, and that accounts for the different tags under the regulations; right?

A That's correct.

Q But -- but basically three things wrong.

A That's correct.

Q Okay. And one of them was the propofol. They were using multi-use; correct?

A Yes.

Q Secondly, scope cleaning problems?

A Yes.

Q And was there a plan of correction for that?

A Yes.

Q Okay. And basically did they say we will -- we'll clean them properly?

A Yes.

Q Okay. So the plan of correction was the deficiencies found in scope cleaning, they will correct and clean them properly, is that fair?

A Yes.

Q Okay. And the third deficiency you said had to do with biopsy forceps?

A Disposable biopsy instruments, yes.

Q Okay. And what was -- what was the deficiency?

A The administrator failed to ensure the policies and procedures were evaluated and revised to reflect the current practice at the center.

Q What's that mean in layman's terms?

A In layman's terms, let me see. The administrative staff indicated that the facility used disposable biopsy instruments, and the policies and procedure had not been updated to reflect the current practice. So the facility had switched from --

Q Reusable.

A -- reusable to disposable, and the policy and procedure was not updated to reflect that current practice.

Q Okay. The policy and procedure still said using reusables and cleaning them, and, in fact, they had gone to disposable biopsy forceps and the policy was outdated?

A Yes.

Q And I guess the plan of correction would be we updated the policy?

A Yes.

Q Okay. Now, I want to go back to your notes. Aside from January 16th interviews at the clinic, did you also interview Vincent Mione, another CRNA? And if you'll go to the third page -- you found it?

A Yes.

Q Is that January 16, 2008?

A Yes.

Q And Vincent Mione, a CRNA?

A Yes.

Q And what did -- in this interview, what did he

explain?

A He indicated that the RN distributes the propofol vials to the CRNA, the vials were to remain in the procedure room, propofol single-use vials, they were 20 milliliter vials. He would open the vial, draw up 20 ccs, same vial, same patient, same syringe. Throw out remaining propofol and open bottle after each patient. The usual propofol dose was 120 to 180 milligrams, and lidocaine 2 percent, they would draw up -- or he would draw up .5 ccs first, and then 10 ccs of propofol.

Q Okay. Now, on January 16th when you interviewed Mr. Mione, his practice on single-use -- because it's January 16th now. So propofol being used single-use vial, and his practice for a patient was the same as Linda Hubbard's; is that correct?

A Yes.

Q Okay. Meaning one needle and syringe, dose patient, if patient needs more, use the same needle and syringe back into the same propofol vial, same needle and syringe back into the patient, and then at the conclusion, discard propofol vial, needle, and syringe; correct?

A Yes.

Q And once again, at that time on January 16th, you didn't say anything to Mr. Mione about this being an improper procedure; correct?

A That's correct.

Q Because at -- at that time it was viewed as a safe aseptic procedure, meaning on January 16th.

A It was a safe procedure. Now, again, not best practice, but, yes.

Q Okay. But the -- I mean, Linda Hubbard and Vincent Mione are telling you in interviews, BLC, this is the way we are doing it under our new policy of single-use propofol; right?

A Yes.

Q And no one said to them, well, this is okay, but it's not best practices; correct?

A That's correct.

Q Okay. That -- that determination came at a later time?

A I'm not sure what you mean.

Q Did -- did you have discussions with Brian Labus like in February about the dangers of such a practice?

A That I don't recall.

Q Okay. Well, at -- at what point was the determination made, as you understand it, to put them on notice that, hey, you need to use a brand new needle, brand new syringe every single time you enter the propofol vial or the patient?

A So a brand new syringe, brand new needle for

each patient?

Q Well, you tell me. You're a nurse and you're an inspector for the BLC; correct?

A I didn't -- I did not tell them that, no. Not during my -- not during the investigation --

Q Okay.

A -- that I participated in.

Q And had you -- had you been there on January 16th and seen a practice that was putting patients in danger because they were operating and doing it exactly the way they were telling you; correct?

MS. WECKERLY: I'm going to object, unless she --

THE COURT: That wasn't really --

MS. WECKERLY: -- observed procedures.

THE COURT: -- a question, either.

MR. WRIGHT: I threw a correct on the end.

THE COURT: Well, I know, but the first part didn't match up with the second part. Is your question -- I mean, state your question again.

MR. WRIGHT: Okay.

BY MR. WRIGHT:

Q I presume other inspectors were there other than yourself; correct?

A Yes.

Q And if -- if a clinic is telling you they are

engaging in certain practices and you have any inkling that those are unsafe practices putting patients at risk, you would stop those practices and advise them; correct?

A That's correct.

THE COURT: Maybe this would be a good time for a morning recess.

MR. WRIGHT: Thank you.

THE COURT: Ladies and gentlemen, we're going to go ahead and take until about 11:30 our morning recess.

During the recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case, and please don't form or express an opinion on the trial.

Notepads in your chairs, and follow the bailiff through the rear door.

And, ma'am, during the break, don't discuss your testimony with anyone else.

THE WITNESS: Okay.

THE COURT: Okay. And if you want to take a break, it's just through the double doors there.

THE WITNESS: Okay. Thank you.

(Court recessed at 11:15 a.m., until 11:28 a.m.)

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session.

Mr. Wright, you may resume your questioning.

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q Did you also observe or interview another CRNA on January 16th, Mr. Vincent Sagendorf? And the -- like on page 5.

A Yes.

Q Do you have that? Yes.

A Yeah.

Q January 16, 2008, interview of Vinnie Sagendorf, CRNA; correct?

A Yes.

Q And what did Mr. Sagendorf explain regarding his procedure?

A The RN distributes the propofol in the morning. He draws up 1 cc of Xylocaine first, then 10 ccs of propofol. It's a 20 cc standard vial. When -- when a patient -- when with the patient and ready to start the procedure, that's when he would draw up the propofol. Start with 100 milligrams of propofol, augment as needed, use a new syringe, discard the propofol after each patient, standard practice for CRNA.

Q Okay. So as -- tell me if I'm incorrect, but

as far as Mr. Vinnie Sagendorf, he indicates that he would be doing what you refer to as best practices.

A Yes.

Q Is that right?

A Yes.

Q Whereas Linda Hubbard and Mr. Mione were reusing needle and syringe for same patient, Vincent Sagendorf is saying every time I draw up again I use a new needle and syringe.

A Yes.

Q And at the end, toss the propofol because it's single-patient use as of now; correct?

A Yes.

Q Okay. And do you recall you and Nadine Howard and Leslee Kosloy, the three BLC investigators, were interviewed by the Metropolitan Police Department in March 2008? Do you recall that?

A Yes.

Q Okay. Have you seen your transcript of interview?

A Briefly.

Q Okay. And do you recall that at that interview in March -- on March 5, 2008, it was all three of you; correct?

A Yes.

Q Okay. And you are all three nurses?

A Yes.

Q And inspectors?

A Yes.

Q Okay. And you explained to the detectives that the procedures described on January 16th by Mr. Mione, Mr. Sagendorf, and Linda Hubbard were proper and correct procedures; right?

A That I don't recall. I'll need to see the --

Q Okay. 23 to 27 -- 23 to 26, read that to yourself, all four pages.

A Okay.

Q Starting like about there on line -- page 23.

A [Witness complied]. Okay.

Q Does that refresh your recollection?

A Yes.

Q And that's on March 5, 2008. I'll tell you because I didn't hand you the cover page.

A Okay.

Q And that's interview of Leslee Kosloy, Dorothy Sims, Nadine Howard at the BLC; correct?

A Yes.

Q And it's by Detective Gray and Detective Hahn of the Metropolitan Police Department.

A Okay.

Q And at that time you were interviewed, you all, let me put it that way, and the practices described of Mr. Mione, Linda Hubbard, Sagendorf were stated by you all to be perfectly acceptable.

A That's correct.

Q Is that correct?

A Yes.

Q And there was nothing in there to the detectives about not best practices or anything else. It was they are using acceptable safe practices --

A Yes.

Q -- correct?

A Uh-huh.

Q And it was talking specifically about reusing needle and syringe; correct?

A Yes.

Q And apparently at some later time after March 5, 2008, there was a determination that that may not be safe practices or best practices; right?

A My opinion, yes, not best practice.

Q Okay. After March 5, 2008?

A Yes.

Q Okay. And -- because on March 5, 2008, you and the other two inspectors are agreeing that those are safe practices; correct?

A Yes.

Q Okay. And you're now saying today it's not best practices; right?

A That's correct.

Q Okay. So that change occurred after March 5, 2008?

A Yes.

Q Okay. And investigation of Shadow Lane had ended by BLC on January 17th when the statement of deficiencies was issued; correct?

A That's correct.

Q Additional -- did additional investigation by BLC occur at the sister clinic on Burnham Lane?

A Did we do an inspection over there?

Q Yes.

A Yes, we did.

Q Okay. And that was after Shadow Lane?

A Yes.

Q Okay. And so -- and you knew Burnham was simply another clinic of the same practice; correct?

A That's correct.

Q Okay. And so BLC went and inspected there --

A Yes.

Q -- correct? And did another statement of deficiencies; correct?

A Yes.

MS. WECKERLY: I'm going to object as to foundation unless she was at Burnham and observed it.

MR. WRIGHT: Okay. Well, the -- I'm not going to go any further with going into Burnham.

THE COURT: Okay. Move on.

BY MR. WRIGHT:

Q There -- thereafter did your agency conduct further investigations of other ambulatory surgical centers, starting in February 2008?

A We did do inspections of other ambulatory surgery centers. I don't know the exact date as when they were started, but we did do other investigations, yes.

Q Okay. And was that precipitated, started because of what was found at Shadow Lane?

MS. WECKERLY: Objection. Calls for speculation.

THE COURT: If she knows.

You can answer. Don't guess if you don't know.

THE WITNESS: That I don't know.

BY MR. WRIGHT:

Q Okay. You don't know why the governor asked all of the ambulatory surgical centers in the state to be inspected starting right after the Shadow Lane clinic?

THE COURT: Well, that would --

MS. WECKERLY: Objection.

THE COURT: -- be speculation.

MS. WECKERLY: That's not in evidence.

THE COURT: Yeah, so --

BY MR. WRIGHT:

Q Okay. Do you know?

THE COURT: Mr. Wright, I already sustained the objection --

MR. WRIGHT: Okay.

THE COURT: -- so you need to move on.

BY MR. WRIGHT:

Q Did you -- in February did BLC inspect another clinic on Maryland Parkway, an endoscopic clinic?

MS. WECKERLY: I'm going to object unless she personally did the inspection. I mean, she could, I guess, say that --

THE COURT: Well, she could --

MS. WECKERLY: -- she heard

THE COURT: -- be aware of it in her role as part of the team.

So do you know whether or not there was another inspection?

THE WITNESS: We did do an inspection on an ambulatory surgery center on Maryland Parkway. I don't know the exact date, though.

THE COURT: Okay. Were you involved in that

inspection?

THE WITNESS: No, I was not.

BY MR. WRIGHT:

Q Would you look at that document and tell me -- tell me what that is?

A Going back to your -- the Judge's question on was I involved with it, is that directly involved with it, or as a supervisor?

Q As a supervisor.

A As supervisor, I may have been involved with it, but I wasn't directly onsite.

Q Okay.

A This is a state --

MS. WECKERLY: My objection, then, is foundation as to any observations if she wasn't onsite.

THE COURT: All right. Lay a foundation, Mr. Wright.

MR. WRIGHT: I'm having her -- I handed her an exhibit and I'm asking her what it is --

THE COURT: Okay.

MR. WRIGHT: -- before I move its introduction.

BY MR. WRIGHT:

Q What is that exhibit?

A This is a statement of deficiency for a gastrointestinal diagnostic clinic on 3196 South Maryland

Parkway.

Q Okay. And is that the inspection we've -- you and I have been talking about?

A The one on Maryland Parkway?

Q Yes.

A Yes, this occurred in February.

Q Of 2008?

A Yes.

Q And that -- and that's a document of your agency; correct?

A That's correct.

MR. WRIGHT: I move its admission.

MS. WECKERLY: Objection. Hearsay.

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

BY MR. WRIGHT:

Q Would you look at that page by page and tell me if that appears to be an accurate copy of a record of your agency?

A [Witness complied]. Yes, this is a statement of deficiencies from our agency.

Q And it's page 1 through 29 and every single page is there; correct?

A Yes.

MR. WRIGHT: Move it's admission.

MS. WECKERLY: Same objection that I previously stated.

THE COURT: Basis, why are you --

MS. WECKERLY: Foundation.

THE COURT: -- admitting it?

MS. WECKERLY: Oh, sorry.

THE COURT: Mr. Wright?

MR. WRIGHT: Pardon? I'm sorry.

THE COURT: I'll see --

MR. WRIGHT: -- I didn't --

THE COURT: -- counsel up here.

MR. WRIGHT: -- hear you.

THE COURT: I'll see counsel up here.

(Off-record bench conference.)

MR. WRIGHT: Thank you, Your Honor.

THE COURT: Go ahead.

BY MR. WRIGHT:

Q Do you have Exhibit CCC -- CC-1; correct?

A Yes.

THE COURT: Two Cs.

BY MR. WRIGHT:

Q CC-1

A Yes.

Q The -- these inspections of an endoscopy -- a gastrointestinal diagnostic clinic, is that an ambulatory

surgical center?

A Yes.

Q Okay. And these inspections take place unannounced?

A Yes.

Q Okay. So it's inspectors walk in the door, watch, and interview?

A Yes.

Q And look at records?

A Yes.

Q Okay. And this occurred on February 15, 2008?

A That's the date that the investigation was completed. It started on February 13, 2008.

Q Okay. Looking at page 25 -- 25 of 29.

A Okay.

Q Did the observations begin on February 14th, general observations of four patients receiving endoscopy procedures at the facility between 7:35 a.m. and 9:30 a.m.?

A Yes.

Q And going to page 26 of 29 -- and this is a different clinic in Las Vegas; correct?

A Yes.

Q It's not -- not Burnham, not Shadow Lane, not associated with the Gastroenterological Center of Las Vegas?

A Yes.

Q Okay. Now, on page 26, Patient No. 3, okay.

A Yes.

Q Would you read the paragraph as to Patient 3?

MS. WECKERLY: I'm going to just object as to foundation unless she was there and observed this.

THE COURT: What was your role as a supervisor on this investigation or document?

THE WITNESS: I would have assigned the surveyors to go out to investigate. They would call for any questions or guidance. And then once the investigation was completed, I would review the report, and then I would mail the report out to the facility. And then I would track the inspection process.

THE COURT: Okay. When you say track the inspection process, what does that mean?

THE WITNESS: I would track as to what facilities we are going at to do any inspections at, which day we started, what day we've completed, did the statement go out, and did we get a plan of correction in.

THE COURT: Okay. And then as the supervisor, did you have any role in making sure the plan of correction was actually adhered to or the changed -- the recommended changes were made?

THE WITNESS: It looks like I reviewed the plan of correction and accepted it. And this is a federal statement,

so because of the conditions we would be then responsible to do a follow up visit to make sure they are in compliance with the regulations.

THE COURT: And you do that as a supervisor?

THE WITNESS: I would assign --

THE COURT: Okay.

THE WITNESS: -- the -- the surveyors to go out and do the follow up investigation. But I would not have been the investigator going out to do it.

THE COURT: All right. Go ahead, Mr. Wright.

MR. WRIGHT: Okay.

BY MR. WRIGHT:

Q And do you all -- your -- your agency, you do the inspections for the centers for Medicare and Medicaid services, federal government; correct?

A Yes.

Q I mean, just the way our government is set up here, the feds for Medicare and Medicaid contract to the state, your agency, to do the inspections of their clinics that are qualified for Medicare and Medicaid services?

A That's correct.

Q Okay. And so that's what was taking place here?

A Yes.

Q Okay. Now, Patient No. 3, read that

paragraph.

A Patient No. 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. The anesthesiologist used an open 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.

Q Okay. And then Patient 4 follows Patient 3; correct?

A Yes.

Q Okay. And what happened with Patient 4?

A Patient No. 4 was brought into the procedure room at 9:15 a.m. The anesthesiologist was observed drawing up propofol in the same -- the anesthesiologist was observed drawing up propofol from the same vial that he had used on Patient No. 3 to inject Patient No. 4.

Q Okay. I had -- I had skipped Patient 2 before that, but read the next paragraph about Patients 2, 3, and 4. What then occurred?

A Patients No. 2, 3, and 4 were observed being transferred into the procedure room one at a time on a gurney

with their intravenous IV bags lying on the gurney with them. An observation was made that one of the patients -- the patient's blood flowed back into the IV tubing. When the IV bag was hung on an IV pole, the blood cleared from the tubing.

Q Okay. Next paragraph.

A During the observation time frame, the anesthesiologist was never observed opening new syringes.

Q Okay. And then was the anesthesiologist interviewed? What's the next paragraph?

A On 2/24/08 at 9:45 a.m., the anesthesiologist stated that it was okay to use a 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. The anesthesiologist stated that because these cases were of short duration there was not enough time for bacterial growth to occur, that way 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 that he would change the needle and 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.

Q Okay. And that -- that was an anesthesiologist, M.D., not a CRNA; correct?

A That's correct.

Q Okay. And the report, the statement of deficiencies, the same syringe was being used by the anesthesiologist, multi-patient, but simply changing the needle; correct?

A Yes.

Q Okay. And all of the investigation at Burnham, Shadow Lane, the entire investigation, there was never any finding ever of any reuse of needles, reuse of syringes between patients; correct?

A At the Shadow Lane, that's correct.

Q Okay. I don't recall the Burnham clinic.

Q Okay. You would have to look at the report on Burnham?

A Yes, I would.

Q Okay. But at Shadow Lane no reuse of syringe between patients?

A That's correct.

Q Okay. And then this on February 15, 2008, reuse of syringe, changing needle between patients and multiple use of propofol; correct?

A That's correct.

Q Okay. And was a plan of correction filed?

A Yes.

Q Okay. And plan of correction is propofol used single-use and new needles and syringes?

A It would be in the attachments because they attached their policies and procedures. But if I accepted it, then --

Q Okay.

A -- they would have changed their policies and procedure.

Q Now, thereafter was a plan put in place to survey or investigate, inspect, I guess, is the correct word, all of the ambulatory surgical centers in the state of Nevada in 2008?

A That's correct.

Q And did -- did you -- did your office participate in that?

A Yes.

Q Okay. Did CDC participate in that?

A Yes.

Q And do you recall the time frame?

A No.

Q Look at that document to yourself and tell me if you recognize what that is.

A [Witness complied].

Q Do you know what that is?

A It looks like it's a report that was done by our administrator, Richard Whitley.

Q Okay. And who is Richard Whitley?

A He is the administrator for the Health Division.

Q And is that your division?

A Yes, it is.

Q He's the boss?

A Yes, he is.

Q And does -- is that report the -- a report of the results of the inspection of ambulatory surgical centers in Nevada in 2008 regarding infection control practices?

MS. WECKERLY: Your Honor, I'm going to object unless she independently recognizes it. It sounds like she -- or it looks like she's reading it.

THE WITNESS: I -- to be honest, I don't recall seeing this report.

THE COURT: Okay.

BY MR. WRIGHT:

Q Okay. Do you know was it -- let me show you Exhibit R-1.

MS. WECKERLY: Can I see that exhibit? I don't --

THE COURT: Yeah. It's already been admitted.

MS. WECKERLY: Right. I just want --

THE COURT: That's fine. He can --

MS. WECKERLY: I just want to --

THE COURT: -- show it to you.

MS. WECKERLY: -- know what it is.

THE COURT: And R-1 is what, Mr. Wright?

MR. WRIGHT: It's a Nevada State Health Division technical bulletin --

THE COURT: Okay.

MR. WRIGHT: -- regarding potential exposures to hepatitis C in -- in ambulatory surgical centers in Las Vegas.

THE WITNESS: Okay.

BY MR. WRIGHT:

Q Are you familiar with that?

A No, I'm not.

Q Okay. Do you -- do you -- who is -- that's in evidence already. That technical bulletin is from whom?

A It looks like it was written by Dr. Ihsan Azzam.

Q Who is he?

A He is the state epidemiologist.

Q Okay. And is he in your agency or in a different state agency?

A It looks like he's with the Nevada State Health Division, so --

Q That's different than you all?

A The Nevada State Health Division is a division

within the Department of Health and Human Services, and then our bureau is like a program within that Health Division. So he's with -- he's the state epidemiologist, but he's not with the Bureau of Healthcare Quality and Compliance.

Q Okay.

A Or the BLC?

Q Do you recall that as a result of inspections taking place a technical bulletin was sent out to healthcare providers about multi-use vials and reuse of syringes?

A I don't recall personally, but this is --

MS. WECKERLY: I'm going to object unless she recalls.

THE COURT: All right. Okay.

BY MR. WRIGHT:

Q Now, you do recall that there was -- your agency participated in an inspection of all the ambulatory surgical centers in the state of Nevada; right?

A Yes.

Q And do you recall how many of them were inappropriately using single-use items, especially syringes?

A I don't recall how many of them.

Q Let me show you something and see if this refreshes your recollection.

A Without seeing the inspection reports --

Q That does not refresh your recollection?

A No. We have a total of about 60 facilities all throughout the state. So without seeing each of the inspection reports, I really can't say.

Q Okay.

THE COURT: That's fine. I mean, the question is does that refresh your recollection.

THE WITNESS: Yeah.

THE COURT: And if it doesn't, then Mr. Wright is going to move on.

BY MR. WRIGHT:

Q Right. My question was do you recall of the number inspected, like 60 of them, how many of them were found to be reusing syringes?

A No, I can't recall how many of them.

Q Does looking at that refresh your recollection?

MS. WECKERLY: I'm going to object. She just said it didn't.

THE COURT: I think she just said it didn't.

THE WITNESS: No, it doesn't.

THE COURT: All right.

MR. WRIGHT: I move the admission of the exhibit.

MR. STAUDAHER: Well --

MS. WECKERLY: I'm going to object as to foundation.

THE COURT: That's sustained.

MS. WECKERLY: Among others.

THE COURT: That's sustained, Ms. Weckerly.

BY MR. WRIGHT:

Q So you don't --

THE COURT: I don't think that's been --

BY MR. WRIGHT:

Q -- have any idea --

THE COURT: -- marked yet, either.

BY MR. WRIGHT:

Q Do you remember you were working and participating in it; correct?

A Yes.

Q Okay. And this is 2008. And an inspection of all the ambulatory surgical centers because we had this outbreak here; correct?

A Yes.

Q Okay. And can you remember if there was zero found? Do you have any memory whatsoever of the results of this investigation?

A Without looking at those inspection reports I couldn't tell you what was found at each of the facilities.

Q Okay. So for all you know it was 100 percent reusing; correct?

A Without looking at the inspection reports, I can't say.

Q Okay. In preparation for your testimony here, have you been interviewed by anyone?

A For?

Q In preparation for testifying --

THE COURT: For coming in today did anyone interview you, like a police officer or investigator or attorneys, anybody like that?

THE WITNESS: I met with the DA awhile ago.

THE COURT: Okay. By awhile, a week ago, two weeks ago, a month ago, what do you mean?

THE WITNESS: Prior to -- prior to jury selection.

THE COURT: Okay. So that would have been a couple of months ago?

THE WITNESS: Yes.

THE COURT: All right. Go on, Mr. Wright.

BY MR. WRIGHT:

Q Okay. Who did you -- you never met with me; right?

A No, I have not.

Q Okay. But you met with the District Attorney's office?

A Yes.

Q Okay. Who did you meet with?

A The gentleman here and the lady here.

THE COURT: Which gentleman?

BY MR. WRIGHT:

Q This is Mr. Staudaher.

A Mr. Staudaher.

Q Ms. Weckerly.

A Yes.

Q You met with them?

A Yes.

Q Did you discuss what I'm talking about here today?

A No.

Q What did you discuss?

A He -- we discussed the police officer's interview.

Q Okay. That March 5, 2008, interview I showed you?

A Yes.

Q Anything else?

A No, I don't recall.

Q Okay. Thank you very much.

THE COURT: Nothing else, Mr. Wright?

MR. WRIGHT: No, Your Honor.

THE COURT: Mr. Santacroce, do you have any questions for this witness?

MR. SANTACROCE: I do not.

THE COURT: Thank you.

Ms. Weckerly, is this your witness?

MS. WECKERLY: Yes.

THE COURT: Cross?

MS. WECKERLY: No cross.

THE COURT: All right. Do we have any juror questions for this particular witness? I see no juror questions.

Ma'am, thank you for your testimony. Please do not discuss your testimony with anyone else who may be called as a witness in this matter.

THE WITNESS: Okay.

THE COURT: You are excused.

THE WITNESS: Thank you.

THE COURT: Thank you.

I'll see counsel at the bench, please.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our lunch break now. We'll be in recess for the lunch break until 1:25.

During the lunch recess you are reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case by any medium of information. Please do not do any independent research, and

please do not form or express an opinion on the trial.

Place your notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 12:20 p.m.)

THE COURT: And before we take our break, I overheard the attorneys commenting that there was an outstanding ruling on something prior to resuming the testimony.

MR. STAUDAHER: No.

THE COURT: Can you enlighten me as to what that might be?

MR. STAUDAHER: Outstanding ruling regarding jury -- so it was related to jury instructions where --

THE COURT: Is that regarding the statute or -- because how can there be an outstanding ruling on jury instructions when we haven't --

MR. STAUDAHER: Well, not --

THE COURT: -- covered jury instructions?

MR. STAUDAHER: -- a jury instruction, but the issue regarding the theft that the Court -- we provided the authority for the Court.

THE COURT: Right. I'm expecting argument on that --

MR. STAUDAHER: Okay.

THE COURT: -- so I don't really think it's fair to

characterize that as an outstanding ruling because I was going to give the defense time to argue that, unless they agree that that's an appropriate --

MR. STAUDAHER: I think we said that we need a ruling from the Court, not necessarily that there was an outstanding ruling.

THE COURT: Okay. Well, I heard outstanding ruling. So I just want to make sure that other than the exhibit that we talked about this morning that there's no outstanding rulings. The only other issue is the graph thing that may be considered outstanding. So I just want to make sure that I haven't neglected to remember anything other than that.

And as I said, I don't consider that an outstanding ruling because I'm assuming -- well, first of all, I don't know. Maybe the defense will agree that that's an appropriate statute to use and an appropriate instruction. I would assume not, but, you know, I'm obviously not as wise as they are, so perhaps they'll agree to that.

If not, I certainly would anticipate there's going to be some argument on something that critical to a case. So I don't consider that outstanding, as I said, because it hasn't been -- it hasn't been argued, litigated yet, and, you know, whatever. So is that --

MS. STANISH: No, Your Honor --

THE COURT: Am I missing something? Is there

anything else that either side feels they need a ruling on that hasn't been ruled on?

MS. WECKERLY: I think we were -- we were discussing jury selection -- or, sorry, jury instructions. And what we were talking about is how we could probably reach agreement --

THE COURT: Right.

MS. WECKERLY: -- on some things, probably not that issue. I mean, I don't know if Ms. Stanish was talking about something else, but that was my recollection, that we thought we could get agreement on certain parts of the --

THE COURT: Right. And you're fine to talk about whatever you want to talk about. All I'm saying is if there is an outstanding ruling, I certainly want to, you know, make sure the record is complete and rule on anything that hasn't been ruled on. So to the extent I may have overheard that, I just want to make sure that I haven't neglected to make a ruling on something that I have forgotten.

Like I said, those are the only two things at the forefront of my mind, but it's possible I'm not recollecting something. So if that's the case, then I need to be made aware of that. The only other potential is the Ms. Pomykal issue, which she's been kept here, you know. I'm concerned about the thing -- I was going to review her -- I've reviewed it already. You folks have reviewed it. You know, if we decide to make her an alternate, then it's going to be the

next number alternate.

I am not going to shuffle the alternates to benefit any particular side. So the next in number alternate, I believe, is the blonde gal that you folks have complained about has been sighing and doesn't appear to like Mr. Wright. That, I believe, is our next in order. And, like I said, I'm not shuffling the alternates unless there is a real reason. And the fact that she may sigh and, you know, express boredom is not a reason to shuffle the alternates.

So just to -- I don't know if anyone would have had that idea, but to the extent someone would have, that is not going to happen. The only one -- you know, we could make Ms. Pomykal an alternate because she has -- and I'm going to decide if I'm even going to make that option available. But, you know, she has expressed something that could create, at least in the minds of the defense, a conflict. So there is that.

The only other remaining issue that really, I don't know is a remaining issue, is the gentleman in Chair 7 who will be allowed to go on his vacation starting early in the morning on July 4th. So, you know, if we finish up Friday like we think, that would give them three days to deliberate, and my belief is he should remain as one of the main members of the jury.

If for some reason it takes longer than that, then

we will consider making him an alternate and moving in one of the others because I don't want them to start deliberating and then he leave on his vacation and everything like that. So those are the only issues I can think of that may still be out there in the wind.

MS. STANISH: Judge --

THE COURT: I just want to make sure I'm not neglecting.

MS. STANISH: You know what, I have to apologize if there was something you heard that was offensive. We had a discussion --

THE COURT: Well, that's fine. You two are free to discuss whatever you want.

MS. STANISH: No, but I wanted to let you know what we discussed because Ms. Weckerly and I started the discussion in the anteroom and then we continued it in the courtroom. And we were discussing the jury instructions. I was describing for them what I had written so far, and we were trying to anticipate what issues we would have.

And the issues are, which we may agree on, is the mental element for the criminal neglect statute, and then we are probably going to have issues regarding the -- the theft statute and how to -- whether the jury needs to be instructed specially on whether or not to take into account services rendered, that whole issue that Mr. Staudaher raised. But we

agree there has to be argument on it.

THE COURT: Right. That's why I'm saying I don't think it's fair to characterize that as an outstanding decision when there hasn't been argument on it.

MS. STANISH: No, it's something that still, you know, is --

THE COURT: And, to me --

MS. STANISH: -- contemplated in here.

THE COURT: -- you know, what do I know, that seems to be a relatively big deal, at least with the theft statute. I mean --

MS. STANISH: It depends --

THE COURT: -- on the insurance --

MS. STANISH: -- on the --

THE COURT: -- defense it doesn't really matter, but --

MS. STANISH: Correct. The great scheme of things. And then the --

THE COURT: So, I mean, what's one more if he's convicted. I mean, you know --

MS. STANISH: And then just to let Your Honor know what we were contemplating doing is hopefully having tomorrow off so that we can meet with Your Honor to do the jury instructions. We wanted to know -- that's why we were talking about what kind of argument we would expect. And hopefully

we'll get that worked out by the end of the day.

THE COURT: Yeah, I don't care when you folks meet. I mean, I would -- if you want to meet tonight, that's up to you. If you want to meet tomorrow morning, that's up to you. I would like to go on the record and settling jury instructions relatively early in the day, like 10 or 10:30.

So whenever you folks need to meet, you know, if you need to meet at 8:00 to do that or you want to do it tonight, obviously I don't care. What I don't want to have happen is waiting until like 2:00 in the afternoon to settling the jury instructions because there may be typing that needs to be done and whatnot.

The Court -- you know, it's my experience that the later we wait, the more burdensome it is on the court staff who then has to do all the typing and corrections. So for that reason I don't want us to be here at 4:30 with my staff having to do all the changes and corrections and everything like that.

So for that reason, it's better if we do it earlier, that way we can get a cleaned up packet, we can number them, we can make sure everybody has time to review the changes, that they've been done correctly, and all of those things. So I don't want to -- in other words, the whole point of that was I don't want to wait until the last minute on getting together in the afternoon because I think it could take, based on

everything else that's transpired in the case, I think it could take some time.

MS. STANISH: And what we were hoping is that we could have the afternoon off so that both parties could prepare for closing and then deliver the closing on Thursday.

THE COURT: Right. And you think we can do the closings and the jury instructions in one day?

MS. STANISH: Well, I thought we would do jury instructions tomorrow.

THE COURT: No, no, I meant read them.

MS. STANISH: If you don't do the lengthy indictment.

THE COURT: Yeah, that's what I was going to say. Do both sides --

MS. STANISH: You already read that.

THE COURT: Do both sides stipulate to the Court not rereading the indictment and just saying the indictment is here as part of Instruction No. 3. It's been read to you already. And both sides stipulate to me not reading it again?

MR. STAUDAHER: State does.

MR. WRIGHT: Who has to read it?

THE COURT: I do.

THE CLERK: It's an hour and 20 minutes.

MR. WRIGHT: You got me. I'll stipulate.

THE COURT: Mr. Santacroce, do you stipulate?

MR. SANTACROCE: Yes, Your Honor.

THE COURT: All right. So that'll save some time, then. And how many proposed instructions including the stocks does the State have?

MS. WECKERLY: You know, there really aren't that many. I didn't number them. But when you take out the indictment it's substantially smaller.

THE COURT: Okay.

MS. WECKERLY: So I think that -- I understand there will be argument on the instructions, but there really aren't -- there's probably less than 30 substantive instructions, or maybe right around 30.

THE COURT: Okay. So -- and both sides, we think we can do all the closings on -- in a single day?

MR. WRIGHT: Yeah.

MS. WECKERLY: Sure.

THE COURT: Well, I don't know. I mean, I don't know if, you know, somebody has got a three and a half hour PowerPoint.

MS. WECKERLY: Not yet.

MR. WRIGHT: I don't PowerPoint.

THE COURT: Okay. So then they'll start Friday, so that takes care of the issue regarding Juror 7. That gives plenty of time for him to deliberate and all of those things. And I think those were the only things that we needed to

discuss at this point.

MS. STANISH: Okay.

THE COURT: All right.

MR. STAUDAHER: We're to be back, Your Honor, at what time?

THE COURT: I told them 1:30.

MR. STAUDAHER: 1:30? Okay

THE COURT: Oh, should we do the Fifth Amendment admonishment, or do you guys want to do that after lunch?

MR. SANTACROCE: Whatever you prefer.

THE COURT: Let's do it now.

All right. We'll start with Dr. Desai. Everyone listen carefully to make sure I cover everything. I do it from memory.

Dr. Desai, I need you to stand up, please. And I need you to respond out loud to the Court. If it takes you some time to speak, that's fine with me. Okay?

All right. Dr. Desai, you -- do you understand that you have the right to take the stand and testify on your own behalf? Do you understand that?

THE DEFENDANT DESAI: No.

THE COURT: All right. Have you had an opportunity to discuss his Fifth Amendment right with him, his right to testify and his right not to testify?

MR. WRIGHT: Yes.

THE COURT: All right. Do you want additional time to go over those rights with him?

MR. WRIGHT: No, it doesn't --

THE COURT: Okay.

MR. WRIGHT: -- change anything.

THE COURT: We'll go over those after the lunch break. You know, I would just note that --

MR. WRIGHT: I'll talk to him.

THE COURT: -- Dr. Desai's demeanor in terms of his posture, I don't know if demeanor is the right word, and inability to face me is a little different than what I've perceived at the breaks in terms of his posture and whatnot. I'm not accusing anyone of anything. I would just say it's different. So I hope there's not some exaggeration going on. Posture, obviously, is different than his ability to understand and communicate. However, it's curious to me that it's manifesting differently than other times when I've seen movement.

MR. WRIGHT: He's not moving.

THE COURT: I understand that. But, I mean, you know, he walks out of the courtroom, he walks down the street, he walks down the stairs, and his posture standing here right now and his hunched over appearance and his failure to look at the Court is, I think, different. You know, he's walking in and out of this building unassisted. I know his daughters are

with him sometimes, but all I'm saying is I just hope that there is not some exaggeration going on because --

MR. WRIGHT: There's no exaggeration --

THE COURT: All right.

MR. WRIGHT: -- going on.

THE COURT: Well, you can say that. We're back -- you know, we're kind of a in a full circle here to square one. You know, I think your representations are well intentioned. That does not necessarily make them accurate in terms of what you're accurately perceiving and how you're communicating, I think that's well intentioned. Whether or not that's the ultimate truth, I don't necessarily know that that's -- that that's the case or the -- that that's fact. So we'll cover this again at the -- after the lunch break.

And, you know, if the State wants to be heard on some of what I've said and their observations, they will be allowed to -- to do that. But, you know, I don't know why Dr. Desai cannot face the Court, and I think that that could be evidence of some exaggeration going on. Because certainly -- well, I'm not going to opine. I'm just saying I don't understand it. So go to lunch.

(Court recessed at 12:36 p.m., until 1:45 p.m.)

(Outside the presence of the jury.)

THE COURT: We'll do the witness, start with the witness, and then at our afternoon recess we'll do the Fifth

Amendment admonishment.

MS. WECKERLY: Okay.

MR. STAUDAHER: Yes, Your Honor. Before we bring the jury in we do have to address the next witness, the scope of that person's testimony.

THE COURT: All right. Go ahead.

MR. STAUDAHER: We had -- I just want to bring it to the Court's attention and actually try and find out exactly where we plan on going with this witness because this is a witness who testified to the Chanin case, gave a deposition and gave opinions in the Chanin case regarding the fact of no transmission at the clinic and there was no genetic match to that person.

That's one of the issues is that he claimed in his attached affidavit that one of the issues as to why that person, Chanin, did not have hepatitis C from the clinic is because there was no genetic link or no genetic match to that one. He testified in a -- and this is not the Endoscopy Center of Southern Nevada. This is the Desert Shadow Endoscopy Center. Sorry, Your Honor.

So it's a different clinic, it's a different non-genetically matched patient, and he was directly involved with the review of those records and testimony about that, which we have received a deposition of. So it's a concern, obviously, that the State has as to the scope because in his

deposition he talks about having reviewed a number of cases.

I don't know which ones he reviewed and didn't review, which if they were genetically linked, if they weren't genetically linked. I know he was involved in Michael Washington, at least, and Patty Aspinwall, I believe there was a reference to that in there, as well as Chanin where he actually did give the deposition. So --

THE COURT: So what are you trying to limit?

MR. STAUDAHER: I'm not trying to limit anything. I'm just --

THE COURT: Okay.

MR. STAUDAHER: -- trying to make sure that they know that I feel it's fair cross-examination --

THE COURT: Yeah, I mean, if you --

MR. STAUDAHER: -- for bias purposes.

THE COURT: I mean, they've been pretty scrupulous about not introducing the evidence on the other 109 or 7 or whatever it is. So is what you're saying that if then they get into all this other stuff he's reviewed, it would open the door, then, to that? Is that --

MR. STAUDAHER: That's partially it.

THE COURT: Okay.

MR. STAUDAHER: That's not the main portion of what --

THE COURT: Okay.

MR. STAUDAHER: -- my concern is. I want to be able to cross-examine him on this that this -- he was involved in a non-genetically matched patient at a different related clinic, and that he opined as to what the infections were or weren't in that case and what he would --

THE COURT: This is another --

MR. STAUDAHER: -- rely upon.

THE COURT: -- another gastro -- one of their centers?

MR. STAUDAHER: Yes --

THE COURT: And so --

MR. STAUDAHER: -- the Desert Shadow, the Burnham clinic.

THE COURT: The Burnham clinic. So there was a non-genetically linked patient at the Burnham clinic and he opined that he, what, wasn't infected at the Burnham clinic?

MR. STAUDAHER: Right.

THE COURT: And, Mr. Wright, do you intend to get into that?

MS. STANISH: No, I had indicated earlier to the prosecutors that the primary purpose of Dr. Worman's testimony was to address Mr. Meana's death, and then touch upon, in general, hepatitis C and dementia, and that's it.

THE COURT: So he is just testifying strictly as a medical expert relating to the cirrhosis and the cause of

death and as to whether or not hepatitis C could cause dementia?

MS. STANISH: Correct.

THE COURT: Not as to causation of the infection or genetic linkage or anything like that?

MS. STANISH: Yeah, we're not challenging the -- the contraction of the hepatitis C by Mr. Meana, but it's to address the proximate cause issue.

MR. STAUDAHER: So that -- I mean, that's -- I mean, they've alluded to it, but I've never heard before that they --

THE COURT: Okay.

MR. STAUDAHER: -- don't challenge the --

THE COURT: If that's all they're -- they're -- I mean, if that's what it's limited to --

MR. STAUDAHER: My concern was the bias issue, that I felt it was -- especially because he had opined as to the fact that it was not that particular clinic that gave him the infection and that he also said in his affidavit that one of the reasons he based that on was that there was no genetic link to Mr. Chanin and that clinic and that he -- he believed that he must have a risk factor, although none were ever articulated, just that he must have a risk factor so, therefore, he could not have gotten it.

He also said that even though in that case Mr.

Chanin, I think a few weeks before, at least within the window of incubation, had had a test for hepatitis C that came back negative. He said, well, that could have been within the window of incubation, so the -- the most he could say was that he contracted hepatitis C from somewhere in February of 2007 up to the time --

THE COURT: So you want --

MR. STAUDAHER: -- at the clinic.

THE COURT: -- to cross-examine -- do you still want to cross-examine him about all that?

MR. STAUDAHER: That he was paid by the -- by the defense to essentially opine in a different case that --

THE COURT: But the --

MR. STAUDAHER: -- that it was not --

THE COURT: -- insurance --

MR. STAUDAHER: -- the clinic.

THE COURT: -- defense?

MR. STAUDAHER: Yes. Not this defense, not these defense attorneys.

THE COURT: Okay. So he wasn't retained by -- I'm assuming it was insurance defense or the defense team, maybe -- who was it, Teva? Was it -- was it the endoscopy's defense, was it the pharmaceutical defense?

MR. STAUDAHER: Well, I believe --

THE COURT: Do you know?

MR. STAUDAHER: Let me look.

THE COURT: Maybe you guys know, Ms. Stanish.

MS. STANISH: Give me a moment, Your Honor, please.

MR. STAUDAHER: Yes, this was -- and this was the first trial, as my co-counsel pointed out. This was the one that went to verdict, the Chanin matter against Teva and Baxter.

THE COURT: So he would have been the pharmaceutical's paid expert.

MS. STANISH: No, I don't think that's correct, Your Honor.

MR. STAUDAHER: Actually, I think --

MS. STANISH: I believe he was hired by the McFadden law firm that represented the endo center early on. And as I recall, and correct me if I'm wrong, they did depositions in groups. And then -- and then the insurance company settles out with the clinic and doctors and, of course --

MR. STAUDAHER: It says here --

MS. STANISH: -- Chanin.

MR. STAUDAHER: -- that he was hired by the defendants for the Endoscopy Center of Southern Nevada and Gastroenterology Center, as well. So that -- it was Mr. McFadden's.

MS. STANISH: Correct.

MR. STAUDAHER: But that's who he represented at the

time.

MS. STANISH: Correct. And then it settled -- the Chanin case went forward to trial, history is made, but he never -- he did not testify at the trial is my understanding.

MR. STAUDAHER: At least I don't know if it --

MS. STANISH: This is --

MR. STAUDAHER: The only thing we have is a deposition. I've asked Ms. Stanish for anything else, and she --

MS. STANISH: Right.

MR. STAUDAHER: -- doesn't have anything else.

MS. STANISH: We -- we received the deposition from the -- in the State discovery. The deposition and a couple reports that we forwarded --

MR. STAUDAHER: Right.

MS. STANISH: -- since there was --

MR. STAUDAHER: He did a report in Washington, he did a report in Chanin, and I don't know if he's done any others.

THE COURT: So, what, you want to ask him, oh, you were retained by the defense in the civil case and you provided an opinion that said Mr. Chanin didn't contract hepatitis because it wasn't genetically linked? What do you want to ask him?

MR. STAUDAHER: It wasn't genetically linked and he

said that there was no -- even though there was reported no risk factors, he opined that there must be one because he had had a hepatitis C test, and even though there was some questioning about the fact that the doctor he went to did it as a routine because his insurance would pay for it, that didn't matter.

He just felt that there should be a risk factor that this person was not disclosing and, therefore, he couldn't -- he didn't think that he was genetically linked to a reasonable degree of medical probability to that claim. I mean --

THE COURT: And you think that shows what? That --

MR. STAUDAHER: His bias.

THE COURT: -- like he's a hired gun and he'll just say whatever or --

MR. STAUDAHER: Well, I think that there is -- in my opinion, based on what he testified to at the deposition, there was no -- there was no basis for him saying that. He gave enough wiggle room. But to come forward with that kind of evidence and say to a reasonable degree of medical probability he did not get the infection at that clinic I think goes to show that he was essentially bias, that he was bias for the defense in that case. He's been hired by the defense in this case and he's -- you know, it goes to his bias, I believe.

THE COURT: Okay. So his opinion wasn't to -- his

opinion wasn't I can't say that he's linked to a reasonable degree of medical certainty, it was I can say that he's not linked to a reasonable degree of medical certainty?

MR. STAUDAHER: That was my understanding of reading his transcript.

THE COURT: All right. Ms. Stanish.

MS. STANISH: Let me just look to see what words he articulated. They ask how -- how he thinks he was infected and the doctor responds, I can only say that he was infected in that time period, and there are many possible routes of transmission. I'm not seeing where he says to a reasonable degree of certainty that he concludes that he did not get hepatitis C. I think what he was saying was he could not state with -- that there was insufficient evidence to connect him to the clinic with a reasonable degree of medical certainty. Do you find --

MR. STAUDAHER: I will -- I will look --

MS. STANISH: -- a different line?

MR. STAUDAHER: -- for it --

MS. STANISH: I guess my other issue --

MR. STAUDAHER: -- because the issue --

THE COURT: I mean, I think that that's --

MR. STAUDAHER: It says did not believe that Chanin got hep C at the clinic, page 13, from February to July. If I go to that page --

MS. STANISH: I see where you're looking. The question was do you think he contracted hepatitis C. Do you have an opinion to a reasonable degree of medical probability how Mr. Chanin contracted hep C that was diagnosed at the end of July '06? He contracted it sometime in the time span roughly of six months before the time or from going back a couple week before that time, and I think that there -- there's many possible ways that he could have contracted hep C, and I don't believe it was from the colonoscopy.

MR. STAUDAHER: So --

THE COURT: And then he says that's to a reasonable degree --

MS. STANISH: No, he doesn't say that.

MR. STAUDAHER: That's how the question was prefaced, to a reasonable degree of medical probability, and then he says he doesn't think he got it at the clinic. So -- or got it from the colonoscopy, which was at the clinic.

MS. STANISH: But then I -- you know, to put it in context, I think he continues about the -- the difficulty of trying to pinpoint what occurred. And there was something about --

MR. STAUDAHER: He never comes --

MS. STANISH: -- he traveled overseas.

MR. STAUDAHER: -- off that, though. I mean, he never says get, well, you know, he could have gotten it at the

clinic. He maintains that position.

THE COURT: All right. I think it goes to bias. I'll allow Mr. Staudaher to question her about it.

MR. WRIGHT: Well, but --

THE COURT: All right. Kenny, bring them in.

MR. WRIGHT: We object.

THE COURT: I got that from her --

MR. WRIGHT: All right.

THE COURT: -- her lengthy argument that she was -- I mean, you know, I guess you're objecting that you don't necessarily think it's relevant to anything, but I think if --

MR. WRIGHT: I don't think the gastro -- the defendants in there wasn't the defendant here. The defense wasn't -- he had no control over the defense in that case, and if he tries to lump us together, it's -- it's not correct.

And secondly, just to bring out he testified to show bias is fine, but I don't understand that you -- to show bias you then bring out what he testified to, and I don't believe what you testified to. That doesn't show bias. The bias is he's held out to give opinions.

THE COURT: Well, no, I mean --

MR. WRIGHT: So we -- we put on his rebuttal that he's right and his opinion is well founded.

MS. STANISH: Plus the standard of proof in the civil case is --

THE COURT: Well, except he's saying to a reasonable degree of medical probability, which is what they all testify to, that it couldn't have been caused that way, that he didn't believe. Now, if he had stated it the other way, that he couldn't attribute a cause, I think that's -- I mean, I see that as a significant difference. Whether he's saying it wasn't the cause or, you know what, I just can't attribute a cause. To me, those things are -- are very different and, I think, significantly different.

Mr. Santacroce?

MR. WRIGHT: But how do we know he wasn't right? I mean, what's the evidence going to be that that was incorrect?

MR. STAUDAHER: Well, the evidence he reviewed, clearly. I mean, he listed a whole list of things and he gives -- I'm sorry, Your Honor -- he gives his --

THE COURT: Well, how are you going to introduce that?

MR. STAUDAHER: He gives his opinion that -- the reason for his opinion is this, that -- just what I said, there was no genetic link, and that because he believed that there must be a risk factor when, in fact, none was articulated that that must be the reason why he got it.

THE COURT: Well --

MR. STAUDAHER: He has a risk factor that he's not disclosing and that --

THE COURT: Well, I don't think that's so out in left field because typically a physician isn't going to test you for hepatitis C. So I think what he's saying is if he's being tested for hepatitis C, he must have articulated a reason to his physician because that's not a standard -- that's not one of the standard tests.

MR. STAUDAHER: Correct. But then they ask him the questions in follow up, well, do you know if his doctor did that as a routine, if it was because of his insurance. They give the doctor, they give the information, and he goes, no, I don't know any of that stuff. Would it change your opinion? No. I mean, that's -- that's what we're basically at. So if he doesn't take into account that information, if he didn't at least say, well, if that had been the case, that would change my opinion.

THE COURT: Well, I don't want to -- okay. Here's the deal. I don't want to get into a lengthy litigation over the Chanin matter and what he should have known or asked or whatever. Now, I mean, I certainly think it's fair for you to bring up that he was retained, just like the defense did for all of the experts that have testified.

Kenny, I need a minute.

Just like the defense has done for the experts that have testified on the State's side. Oh, you were retained to, you know -- you testified and you -- you know, that the State

wound up subpoenaing that. In fact, they had originally been retained by plaintiff's counsel in those cases.

So I certainly think it's fair and goes to bias that, just like you guys did or the defense did, for those at least a couple of witnesses that the State learned about through plaintiff PI counsel. So they can certainly bring out that he opined in a civil case and that he was retained to do that and that was by the civil defense attorneys, and this was what he opined.

Beyond that there really -- he can't really comment too much because we're not going to litigate the merits of the Chanin case. So, I mean, that's -- that's what he can ask him. You were, you know, a retained expert, who retained you and what was your opinion?

Now, beyond that we're not going to -- as I said, we're not going to get into a mini trial over the merits of the Chanin matter. So, you know, do with that -- you know, do what you will with that, but that's the extent of what the State is going to be able to get into.

I do think it goes to bias that he was retained and he gave an opinion favorable to the defense attorneys in that matter, just like with the State's witness, the defense got to get into, oh, you were retained by the PI lawyers and you gave an opinion favorable in those cases and you made all this money. You know, certainly I think that that's a fair subject

for cross-examination and he can get into it in that limited way. So -- yes?

MR. SANTACROCE: I just want, for the record, to state my objection, as well. I think you've stated my objection, so I don't need to go over it again, but I think to introduce another name and an infected patient, we'll have to re-litigate that issue, put it before the jury. This serves to confuse the jury and it's really kind of a backdoor approach of the State to get in more information about infected patients at Burnham.

So I think that, yes, it's fair game to go after the bias that he was paid by the defense to testify here today, he's testified for the defense in the past and he's been paid for that. But to go into specific names and diseases and what you testified to as to whether he had hep C or not, I think it's irrelevant, it's confusing to the jury, and it's highly prejudicial over probative.

MR. STAUDAHER: We didn't choose the expert. I mean, they picked him knowing full well that he had testified in that case, that it was a non-infected patient, that he actually provided an opinion and that information has been out there, so --

THE COURT: It wasn't -- why don't you do this. Here is, I think, balancing everything you can ask -- don't introduce the name because we haven't heard about this name

before and I think that that would be unduly confusing. Again, I don't want to litigate the infection of this person and whether he got infected or not. He's not a named victim. You know, we're here at the defense's case. I don't want to, you know, open the door.

But, again, you can certainly ask he was retained in one of the civil cases for a non-genetically linked patient who was infected with hepatitis. You can ask what he was paid and that he gave an opinion that -- you know, favorable to the endoscopy center, that he did not contract hepatitis there without getting into the name or who it was or whatever. Just point out it wasn't one of the, you know, genetically linked.

MR. STAUDAHER: Can I at least put out that he -- it was at a different clinic, it was at the Burnham clinic and not the Shadow Lane clinic? I mean, that's germane because it's not a genetically linked patient. I don't want to have -- it's a misperception to the jury that it may be one of the patients like Lakota Quannah or somebody like that who was non-genetically linked who is in our case.

I mean, I understand this Court's stricture on -- on the name. I don't have an issue with that. But as far as at least a different clinic and that he -- am I going to be able to at least ask him what the basis for his opinion is?

THE COURT: Why don't you say this? You know, I don't want to start now -- I mean, I just -- you know, a

non-genetically linked patient who is not part of this case or something like that, not part of this case and you were retained, how much did he get paid, and he gave a favorable opinion that he wasn't infected at the center or he didn't receive the infection through a colonoscopy or something like that. That way we're not litigating a side issue, but the State is able to introduce this kind of, you know, hired gun, bias idea if that's -- obviously you can't refer to him as a hired gun because we know that that would be misconduct, so --

MR. STAUDAHER: And I did not use those words at all.

THE COURT: Right. I'm just saying, I mean, to me that's the gist. Those are my words, for the record, not Mr. Staudaher's words. I'm just cautioning not to use those words because that would be misconduct. But I think that's the idea, that this guy is retained, he's going to say whatever is favorable to the defense.

And, again, the defense has been allowed to cross-examine the State's experts on their bias as a result of having been retained by PI lawyers, plaintiff's attorneys in this -- in the related matters and making a lot of money from that. So I think it's the same -- it's the same line of thinking.

MR. WRIGHT: That's as far as it went, though. I didn't ask a single one of those witnesses, and what was your

opinion and what did you testify to in that other case? The bias is shown by being --

THE COURT: Well, no, I think you did because you got into the whole idea, well, who are you suing and it's the propofol and, oh, and if it wasn't the propofol or it wasn't -- if it was the -- I remember on one if it was the saline then that would be against your theory that it's the propofol. So that did come out. Somehow I remember the -- I mean, the idea was, well, you have to say that it was the unsafe injection practices through the propofol because that's where the money is was the gist of it. Not your words, but that was the -- the import of the cross-examination that I took from it that --

MR. WRIGHT: You're right.

THE COURT: -- that the reason they -- you know, they have to say it is because the saline, there's not -- there's not a lot of money there. And, you know, again, I think that goes to the bias and I -- I don't know that we have to discuss anything.

Mr. Staudaher, I trust you'll stay within the parameter set by the Court, and I'll bring them in.

MS. STANISH: If I may, Your Honor, I just want to tell the witness.

THE COURT: That's fine.

(Inside the presence of the jury.)

THE COURT: All right. Court is now back in session, and the defense may call its next witness.

HOWARD WORMAN, DEFENDANT'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Okay. Is this the mic here that picks me up?

THE COURT: It is.

THE WITNESS: I'm fine?

THE COURT: The black box. Yes.

THE WITNESS: Howard Worman, W-O-R-M-A-N.

THE COURT: Howard, H-O-W-A-R-D?

THE WITNESS: H-O-W-A-R-D, yes.

THE COURT: All right. Thank you.

Ms. Stanish, you may proceed.

MS. STANISH: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. STANISH:

Q What do you do for a living?

A I'm a professor of medicine and pathology and cell biology at Columbia University.

Q And are you a practicing physician?

A In New York State I am, yes.

Q And what exactly do you do as a practicing physician in New York State?

A Well, my clinical work is focused primarily on liver disease, and I also attend on general medicine in the hospital we're affiliated with. And then I do research and teaching at the medical school.

Q And let -- let me have you take us back to your younger days of your medical education. Please describe for the jury your educational background.

A Okay. So I got a bachelor's degree from Coronel University. That was 1981. M.D. Degree from the University of Chicago in 1985. Then I trained in internal medicine at what was then New York Hospital for two to three years. Then I did a three year fellowship in cell biology at Rockefeller University with Nobel Laureate whose name was Gunter Blobel.

Then I got an assistant professor job at Mount Sinai School of Medicine where for a year I had intensive training in liver disease from someone whose name was Fenton Schaffner. I worked at Mount Sinai for three more years, then started at Columbia in 1995, assistant professor, associate professor, tenured associate professor, full professor, until now.

Q And as I understand what you explained to us earlier, you -- you -- are you consulting -- are you a consulting doctor for other doctors who have patients with liver issues?

A Well, yeah, my clinical work would be divided

up into sort of two groups. One is there's a liver clinic at Columbia where there are probably 1,000 or so patients with hepatitis C where the fellows care for them and I oversee them and that's a large group of patients referred to other doctors at the medical center. And then I have a smaller practice where I see patients for second, third opinions who have usually seen gastroenterologists or hepatologists beforehand.

Q And you mentioned that you were involved in research. Could you overview for us what type of research you do in the area of livers?

A Okay. Well, in the area of liver disease, if I go back, I first got into that by studying auto-antibodies in a rare liver disease called primary biliary cirrhosis. After that I did some work in the laboratory on hepatitis C, characterizing some of the proteins of what was then a newly discovered virus. I've done clinical trials for hepatitis C back when interferon and ribavirin were relatively new drugs.

I did two or three clinical trials to treat patients with hepatitis C with interferon and ribavirin, one trial before the drugs were approved. And I've done some other projects in liver disease in the lab looking at some genes that cause fatty liver, involved in a project like that, and I do basic cell biology research, as well, that relates to diseases other than liver diseases.

Q And do you publish articles or review articles

in those journals that most of us don't read?

A Yes. I mean, shall I elaborate?

Q Approximately how many articles have you written in the area of liver disease?

A Oh, I can't say. It's in -- all together I've published about 180 medical articles, and maybe 30 to 40 to 50 on -- somehow related to liver disease.

Q And you are here today as an expert retained by the defense; correct?

A That's correct.

Q How much of your working life is devoted to testifying in -- in or reviewing cases involving litigation?

A It varies from year to year, and I'd say it varies from 10 percent of my time to the most, some years, 15 or so percent of my time.

Q And had you been previously -- had you previously worked for a civil law firm that represented the corporate corporation at the endoscopy center?

A I believe the -- the defendant there was called the Endoscopy Center of Southern Nevada and I worked for a law firm that was defending them.

Q And that case involved a non-genetically connected patient that was -- had nothing to do with the dates of September 21, 2007, and July 25, 2007?

A The case that I testified in?

that there was an outbreak as a result of that showed that there was a risk to patients, so -- but it was based on those two items, the two pieces that -- clearly the unsafe-injection practices.

Q Right. And whether there had been a hepatitis spread or not, you were going to give notification, correct?

A Well, that was part of the discussion. And I can't say what would happen if there wasn't hepatitis because we didn't have that particular situation. So I can just say what we did, and that was --

Q Okay.

A -- to make that --

Q But didn't --

A -- notification.

Q -- didn't you tell Dr. Carrol that in some of the exchanges with him? You just don't get it, Dr. Carrol, even if there had been no transmission whatsoever, the outbreak is what got us into your clinic to observe, and what we observed is infection -- unsafe-injection practices which may put patients at risk, and we're going to send out notices regardless -- regardless of what actually caused the transmission of hepatitis C, correct?

A Yes, that's correct.

Q Okay. And so -- and as I recall, right, in reading one of your depositions, now Dr. Carrol suggested it

could have been -- he was baffled about how it had happened, correct?

A Yes.

Q Okay. And he even suggested -- you met with him a couple times?

A Yes, we did.

Q Right. When he was concerned about whether the notification was premature, or was broader than necessary?

A Yes, that's correct.

Q Okay. And he even suggested at one point that it could have been some person, like, intentionally did this?

A Yes, he did.

Q Okay. And the -- I -- tell me if I'm wrong, but I recall your testimony that he would have note -- given notification even if that was true. If it was, like, caught on videotape, some person having done -- intentionally caused the infections, we still would have given notice because of the unsafe practices we saw?

A Yes.

Q Okay. Now, that -- and that was the basis of your notification decision, and the breadth of the -- the scope of the notification because those practices, as best you could determine, had existed going back four years --

A Yes, that's correct.

Q -- right? Because the clinic told you that we

have not changed anything over the past four years, our propofol use, and what we have done hasn't changed day-to-day?

A That's correct.

Q Okay. Now, when -- when Dr. Cliff Carrol was talking with you and proposing his -- he was questioning whether you all were moving too fast --

A Yes, that's --

Q -- right?

A -- correct.

Q And the -- he showed you his schematic, or chart, that raised questions as to how the contamination could have spread, utilizing your theory, correct?

A Well, I'm not sure how he developed the chart, but yes, he did show me a chart.

Q Okay. He showed you a chart, and it had the rooms separated, correct?

A I don't remember if it did or not.

Q Okay. Well, the -- do you recall that -- I don't know if the chart did or not either, but he -- he was able to tell you what was wrong with the conclusions being reached because he had patients in separate rooms?

A I don't remember that specific --

Q Okay.

A -- part of the conversation.

MR. WRIGHT: I'd like to -- 71.

BY MR. WRIGHT:

Q It's your interview with Metropolitan Police Department --

A Okay.

Q -- in May 2008. Page 71, 72, just read that to --

THE COURT: Is everybody okay?

BY MR. WRIGHT:

Q -- read that to yourself.

THE COURT: Okay.

BY MR. WRIGHT:

Q See if it refreshes your recollection.

A (Witness complied.)

Q Does that refresh your recollection?

A Yes.

Q Okay. And the -- Cliff Carrol had a method of determining which patient was in which room, correct?

A Yes.

Q Okay. And this -- this was in February 2008, correct?

A Yes.

Q Because it -- the notification was February 27?

A Yes.

Q Okay. And this conversation with Cliff Carrol predated the notification?

A Yes, it did.

Q Okay. And it -- it was during -- and did you ask him at the time? I mean, because you all hadn't been able to distinguish rooms, correct?

A That's correct.

Q Okay. And so Cliff Carrol is showing you a -- or talking to you or showing you problems with your theory or your conclusion as to the mechanism of transmission by putting patients in different rooms, right?

A Yes, that sounds correct.

Q Okay. And so did you ask him how do you do that?

A Yes, I did.

Q Okay. What did he say?

A From that interview it was that he had some way of doing it to the computer system.

Q Okay.

A And we had previously asked them for that a number of times, and they were never able to previously provide that to us.

Q Okay. But now -- now, he -- he is -- this is in February and he is telling you it can be done, correct?

A Yes.

Q Okay. And then you didn't pursue that at all?

A To stop the notification? No.

Q Right. And/or to try to figure out which -- which person is in which room, correct?

A I didn't believe what Cliff Carrol had to say, so no, I didn't.

Q Pardon?

A I didn't believe what he had to say, so no, I didn't --

Q You didn't believe --

A -- really --

Q -- him?

A -- no, I didn't.

Q Okay. You thought he was just -- what didn't you believe?

A We had asked him for how to split the rooms up a number of times and he could never tell us, and a week or two before we were going to make this big announcement, all of a sudden he knows a way through a computer system that we can't verify to split the two rooms up. It seemed a little self-serving at the time.

So I -- it wasn't something that was going to change the notification at that point, and that's really what he wanted to do. He wasn't arguing about how the outbreak happened, it was really another attempt to stop the notification.

Q Okay. And so you -- you didn't ask him how he

had come up on this date glitch on the computers?

A No, I did not.

Q Okay. So you just distrusted what he was telling you at the time?

A Yes.

Q Okay. And because he -- Cliff Carrol -- Dr. Carrol just couldn't seem to get it through his mind that this notification was irrelevant, totally irrelevant to the method of transmission of contamination, correct?

A Yes, that's correct.

Q And you had tried to explain that to him that it doesn't matter anymore how the hep C was spread, this notification is because of patient risk, based upon practices that we observed, right?

A Yes.

Q Okay. Now, having made that determination, and of course, you all prevailed and it was notification to patients from 2004, like, March 2004 through January 2008?

A Yes, that's correct.

Q Okay. And you had made some determination as to the prevalence of hepatitis C in Clark County, pre -- already existing hepatitis C, and in the clinic population, correct?

A Yes.

Q Okay. And you expected a back -- what I call in a background incidents. In other words, people that walked in

the door of the clinic already having hepatitis C would be some percentage of the population of the patients, correct?

A Well, I'd use the term prevalence, not incidents, it's an Epi term, but yeah, there's --

Q Okay.

A -- a background rate of disease in the population coming in.

Q Okay. And you made the determination that because -- that the endo -- the clinics, Burnham, Shadow Lane, because of the age of the patients, the age of people that get those type procedures, and the nature of the procedures, that you expected a prevalence of 6 percent, correct?

A I don't think it was that high. I thought it was 4 percent, but there was a background rate in that range.

Q Okay. I'll show you your grand jury testimony.

MR. WRIGHT: 116.

BY MR. WRIGHT:

Q April 15, 2010. Page 116 and going over to 117. Read that, see if that refreshes your recollection?

A (Witness complied.) Yes.

Q Okay. And that's 6 percent, correct?

A Well, like I said, it was the range, and that's the high end of the range. So it wasn't a fixed 6 percent. It was in that range of up to 6 percent.

Q Okay. At most a 6 percent background of

hepatitis C patients walking in the door infected before they ever set foot anywhere near the clinic --

A Yes.

Q -- correct? When you were -- at the clinic, did you meet Dr. Desai?

A Yes, I did.

Q Okay. Do you recall how many occasions?

A It was twice on Thursday. The first time was getting out of the elevator, I was introduced to him, and then our usual Thursday evening meeting or at the end of the day, I went to Tonya's office and he was there.

Q Okay. Now, I have an unrelated question to what we're talking about, but it has come up throughout the trial. Should a known hepatitis C patient, one of those 4 to 6 percent walking in the door, assuming they know it -- now, let me back up.

Of that 4 to 6 percent, some of them might not even know it, right?

A Yes, that's correct.

Q Okay, but assuming I know it, I've got hepatitis C, it's chronic, and I'm hepatitis C positive, I'm going into a clinic for a procedure, are -- are they supposed to treat me differently?

A No, they're not.

Q Okay. What are they supposed to do?

A You assume that every person coming in is basically infected with everything, and so you take precautions to protect yourself and the other patients.

Q Okay. And you're to treat them equally with every other patient?

A You know, like I said, you assume everybody has every disease, so you treat them all equally.

Q Okay. Now, before this event occurred there -- there had been discussions with the Southern Nevada Health District and other agencies in this state about the lack of regulation over ambulatory surgical centers, correct?

A There may have been. I wasn't part of them, though.

Q Pardon?

A I wasn't part of those discussions. I didn't really become involved with ASCs until this particular incident. So what predated the regulatory history of this event, I don't know.

Q Okay. But that NACCHO meeting, do you recall when this was?

A No, I don't.

Q Patricia Rowley is your boss --

A Yes.

Q -- was?

A Was, yes.

Q Office of epidemiology manager here at the Health District?

A Yes.

Q Do you recall at that meeting in which you were present --

MR. WRIGHT: Page 41.

MS. WECKERLY: I think this is hearsay. My objection is hearsay to this.

THE COURT: I'll see Counsel up here.

(Off-record bench conference.)

BY MR. WRIGHT:

Q Take a look at this. I think you looked at it before at deposition, and tell me if that's -- if you are Male No. 1?

A Yes, that's me.

Q Okay.

A Because I identify myself on the first page here, so yes --

Q Okay.

A -- that's me.

Q And you were present at this meeting. And Female No. 2 is Patricia Rowley?

A That's what it says, yes.

Q Okay. And you were -- and this meeting was with NACCHO representatives discussing the outbreak here in Las

Vegas and assisting them in their planning purposes for a template for future notification issues. Is that what this was about?

A We had several meetings around that same topic. I'm not sure which meeting it was, but those -- that was a general topic of all those meetings.

THE COURT: How many meetings did you have about that topic?

THE WITNESS: Three, four maybe.

THE COURT: Okay.

BY MR. WRIGHT:

Q So my -- and were you discussing with them there the various planning that went into it, and the responses of various government agencies?

A Yes.

Q Okay. And at that time was it stated regarding --

MS. WECKERLY: Objection. Hearsay.

THE COURT: Well, let's let him -- I -- I don't think it's offered for the truth, just that that was a topic of discussion and what this witness was aware of. So it can be considered for that purpose.

Go ahead, ask your question.

BY MR. WRIGHT:

Q Do you recall --

Patricia Rowley: We had started discussions about a year before the outbreak about how there was really no oversight with infection control in dentist offices, doctor's offices, ambulatory surgical centers.

Is that accurate?

A If that's what it says she says. I don't --

Q Okay. Well, the -- is --

THE COURT: Well, do you remember that that's what happened, or --

BY MR. WRIGHT:

Q Do you have any memory of this?

A I vaguely remember the meeting. I don't remember the specific details.

Q Do you recall she stating, We were having these ongoing discussions about the lack of oversight and then this happened, and then it's, like, oh, my god, here's our worst nightmare, the thing that we thought might happen because there really is ineffective oversight and now it's happening.

Because the big question that kept coming back to us was this has been going on --

THE COURT: Well, Mr. Wright --

MS. WECKERLY: Objection.

THE COURT: -- I'm going to sustain because you can't just read everything that she said. I mean, you can ask him what he knew, or what his concerns --

MR. WRIGHT: Okay.

THE COURT: -- were at the time, or what the --

MR. WRIGHT: Well, it --

THE COURT: -- you know, he was --

MR. WRIGHT: -- okay.

THE COURT: -- directed to be concerned about or whatever.

MR. WRIGHT: Well, okay.

BY MR. WRIGHT:

Q Do you recall your boss -- do you recall it was a big concern because of the lack of regulation of dentist offices, doctor's offices, ambulatory surgical centers, that something like this would happen, and then your worst nightmare, what you thought would happen, happened?

A I remember discussions about doctor's offices, vaguely over time. I didn't know what an ASC really was until this particular investigation. So any discussions about that prior to this outbreak --

Q Okay.

A -- really -- I don't remember any of those.

Q The -- after -- after the outbreak -- looking at 2008 now, after the public notification February 27, 2008, did you then participate in meetings or discussions about how widespread the practices were in the State of Nevada and what needed to be done about it?

A Yes.

Q Okay. And did that result in another Epi-Aid participation by CDC to come to Nevada to inspect all of the ambulatory surgical centers?

A Yes, it did.

Q Okay. And do you recall that there were widespread practices of multi -- of -- boy, I mix this up every time -- using single dose vials as multiuse vials?

A I remember they identified some of those issues; I don't know how widespread they were or the full details. I wasn't involved in that particular Epi-Aid, so I don't know the details that well on it.

Q Okay. Who -- would BLC have been more involved in that?

A Yeah, it was -- it was BLC and the State Health Division that coordinated statewide. We're only responsible for Clark County and we don't regulate ASCs, so if it was an ASC issue it would have been BLC within the State Health Division that did it.

Q Do you recall that the State sent out a technical bulletin in February 2008 because of the widespread practices?

A I don't know if it was February 2008. I remember them sending out the technical bulletin in response, but I don't know the date on it.

Q Would you look at Proposed R1, sir?

A (Witness complied.)

Q Is that -- are you familiar with that?

A Yes.

Q Is that the notification?

A Well, you were referring to the second Epi-Aid. This was based off of the first Epi-Aid, prior to that second Epi-Aid was ever initiated. This was right after -- if it was February 2008, it would have been right after our announcement.

Q Okay. And it -- so right at -- and the February 2008 date is on there, correct?

A Yes.

Q Okay. And so that was essentially sending out a notice to the State to engage in safe-injection practices and don't multiuse single-use vials of medication, correct?

A Yes, that's correct.

Q Okay. And that was -- and, in fact, that was sent out, correct?

A Yes, it was.

Q Okay.

MR. WRIGHT: I'd move its admission.

THE COURT: Any objection?

MS. WECKERLY: No objection.

THE COURT: All right. That will be admitted. What

was that, R1?

MR. WRIGHT: Yes.

THE COURT: All right.

(Defendant's Exhibit R1 admitted.)

BY MR. WRIGHT:

Q And after what transpired in your investigation, and after that notice going out to all providers in the State of Nevada, then the Epi-Aid -- the second Epi-Aid, the inspection of all the ambulatory surgical centers took place, correct?

A Yes, that's correct.

Q Okay. And it -- it's your understanding that even after that notification and the publicity, there was still multiuse of vials taking place, discovered during the second inspection --

MS. WECKERLY: Objection. Foundation.

BY MR. WRIGHT:

Q -- correct?

THE COURT: Well, if he -- if he knows.

THE WITNESS: Yes, that's correct.

BY MR. WRIGHT:

Q Did you all at the Health District take a personal dislike with Dr. Desai?

A I can't speak for anybody else at the Health District. Every time I dealt with him he was pleasant and I

had nothing bad to say about the dealings I had with him.

Q Do you recall during the NACCHO meeting, people from the Health District referring to him as Dr. Death, rather than Dr. Desai?

A I don't remember that, and --

Q Okay.

MR. WRIGHT: On page 46.

THE WITNESS: (Witness complied.) Okay.

BY MR. WRIGHT:

Q Does that refresh your recollection?

A I don't remember it, but if it's there, that's probably the discussion that happened.

Q Thank you, sir.

THE COURT: Does that conclude your cross?

MR. WRIGHT: Yep.

THE COURT: All right. Ladies and gentlemen, before we move into Mr. Santacroce's cross, let's just take a quick, about 10-minute break until 3:00.

During the break you're reminded that you're not to discuss the case, or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case, and please don't form or express an opinion on the trial.

Notepads in your chairs. Follow the bailiff through

the rear door.

(Jury recessed at 2:45 p.m.)

THE COURT: I'm sorry?

THE WITNESS: The exhibit --

THE COURT: Oh, give it to --

THE WITNESS: -- do you get that or --

THE COURT: -- me.

THE WITNESS: -- do I hand it back to him?

THE COURT: You can give it to me, so I can hand it to the clerk. Thank you. And once again, don't discuss your testimony with anyone during the break.

Ms. Weckerly, I'm thinking you'd better line up witnesses for tomorrow. Line up witnesses for tomorrow.

MS. WECKERLY: Okay. We will try to do that.

THE COURT: I mean --

MR. STAUDAHER: We're -- we're really --

MR. WRIGHT: We -- we get to watch a movie --

MR. STAUDAHER: -- limited on --

MR. WRIGHT: -- tomorrow.

THE COURT: Oh, we can watch the --

MS. WECKERLY: That's true.

THE COURT: -- movie tomorrow. Yeah, that's --

MS. WECKERLY: That's 90 minutes.

THE COURT: -- a good idea.

MS. WECKERLY: And I know Mr. Wright has no objection

to it being played.

(Court recessed from 2:46 p.m. to 2:58 p.m.)

(Outside the presence of the jury.)

(Off-record colloquy.)

THE COURT: So tell him we're ready. Just so you know, one of the jurors has an appointment tomorrow morning, so we'll probably start around 10:30.

MR. STAUDAHER: Well --

THE COURT: That we told him to move, but he --

MR. WRIGHT: Good.

MS. WECKERLY: That's fine.

MR. STAUDAHER: We're trying to get this worked out. We've got one confirmed witness for tomorrow right now, and his flight --

MR. SANTACROCE: Can I use your chart?

MR. STAUDAHER: -- into town is at about 10 or 10:30. So we're -- as soon as she gets here, we can do her.

THE COURT: Can we stick one of the insurance people on?

MR. STAUDAHER: That's an insurance person --

MS. WECKERLY: That's who it is.

MR. STAUDAHER: -- but the problem is --

THE COURT: Is there any local insurance --

MR. STAUDAHER: -- we're trying --

THE COURT: -- people?

MS. WECKERLY: They don't have their documents ready yet. We can watch the video.

THE COURT: Oh, yeah.

MR. STAUDAHER: It's the -- you know, we're in the process of getting it done --

THE COURT: And that's 90 minutes, you said?

MS. WECKERLY: Mm-hmm.

THE COURT: Okay. Then, so for that reason maybe we'll go a little bit later today -- Mr. Wright, a little bit later today, then, since you guys don't have to be back until 10:30?

MR. WRIGHT: Yep.

THE COURT: Of course, that doesn't help any of us, but -- because when -- when we start late, then I have to do my own work. I have to do my own calendar, so it doesn't help me any.

Ready.

THE MARSHAL: Ladies and gentlemen, please rise for the jury.

(Jury entering at 3:00 p.m.)

THE MARSHAL: Thank you, everybody. You may be seated.

THE COURT: All right. Court is now back in session. And Mr. Santacroce, you may begin your cross-examination.

MR. SANTACROCE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Mr. Labus, I represent Mr. Lakeman back here. I'm going to ask you a few questions about what you testified at your direct examination. Is it appropriate to call you Mister and not --

A Yes.

Q -- Doctor.?

A Mister.

Q Okay. So you're not an MD?

A That is correct.

Q When you conducted your investigation of the hepatitis C outbreak, as I understand it, it was a multijurisdictional investigation; is that correct?

A Yes, it is.

Q So it was the Southern Nevada Health District, the BLC, CDC. Anybody else involved?

A Those were the three main groups. CDC was doing their own investigation, but it was kind of as a technical consultation of the Health District. They were functioning under our authority. So the CDC and the Health District are kind of tied together in some ways.

Q Okay. Was the Metropolitan Police Department involved?

A No, they were not.

Q District Attorney's Office?

A No.

Q Okay. You testified in -- in front of the grand jury and you said it was not like a criminal investigation. What did you mean by that?

A We were conducting a public health investigation. We wanted to know what happened. We really don't care who's responsible, who's at fault, if there is anybody at fault, any of those sort of things. We weren't trying to establish guilt or innocence of anybody. We wanted to find out what happened so we could stop it. And the motivation behind it really didn't matter, as long as we could find out what it was and prevent any additional cases from occurring.

Q It wasn't your intent or purpose to prove the mechanism of transmission beyond a reasonable doubt?

A That's correct.

MS. WECKERLY: Objection. Calls for a legal conclusion.

THE COURT: Well, overruled.

BY MR. SANTACROCE:

Q Correct?

A Yes.

THE COURT: He's already answered.

BY MR. SANTACROCE:

Q So basically you were trying to find out, as the CDC put it, the likely method of transmission?

A Yes, that's correct.

Q And when you started your investigation, you went in there with some sort of a theory or hypothesis that it was through unsafe-injection practices, correct?

A That was the top on the list, but it wasn't the only thing we considered.

Q All right. Well, we're going to talk about some of the other things you did consider, okay? When you went into the investigation, I believe you -- the first day you did some records check -- checking?

A The first full day, yes. We met with the clinic, the first day we met with them on Wednesday. Thursday, our first full day of investigation, we went through records.

Q And then, the next few days, I guess you did some observations?

A Friday we did observations, and then it was mostly records the early part of the following week.

Q And did you conduct interviews?

A Yes, we did.

Q Do you know who you interviewed?

A We talked to a number of people walking around the clinics, sometimes -- they weren't really formal

interviews, it was kind of, you know, if we saw something we'd ask whoever was working with it what was going on. We had the people who were responsible for doing different things show us what they did.

We also did blood draws on all the staff members to look for hepatitis C, and many of them said different things because they had an opportunity to talk to the investigators, but it wasn't a -- a formal interview or anything like that.

Q So it wasn't a sit-down interview that was tape-recorded or -- or written or transcribed?

A No.

Q And the people you interviewed weren't necessarily the same people that were working on July 25th of 2007, or September 21st 2007, correct?

A That's correct.

Q Now, when -- when you go into these investigations, I guess you're looking for sort of commonalities, correct?

A Generally, yes.

Q And you said you looked at certain other things other than the unsafe-injection practices. What are some of the other things you looked at?

A Well, we wondered if it was a particular staff member, either directly transmitting the virus to patients, or the particular actions of a -- of one particular person. So

we looked at that. We looked at the cleaning of the scopes. We evaluated the records to really see if anything kind of jumped out of procedure-type, or what -- kind of those -- the common big groupings you could have. Would it be an upper or lower endoscopy? Did they have the same doctor? same CRNA? same nurse? Anything like that.

Q And as I understand it, you didn't have all the information you needed, and what I mean by that is, for example, you didn't know what room these individual patients were in; is that correct?

A Yes, that's correct.

Q And you didn't know what time the procedures that they had actually occurred?

A Well, we had a number of times on the charts, and we had difficulty putting that together into a number that we could say we were absolutely confident this is the exact order down to the minute of how things occurred.

Q But you did come to some conclusion regarding the times, did you not?

A In general, yes, but it was very specific to do a -- a minute-by-minute analysis because that data just wasn't reliable.

Q And I -- I think what you testified to in the grand jury was that you finally came to the conclusion that the nurse's notes were accurate as far as the times went?

A We decided there were a couple things we were going to use. They had a computerized system, so at the beginning of the procedure, I believe, we used the time the nurse wrote down that said, it's now, you know, 3:15 p.m., and wrote that down as when it started. There's some fuzziness to that because it could have been the clock on the wall, they could have looked at the computer, they could have looked at a watch.

So, you know, the -- all the times aren't exactly synched up. For the ending time we had that time as well as a timestamp that was basically when the doctor finished, they kind of signed the chart, and that was a timestamp on there that we would use as the completion of the procedure, basically when the doctor was done. Even if there was 20 minutes of cleaning up and all those things, it didn't matter because we knew the procedure itself was basically done at that time.

Q And I believe you testified that you actually observed the nurses looking at a clock and writing times down, correct?

A Yes.

Q Okay. And you sort of take -- you took that time as -- as being as accurate as you possibly could be?

A That's correct.

Q I want to talk about some of the things that you

investigated, and I'm going to show you this chart -- Exhibit 228 by the State. And these were some of the things that -- who prepared this? You did?

A I did.

Q Okay. The staff, the patient, you ruled that out. You didn't see any -- you tested everybody, all the staff for hep C, they didn't have it, so you ruled that out, correct?

A Yes, and we also had the names of former staff members, and we cross-referenced those against a list of people we knew to be hep C positive in Southern Nevada and didn't find any matches.

Q And the next one, what did that mean, physician?

A Was there one physician. The actions of one physician make it more likely. So, for example, Dr. A or Dr. B was more responsible for the cases than another one.

Q And then CRNA?

A The same sort of thing. Was one CRNA responsible for the -- the cases, or was it a general issue?

Q Okay. And the next one, technician?

A The same thing.

Q Okay. But who -- which technicians are we referring to?

A The technician that was listed on the chart as assisting the provider. The one who basically helped handle

the scope, handed equipment to the -- the doctor. So there was a -- a technician posted right next to the -- the equipment, and that technician's name was on the chart.

Q And you obtained the name of those GI technicians through the patient charts?

A Yes, we did.

Q Did you interview any of those people?

A We talked to some of the technicians, just in the course of our investigation, but it wasn't a formal interview. The techs that were doing the scope reprocessing, we had them show us the process; so we spent a little more time with them, but we didn't sit down and do a formal interview with any of them.

Q Did you interview or talk to any of the GI techs that were reprocessing scopes on the two infection dates?

A We didn't have a list of who was doing that on those dates, so we may have, but I don't know.

Q Well, you said you reviewed the patient charts for those dates, didn't you?

A The techs that are listed on there were the techs directly assisting with the procedure. The one that was reprocessing isn't listed in the chart.

Q Okay. And what is the issue with the scopes? Or what was the issue?

A When the process was presented to us, they'd use

an enzyme detergent, and it goes in a basin and they -- it's kind of like soapy water in your sink with an enzyme detergent. They use that to clean the scopes. They use brushes and -- that detergent is supposed to be used for one scope, and they were doing two scopes at a time. The two scopes were basically done together and then went into the automated reprocessor. So they were using the detergent on more than one scope.

Q And what's the danger with not cleaning the scopes properly?

A There could be a potential transmission of infection if the scopes aren't cleaned properly.

Q Okay. And did you note how long it took them to clean the scopes?

A Yes, we did.

Q How long was that?

A The automated process was about 17 minutes, the overall process was 30 to 35 minutes or so. It took about a -- a half-hour a scope is a safe estimate. They had to do a -- a manual part first, and then it went into one of two reprocessing machines where they passed a high-level disinfectant through the machine and basically sanitized it. And then -- that was -- and then they just -- I think, air dried it or blew some air through it to dry it out there, then hung it for the next person. So it took roughly a half-hour

or so.

Q So if we had testimony from an expert on Friday that says it takes 55 minutes to clean the scopes, they weren't -- they weren't taking 55 minutes, were they?

MS. WECKERLY: I'm going to object. There's no evidence that it's the same machine, same manufacturer, nothing.

THE COURT: All right. That's sustained. You can say that --

BY MR. SANTACROCE:

Q What --

THE COURT: -- there's no -- and then --

MR. SANTACROCE: I'll ask it a different way.

THE COURT: -- anything else is argumentative to the --

BY MR. SANTACROCE:

Q Did you review any of the manufactured-recommended cleaning instructions for the scopes?

A Yes, we did.

Q And how long did the recommended manufacturers guidelines tell you it would take to clean the scopes?

A It was an automated process, and so it wasn't -- I don't believe they set a time on it or it had a time. It was basically press the button and go kind of thing.

Q Were you aware that some -- at some points the

Medivators that clean the scopes were broken?

A Yes, we had heard reports of that.

Q And, in fact, you testified in front of the grand jury as to that, correct?

A I may have.

Q And what did you tell the grand jury that the GI techs would do when the Medivators were broke?

A When the Medivators were broken there were two things. They could get replacement equipment if needed, but there was a manual process where they would basically soak the scopes in the high-level disinfectant, rather than use the machine.

Q And you noted that there was an issue as to the otoscopes they were cleaning before changing the enzymatic fluids, correct?

A Yes.

Q I'm going to show you State's Exhibit 150. Did you ever view this room -- the room where the scopes were hung up to dry?

A Yes.

Q There was testimony in this case that some GI techs, or some nurses observed fecal matter on these chux here after scopes were allegedly cleaned. Did you note any of that?

A We didn't see any of that.

Q Did you talk to anybody that told you that?

A No.

Q If that was, in fact, true, would that be a problem for you?

A It would have been a concern, yes.

Q Now, the BLC -- were you aware that the BLC did a summary statement of deficiencies for the clinic?

A Yes.

Q Had you seen that?

A Yes.

Q Showing you State's Exhibit ADE-3. This is allegedly an observation by the BLC on 1/16/08. The GI tech was asked to describe the measured amount of M power with what amount of water. The GI tech stated, Add two to three pumps. Not sure the capacity of the basin. And then it says, I don't have an answer for that.

Were you -- were you aware of that? Did you observe that?

A Yes.

Q Okay. And the recommendation by the BLC -- are you aware what that recommendation was?

A I remember reading them, but I don't remember what their specific recommendations were.

Q Here it notes -- can you read this? Do I have it down far enough for you? The GI techs cleaned two

endoscopes before discarding the enzymatic detergent solution in a water rinse. Did you observe that too?

A Yes.

Q Did any of the GI techs tell you that they had actually cleaned more than two scopes, possibly six, seven, eight, nine scopes before changing the enzymatic fluid?

A No, they did not.

Q Would that have been a concern to you?

A Yes, it would have.

Q Now, going down your chart here, you talk about biopsy equipment. What was the concern regarding the biopsy equipment?

A If a particular piece of biopsy equipment could have been the source of transmission was something that we ruled out, as not all patients had a biopsy and those with a biopsy were no more likely to be infected than those who didn't have a biopsy.

Q The biopsy equipment was reused?

A That was reported later on. During the initial investigation it was just -- for this particular one, was there an increased risk due to having a biopsy or not?

Q And you ruled that out because of what?

A Not all patients had a biopsy and the -- basically the patients with a biopsy weren't at a higher statistical risk than those who did have a biopsy.

Q I'm showing you Exhibit 157. This purports to be a chart of -- have you seen this before, so I don't have to explain it?

A Could I see the actual chart itself?

Q Sure.

A That may make it a little easier than --

Q Have you seen that?

A Yes.

Q Okay. So you know what it is?

A Yes.

Q Were you aware that on July 25th that the source patient Ziyad Sharrieff and Michael Washington both had biopsies?

A Is that what it says on the chart? I'd have to look and see. I -- it's not on the column up there, but --

Q Okay. I'm asking you if you were aware of that when you ruled out that biopsy equipment was the source of transmission?

A Well, that's not related to that table. That table was about September 21. So we ruled it out for September 21.

Q So this table only applies to September 21?

A That's what the title says at the top.

Q So the biopsy equipment could be the source of transmission for the 25th?

A I didn't do a statistical calculation on the biopsy equipment for that particular day.

Q So, I guess my question is, you can't rule it out for that date?

A Statistically, no, we couldn't do any calculations for that day because there was only one infected person.

Q Now, what's the next thing? The endoscopes, which I believe we already talked about, correct?

A Yes.

Q And the next -- next one?

A Procedure type where patients with a colonoscopy are more likely to be infected than those with an upper endoscopy or vice versa. There was no statistical finding that either one was a higher risk.

Q And bite blocks?

A The same. Same thing. It's very closely tied to the procedure type. Only upper endoscopies had bite blocks.

Q Now, were you aware that they were reusing bite blocks?

A Yes.

Q And the next issue?

A That would be the IV placement.

Q And why did you rule that out?

A In order to contaminate a common saline bag you'd have to have a reentry into that saline bag. It was a single flush on September 21. In addition, on July 25, the source patient didn't go into the IV room, his IV was done in the procedure room. So the -- the IV placement room wouldn't have been a factor if the source patient never went into that IV placement room.

Q Were you aware that there was a mistake on the CDC's report as to who gave the -- who started the IVs on July 25?

A Yes, I believe they had an incorrect name or something on there of -- of who did it.

Q Okay. So the fact that you ruled it out because you believed that the same person started the IV heplocks was incorrect?

MS. WECKERLY: I'm going to object. I think that misstates the testimony.

MR. SANTACROCE: Well, he can state what he testified to.

THE COURT: I'm not -- you can answer the question.

THE WITNESS: From the chart it appeared that the IV was placed in the procedure room, and not in the -- the IV prep room.

Q But that was incorrect that you came to find out later?

A In the CDC report --

MS. WECKERLY: Objection. No -- they're talking about --

THE COURT: Okay. When you say the --

MS. WECKERLY: -- that misstates the testimony.

THE COURT: -- IV placement here, what are you talking about?

THE WITNESS: The -- the patient -- they put a heplock in the arm they could inject into.

THE COURT: Okay.

THE WITNESS: On July 25, the patient didn't go into the IV prep room to get the heplock placed, it was placed in the surgical room itself. And that was based on observations of the patient charts.

THE COURT: Okay.

BY MR. SANTACROCE:

Q Okay. And my point is that the CDC erroneously reported that both patients -- that is, the source patient and the infected patient Michael Washington -- their IVs were not both started in the procedure room.

A I never said that Michael Washington's was. It was the source patient that was starting the procedure. On the subsequent ones for the day would have been done in the -- the IV placement. They basically had their IVs placed in two different places.

Q How about on September 21?

A I believe those were all placed in the IV placement room.

Q Okay. Did you find any commonalities with regard to that?

A No, we did not.

Q I'm going to show you this chart for September 21. The top line is all the patients that were in Room 1. And the bottom line are the patients in Room 2, and those are the patients that were tested and reported having hep C. You see Kenneth Rubino, the source patient, up here?

A Yes.

Q Started by Lynette Campbell in the preop area. Did you interview Lynette Campbell?

A I don't believe that she was one of the people I talked to.

Q Do you see Rodolfo Meana?

A Yes.

Q Started by Lynette Campbell.

A Yes.

Q Sonia Orellana? Lynette Campbell. Gwendolyn Martin? Lynette Campbell. Nguyen Huyhn? Lynette Campbell. Patty Aspinwall? Lynette Campbell. Carole Grueskin? Lynette Campbell. The other two patients were started by Jeff Krueger in the same preop area. Did you note that?

A I'd have to look at the table, but I -- I see what you're saying, yes.

Q Okay. And Jeff Krueger testified that they shared saline in the preop area.

A Okay.

Q Knowing this commonality and knowing the fact that they shared saline, does that give you any cause for concern?

A No, based on the -- the CDC observations of the IV prep room, it was known that it was a shared saline. We -- that's not a surprise. It is a multidose vial, and it appeared to be used appropriately from the CDC observations.

Q Is multidose vials of saline acceptable practice?

A Yes, if the saline is labeled for multidose, and in that case I believe that it was.

Q Going back to the BLC statement of deficiencies, that's Exhibit ADE-3. Calling your attention to this area here, do you see that? What was the BLC's recommendation regarding the intravenous fluids?

A Do not use bags or bottles of IV solutions, a common source of supply for multiple patients.

Q So the fact that they were using it was not appropriate practice, at least according to this; wouldn't you agree?

A Well, according to that, yes, that's what they said.

Q Now, we're going to talk about propofol. And you talked about your theory that the mechanism of transmission was unsafe injection practices contaminating propofol bottles, correct?

A Yes.

Q And you testified that you didn't actually know what room the patients were in, when you came to this conclusion?

A Yes, that's correct.

Q In fact, the CDC issued a preliminary finding before they left Las Vegas in mid-January that the -- that's what they believed the cause was?

A Yes.

Q Okay. We had both of the doctors from CDC testify here, and Dr. Gayle Langley Fischer testified that in order for the transmission to have occurred through contaminated propofol, there would have to be a showing that the bottle traveled from room to room. Do you concur with that?

A I would agree that propofol had to travel from room to room; not necessarily a bottle, but yes.

Q A contaminated bottle?

A Or a syringe that was drawn with contaminated

propofol.

Q Well, her opinion was that the contaminated bottle would have to travel from room to room. Do you disagree with that?

A Yes, I do.

Q Again, I -- I'm going to show you State's Exhibit 156. And I guess it's your belief from the last answer that -- you believe that the contaminated bottle wouldn't necessarily have to go from room to room, but an infected syringe would?

A A syringe that had been drawn with contaminated propofol.

Q You didn't have any evidence that a -- first of all, that CRNAs went from room to room except during lunch periods and brief periods of breaks, correct?

A And on the table here you can see that -- if it's set up by room you see people in both.

Q And we'll get to that. I want to know what you testified to in front of the grand jury. You told the grand jury that you had no evidence, or didn't observe any CRNAs moving from room to room except at lunch breaks or a bathroom break, correct?

A Yes.

Q And you didn't see any syringes go from room to room either?

A That's correct.

Q But it's your theory that on this particular date, September 21, somehow a contaminated syringe went from room to room?

A Or a vial. Well, it had to be one of the two. I wasn't saying it was --

Q Had to be one of the two?

A -- I wasn't saying it was exclusively a syringe, but it -- one --

Q Let's look --

A -- one of those.

Q -- at the chart. Room 1 is on the top of your screen there, okay?

A Okay.

Q You see Kenneth Rubino. That's the source patient, correct?

A Yes.

Q And his procedure started at 9:45, correct?

A What's the column header on that one?

Q Let's take a look.

A I just want to see what's on the top of that --

Q Let's -- actually --

A -- that table.

Q -- let's use the nurses' time because that's what you said, I believe, you relied on; is that correct?

A Well, I don't know what column that is, so...

Q Can you see the nurses' times there? The nurses' log notes?

A Yes.

Q Right here?

A Yes.

Q Okay. And what time does it say Kenneth Rubino started?

A 9 --

Q He's the orange one.

A -- 9:49.

Q Okay. And what time did he end?

A 10.

Q And what time did Stacy Hutchinson -- she's right here, Stacy in Room 2.

A I can't see that on the screen. Okay. There it is.

Q See that?

A Yes.

Q Stacy, Room 2? Then sliding over to the nurses' notes, what time did she start her procedure?

A 9:55.

Q So Kenneth Rubino didn't finish his procedure until 10:00. Stacy Hutchinson began before Rubino finished. So presumably Mr. Rubino was already still under anesthesia at

the time that Ms. Hutchinson was undergoing her procedure, right?

A Yes, that's correct.

Q So somehow the bottle from Room 1, from Rubino, would have had to have been transferred to Stacy Hutchinson, or an infected syringe, correct?

A Yes.

Q Even though both of them were undergoing a procedure at the same time in different rooms?

A Yes.

Q Now, what is the next item here? These are what we just talked about, the sedation and injection practices?

A Yes.

Q Okay. You were a co-author on the CDC's -- on this report here, correct?

A Yes.

Q And let me give this back to you before I forget. Thank you. This is Exhibit 105. What contributions did you make to this article?

A Review and comments on it. The main authors were Gayle and Melissa.

Q Okay. So you reviewed it, commented, signed off on it?

A Yes.

Q And you're aware that their conclusions were

drawn prior to any of the information we discussed regarding the assignment of the rooms, the times, all of that, correct?

A Yes.

Q And you'll notice on the last page, there was a caveat to the report. Do you recall what that caveat was?

A No, not off the top of my head.

Q The investigation and conclusions reached are subject to unavoidable limitations. Do you know what those limitations were?

A Yes, and they're described in the rest of that paragraph.

Q Okay. And that is that it -- the investigation was done over a 10-day period, five months after the outbreak, was subject to recall bias?

A Yes.

Q And in fact, you didn't interview the GI techs that were involved on the days of the infections. You didn't interview Lynette Campbell, who was involved on the infection date, did you?

A That's correct.

Q I have nothing further. Thank you.

THE COURT: All right. Redirect?

MS. WECKERLY: Mr. Santacroce, may I just have that for one second? Thank you.

REDIRECT EXAMINATION

BY MS. WECKERLY:

Q Mr. Labus, Mr. Santacroce showed you State's Exhibit 165, which was the published article about this investigation, just a second ago on cross-examination. And he talked about the reference to the limitations of the investigation, I guess, in this case; is that right?

A Yes.

Q Is that unique to outbreak -- this particular outbreak investigation?

A No.

Q Why is that?

A In an outbreak investigation you're going in after something happened and trying to figure out what happened in the past.

Q Okay.

A So it's difficult to know. You weren't there to observe what happened on those days, and so there's always the potential that people will forget things or do things differently by the time you do your investigations.

Q So there's nothing unique about this particular investigation; those limitations occur all the time?

A Yes, that's correct.

Q And the -- the fact that there was some eyewitness observation of unsafe injection practices by yourselves -- by yourself and members of the CDC, I mean, was

that unique, actually?

A No, in an outbreak investigation sometimes you observe what you believe to be the cause of the outbreak.

Q So there's always sort of a combination of sort of observations and scientific conclusions?

A Yes.

Q Now, you were asked about -- or you were shown the -- the chart of all the procedures by Mr. Santacroce. When you and members of the CDC did the chart review in this case, were you able to establish an accurate order of procedures on September the 21st?

A The order, yes, we -- we're pretty sure that one is accurate.

Q Okay. And were you able to get, like, specific times as to each patient in that order?

A No.

Q Why not?

A There were a number of times recorded in the chart; there were a lot of things that just didn't add up and didn't seem to be correct. We had a lot of difficulty relying on most of the times that were in the chart to do anything meaningful.

Q And, I mean, the chart times are -- are variable, correct? Depending on which time you use?

A Yes.

Q And because of that, is it possible to give a precise order of patients?

A The order, probably, but exactly what time they started and stopped, no.

Q Okay. And -- I mean, was there -- do you know if even the two rooms, as we know now, would have synchronized times?

A There were clocks on the wall; they just looked to be standard clocks. They may have been set differently. We don't know, we didn't -- we didn't check the clocks on the wall, and if we did it was still five months after the fact, so...

Q Now, you were asked about biopsy equipment as a possible source on -- of contamination or of transmission on July the 25th, and I thought I heard you say on cross-examination that you weren't -- you weren't able to do a statistical calculation on that date, like you were for the -- the chart in State's 228, on -- that references September the 21st; is that right?

A Yes, that's correct.

Q And why would that be, scientifically?

A You want to compare people that were exposed to those who are unexposed. And if only one person got sick, he's either exposed or unexposed to each item. So there's really no way to do a comparison of just one person.

Q And that's because the -- the sample of the one person who was exposed, or who tested positive on the 25th, there's -- there's no other way to -- to draw a comparison with him and someone else?

A Right. You're trying to do a comparison of groups, and you have a group of one versus a group of zero. So there's no way to do a comparison or any calculations.

Q Okay. But I think you did talk about how the source patient on the 25th went directly to the procedure room, and that was one of the reasons why you were able to conclude a saline flush was not likely to be the cause of transmission?

A Yes, that's correct.

Q And it doesn't matter whether or not the -- Mr. Washington, who was ultimately infected on that day, had a saline flush because you need contamination from the source patient; is that fair?

A Yes, that's correct.

Q When you -- when you learned of the -- the computer error that could help assign which patients were in which room, did you review your conclusions or did you consider whether or not that information would affect the conclusion you drew regarding how the disease was transmitted on the 21st?

A Yes.

Q And did it affect your conclusion at all as to the mode of transmission?

A No, it did not.

Q Mr. Wright asked you about that -- I think it was a notification that was sent out on -- on, I can't remember which day, but it was February of 2008?

A February 7, 2008.

Q Okay. You have a better memory than me. Was that notification issued before you finalized the Health District report regarding this outbreak?

A Yes.

Q So that was sort of a preliminary warning?

A It wasn't really a warning, it was kind of a separate -- we discovered a problem upon doing the outbreak investigation, and did the notification as a result of that problem that we identified.

Q Okay. And your -- your ultimate report was issued some -- some months later, correct?

A Yes.

Q Mr. Wright asked you about that -- that second Epi-Aid, that -- that, I guess, took place after the one you were involved with, correct?

A Yes.

Q And I think he asked you if you were aware of whether or not the Epi-Aid revealed that there was multiuse of

propofol or multiuse of a certain medication. And I think you said you -- your understanding was that that was the case?

A Yes.

Q To your knowledge was -- did that also include the combination of syringe reuse within a patient, or was it limited to -- to multiuse of medication?

A I don't remember the specific details of that investigation. Like I said, I wasn't involved in that one. It was a different agency, and they did a separate response that we weren't involved in.

Q Okay. And I -- I think when you were asked about ambulatory surgical centers and whether or not there were regulations or whether or not they were properly supervised before this outbreak, really wasn't something that you were involved with or even became aware of until this investigation?

A Yes.

Q So you would have -- I -- limited knowledge of what the issues were with those centers prior to the outbreak?

A Yes, I -- I had seen a report at a conference before about an outbreak at an endoscopy center, but really didn't quite understand how ASCs work or regulated or what their role in medicine really is.

Q Okay. Mr. Wright asked you about your conversations with Dr. Carrol and -- and the notification

process. And if -- if I understand you correctly, the notification is a -- is a response to a -- a public health issue; is that fair?

A Yes.

Q And the -- the purpose of that is so people get treatment or find out what their status is?

A The purpose was for people to get tested, and then, if they're positive, get treated or managed as appropriate.

Q Okay. And it really, as -- as you discussed with Mr. Wright, didn't relate to your conclusions regarding the mode of transmission?

A That's correct.

Q When you were speaking with Dr. Carrol, he brought you, I guess, a chart that was based on anesthesia time?

A I'm not sure exactly what he based his chart on, but he did have a chart that he showed me.

Q Okay. Did anything that he showed you make you doubt your conclusions, or make you think, boy, I got to relook at this whole thing because Dr. Carrol here, you know, seems to have a point? Or was it something that you had already considered or...

A I think the biggest thing I took away from him showing that chart was we identified an additional patient

that we hadn't identified earlier because he had somebody listed as a case that was a name we didn't see.

Q Okay. So it actually --

A It gave us one more case, but that really didn't change anything at that point.

Q Okay. Did it -- did it at all make you question your conclusions regarding the source of transmission?

A No.

Q And as -- as you sit here now, you know, some five or so years later, is your conclusion or belief the same regarding what caused the transmission of the hepatitis C virus to these individuals?

A Yes, it is.

Q It's the same? Thank you.

THE COURT: All right. Mr. Wright, any recross?

MR. WRIGHT: Yeah, just on that.

RECROSS-EXAMINATION

BY MR. WRIGHT:

Q Questions about the second Epi-Aid and whether it dealt with any findings of reuse of syringes, do you recall that another clinic was closed down because an anesthesiologist M.D. was multidosing with vials and reusing syringes?

A Yes, but it wasn't from that report.

Q Okay. It -- it was from BLC inspections?

A Yes, it was a separate BLC inspection of that facility.

Q Okay.

A It wasn't the -- the -- I don't think it was the CDC response on that one.

Q It -- that -- that incident predated the second Epi-Aid?

A I'm not exactly sure. I think so, but I'm not exactly sure.

Q Okay.

MR. WRIGHT: No further questions.

THE COURT: Mr. Santacroce?

RECROSS-EXAMINATION

BY MR. SANTACROCE:

Q When you said you had no statistical comparison for July 25th as to the biopsy forceps being reused, is that the same analysis for the propofol contamination? If you only had one infected patient, can you do a statistical analysis?

A I hadn't done a statistical analysis on the propofol contamination before. All patients received propofol, so there was no non-propofol group. If there were multiple medications used, you could have done a comparison, but I couldn't do it on September 21st because everybody was exposed to propofol. There's no way to compare it to anything else.

Q No, I said, July 25th?

A The same thing on July 25th.

Q Okay. You testified that you had problems with the times, but in front of the grand jury you testified that you came to the conclusion that the nurses' times were the most accurate, correct?

A Right.

Q Okay. And you testified that the sequence of the patients was correct; is that your testimony?

A Yes.

Q So we know, for example, that the source patient Kenneth Rubino, was before this patient in yellow, correct?

A Yes.

Q Okay. And then we know that this next patient happened after that, this one, this one, this one, this one, and down the line, correct?

A Generally, yes.

Q The -- well, you're confident, and you testified that that was correct. Is it correct or --

A Yes.

Q -- not correct?

A Yes, it is.

Q Can you see the CRNAs on -- on what's displayed there?

A Yes, I can.

Q Okay. Can you point to which column that's in? Because I can't see it from here.

A It's the --

Q Just point on your screen.

A Oh, my --

Q Okay.

A That's a --

Q I want to --

A -- CRNA --

Q -- move that over --

A -- okay.

Q -- so we can get -- you can -- tap the bottom of the screen, if you would.

MR. STAUDAHER: On the right-hand corner.

BY MR. SANTACROCE:

Q There you go. Okay. So the sequence is correct, and we know that the CRNAs, according to your testimony, only changed rooms at lunch breaks and at potty breaks, and we know that Kenneth Rubino, Stacy Hutchinson, were contaminated in different rooms, correct? Who were the CRNAs in Room 1 with Kenneth Rubino?

A Keith Mathahs.

Q Who was the CRNA for Stacy Hutchinson?

A Ronald Lakeman.

Q And when did -- and if you look down below Stacy

Hutchinson, who was the CRNA for that procedure?

A Keith Mathahs.

Q So Mathahs didn't come over to relieve Mr. Lakeman for a potty break until after Stacy Hutchinson, correct?

A These times, yes.

Q Times or chronology or sequence of --

A Or the --

Q -- patients?

A -- according to the sequence, yes.

MR. SANTACROCE: Nothing further.

THE COURT: Ms. Weckerly?

MS. WECKERLY: Nothing further.

THE COURT: I'll see Counsel at the bench.

Any additional juror questions?

(Off-record bench conference.)

THE COURT: All right. I have a question on -- changing a little bit.

THE WITNESS: Okay.

THE COURT: Did you video or audio record any of the interviews during your investigation at the endoscopy center?

THE WITNESS: No, we did not.

THE COURT: All right. Is that something you normally do, or no?

THE WITNESS: No, that's --

THE COURT: Or ever do?

THE WITNESS: -- that's not normal in our procedures.

THE COURT: Okay. All right. Any followup to that last question? Ms. Weckerly?

MS. WECKERLY: No, Your Honor.

THE COURT: Any followup, Mr. Wright?

MR. WRIGHT: No, Your Honor.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: No, Your Honor.

THE COURT: Any additional juror questions for this witness?

All right. Sir, thank you for your testimony. I'm about to excuse you, but I must admonish you not to discuss your testimony with anyone else who may be a witness in this matter.

Thank you, sir. And you are excused.

Does the State have any other witnesses scheduled for today?

MS. WECKERLY: No, Your Honor.

THE COURT: All right. Ladies and gentlemen, we're going to go ahead and take our evening recess. We will be reconvening tomorrow morning at 10:30.

May I see the bailiff at the bench.

We'll reconvene at 10:30. During the evening recess you are reminded that you're not to discuss the case or

anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Do not do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

Notepads in your chairs, and follow the bailiff through the rear door. We'll see you back tomorrow at 10:30.

(Court recessed for the evening at 3:47 p.m.)

CERTIFICATION

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

AFFIRMATION

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

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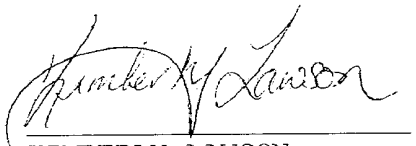

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 40

THURSDAY, JUNE 20, 2013

APPEARANCES:

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

RECORDED BY JANIE OLSEN COURT RECORDER
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INDEX

WITNESSES FOR THE STATE:

EXHIBITS

LAS VEGAS, NEVADA, THURSDAY, JUNE 20, 2013, 9:14 A.M.

* * * * *

(Outside the presence of the jury.)

THE COURT: All right. I just wanted to go on the record out of the presence of the jury. We're still waiting for a couple of late arriving jurors.

On Mr. Santacroce's motion to strike the testimony of the last witness, that is denied. While the Court is concerned about the fact the State isn't proving up the numbers, I don't think striking the testimony is the remedy. I think the remedy is for defense to point that out in their argument that the, you know, testimony may be incomplete or inaccurate or confused or whatever it is you want to argue.

I don't think the remedy is for the Court to evaluate the testimony and then step in and say because I don't, you know, agree with the way the State presented it that it should be stricken. So that motion is denied, and I would remind the State, who is not listening --

MS. WECKERLY: No, I'm listening.

THE COURT: -- that, you know, basically you need to confine your arguments to what the testimony actually was, and in your closing arguments to be very mindful of what the testimony was and not deviate from that. So that's all I'll -- my only comment on that. But the motion, the joint motion to strike the testimony is denied.

MR. STAUDAHER: And just for the Court, also based on the issue of whether they're -- that document that was attached that she testified to was part of the record. We actually are -- have a photocopy of a .pdf version. We'll have the actual version of a COR production from the company with that document attached as -- as being part of it that we will move to admit to allay that issue.

THE COURT: Okay. And then since it's a .pdf version, can you just email that to the other side so they can --

MR. STAUDAHER: I think I did already.

MS. STANISH: Yeah, we received some --

THE COURT: Okay. So you already got that? Okay.

MR. STAUDAHER: The actual hard copy is following. It should be here this afternoon --

THE COURT: Okay.

MR. STAUDAHER: -- or tomorrow. I've got the .pdf now, but I'm -- if -- I'm going to wait to see if we get the actual hard copy by tomorrow to go ahead and -- go ahead and make that as part of the evidence.

THE COURT: Okay. And then I think that was the only pending legal issue. Okay. And then as soon as all the jurors get here, we can get started.

(Court recessed at 9:17 a.m., until 9:24 a.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the deputy district attorneys, the presence the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

And the State may call its next witness.

MR. STAUDAHER: The State calls Miriam Alter to the stand, Your Honor.

THE COURT: All right.

MIRIAM J. ALTER, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Miriam J. Alter; M-I-R-I-A-M, middle initial J, last name Alter, A-L-T-E-R.

DIRECT EXAMINATION

BY MR. STAUDAHER:

Q Dr. Alter, what kind of a doctor are you?

A I have a PhD in infectious disease epidemiology.

Q And can you give is a little bit about your background and training in that area? Tell us where you went to school, what you've done, that kind of thing.

A Okay. Actually, my original degree was Bachelor of Science in nursing from the University of Pennsylvania in 1971. And then went on, actually, to do

infection control in hospitals. Went to Johns Hopkins University for my master of public health and PhD in infectious disease epidemiology, and then went to work for the Centers for Disease Control and Prevention in Atlanta, where I worked for 25 years in the division of viral hepatitis. And as an epidemiologist, that meant investigating epidemics, which is, you know, just the term for the -- the formal definition basically.

Q Well, let's go -- let's go back to the CDC involvement. So when do you actually go to the CDC?

A In 1981.

Q And you said you were there for --

A 25 years.

Q -- 25 years? And it's going to be really hard if we talk over each other, so -- because we have to record this.

A Thank you.

Q If you let me finish my question, I'll try to let you finish --

A No --

Q -- your answer.

A -- it's okay.

Q Okay?

A Sorry.

Q As we go forward, this time that you said you

were in the area of viral hepatitis, did you say?

A Yes.

Q Was that for the entire 25 years, or --

A Yes.

Q So you -- I mean, that was your whole area the entire time?

A Yes. There are --

Q Go ahead.

A Yes.

Q You started to say there --

THE COURT: I'm sorry. Was that yes?

THE WITNESS: There are -- it is -- there are five different types of known hepatitis viruses. They're transmitted in different ways, they have different risk factors, so it's like being involved in five different -- completely different diseases. And their transmission patterns and their public health interventions are also completely different. And there was technology that evolved during the -- all that time that provided a lot of variation in your day to day activities, so it doesn't -- it wasn't boring at all.

BY MR. STAUDAHER:

Q You said five different areas within that? Five different viruses; is that right?

A Yes.

Q Okay. So can you describe for us the differences? And then you said they had different transmission patterns, can you tell us about that?

A You're probably familiar with the term hepatitis A, hepatitis B, hepatitis C, you might also have heard of hepatitis D and hepatitis E. And hepatitis is just a non-specific term for inflammation of the liver. And you can have an inflamed liver for many reasons that have nothing to do with infection. You drink too much, you jogged that day, a variety of medications can have a side effect that can infect your liver because your liver detoxifies almost everything that you take into your body. So it's a filter. It's a big filter.

And if you have too much of something that is toxic to your body, then the liver can react adversely and it produces chemicals in your blood stream which show that you have liver inflammation or liver disease. And all of these things cause the same symptoms and some of the laboratory test results will be the same. But for infections with these viruses, even though they're all called hepatitis viruses, that's because they all inflame the target organ. Where they go when they first enter the body is to the liver, and that's where they replicate and grow and multiply and then get released into your blood stream. That's it's only commonality.

So hepatitis A as you're probably familiar with is very common among young children. It's due to poor hygiene. The route is actually fecal oral, eating contaminated foods, that type of thing, changing diapered children without washing your hands.

Q So hepatitis A is not a blood-borne type of --

A It can be under very unusual circumstances, but it has a very short period in which the virus is in the blood, so it's unusual. The circumstances under which it's transmitted by blood are unusual and are not part -- are not common -- commonly -- common in the hospital, in the healthcare setting.

Q So hepatitis E, if I under -- or, excuse me, A, as I understand it that would be -- the transmission route would be fecal oral from contaminated food and the like, is that fair?

A Right. You know, and particularly among contacts in the household where, you know, someone is preparing the meals and, you know, food can get contaminated.

Q So what is the next one?

A Hepatitis B and hepatitis C are both blood-borne viruses. They're completely different viruses. In fact, all these viruses are completely different. They're only commonality being the term hepatitis. And they're both transmitted by the blood-borne route, which means that virus

from the blood of one person goes -- if it gains entrance into the blood stream of another person, it can cause infection. This occurs through breaks in your normal barrier, mucus membrane or skin barriers.

So this can happen by, before screening, blood transfusions, injections, contaminated injections both from illegal as well legal drug use, sex are the primary modes of transmission. Now, for hepatitis B, actually, sex is one of the biggest risk factors even though it's a blood-borne virus. And for hepatitis C, direct blood to blood is the most common method, although it is transmitted sexually, as well.

Q Is that a lesser component, though, of transmission?

A Yes. For C, yes, it is.

Q Now, you mentioned the other ones. I think you said D and E, also. What is -- what are they?

A Hepatitis D and hepatitis E, again, two entirely different viruses. Hepatitis D is actually -- is -- is not as common in the United States, and it's also a blood-borne and sexually transmitted virus. But it's got a problem in its genetic code, and it can only be transmitted along with hepatitis B. So -- but it's not that common. So it has the same transmission modes.

Hepatitis E has the same transmission mode as A -- see, I told you it was not a boring career -- in that it's

transmitted by the fecal oral route. But it's rarely seen in the United States and other western type countries. It's more common in countries that have poor -- really poor sanitation and monsoon rains that then swell the rivers and you've got a lot of refugee camps and the rivers -- the drinking water is downstream from the latrines and you see the point. So they become contaminated and you get large outbreaks.

Q I'm going to focus primarily on the hepatitis C aspect of things, maybe B if it -- if it's germane to whatever you need to tell us. But you had mentioned that you did over this 25 year period outbreak investigation; is that -- is that correct?

A Yes, that is correct.

Q Can you tell us what that means and how you typically go through when you get a call, or how -- how does it happen? How does it work?

A Being a federal agency, the Centers for Disease Control and Prevention has to be invited by the state health department to come into the state and investigate whatever it is the state thinks is a problem, unless, of course, those rules are suspended in an emergency. But other than that we usually receive a call from the state or county health department telling us they think they have a problem and they'll describe it to us, and we -- and -- and then after usually a few discussions they will invite us in.

And so several -- usually several people from the division that's appropriate for that disease will -- who have been trained in epidemic investigations will go to the state and assist the state and local health departments in the investigation. So you want to confirm that, in fact, they have an outbreak. You want to confirm what the outbreak is due to, in other words you want to confirm the case, the case diagnosis and -- before going any further.

Q And before I go any further, I neglected to ask you are you still working at the Center for Disease Control?

A No, I am not.

Q Where is -- are you still working at all at this point? And when I say that as in an academic or any other setting?

A I retired from CDC in 2006 and went to the University of Texas medical branch in Galveston as the Robert E. Shope professorship in infectious disease epidemiology.

Q And you were there until what year?

A The end of 2011.

Q And then did you completely retire, at least from that aspect of your career?

A From the -- well, I still teach. I'm an adjunct professor. I teach, I consult, help people with study design and making sure that -- you know, helping them with

their methods for researching any kind of disease, which is what epidemiology is. And -- and I also do a little private consulting.

Q In this particular instance, I mean, were you asked to consult regarding an outbreak that here occurred locally?

A Yes.

Q And we'll get to that in a moment, but I want to go back to the -- the beginning, the --

A Right.

Q -- outbreak investigation that we started with, you know, the process that you go through. You said that one of the things that you do is -- I mean, you being the CDC, and I'm having you wear that hat for the moment, if you would. When you get the information and you decide if you're -- what you're going to do to help the state that's asking for your assistance, you mentioned that you had to do some sort of confirmation or confirmatory testing. Can you describe what that is?

A Well, in this particular instance?

Q Well --

A Or in any --

Q -- in general.

A -- instance?

Q For hepatitis C, let's say.

A Actually, in any instance you would want to make sure that the test results were consistent with the diagnosis that you were being told these people had. So you either rely on a formal laboratory report from local health departments, or from the local laboratories, whoever did the testing, as well as usually, if you have time, asking them to send samples to the CDC so the CDC can begin its own testing, just in case additional testing is required.

Q So what kind of testing would the CDC do over and above whatever was done locally?

A Well, that depends on what was done locally. But for hepatitis C, often the screening antibody test is the only test that can -- may be done initially. And that test needs to be confirmed that it's actually real and not a false positive. And then you want to go on to determine whether or not that person continued to -- had recovered or continued to circulate virus in their blood.

Q Do you ever do any kind of genetic sequencing and matching to try and see if you can source the patient, so to speak?

A We do, yes. We often are called upon to do genetic sequencing to determine the relatedness of viruses from different patients. Under those circumstances -- under most circumstances we only do that -- see, I still talk like I work at CDC -- we only do that if an investigation is also

being carried out.

Q Assuming an investigation is being carried out, I know we kind of jumped the gun with that a little bit.

A No, that's okay.

Q But assuming that has occurred and the testing -- you've confirmed whatever you needed to confirm at that level, now we're onto the genetic sequencing. What kind of information are you trying to get out of that kind of work?

A That's really -- you really -- you want to jump that -- because you wouldn't -- you want to jump that far? Q Then let -- then let's back up, then. I don't want to jump that far.

A Okay.

Q So let's go back to the investigation stage and let's pick up where we left off and you continue on.

A Okay. So -- so we arrive, you know, and we look at the information about the cases that they already know about. And then we try and identify additional cases from a variety of sources. In this particular disease, many people don't show any symptoms initially. So it's really hard. So you may not get a lot of clinical case reports, but there may be some that were overlooked. And you -- so you'll do a variety of surveillance over on different day to day basis or by surveying physicians most likely to see people with hepatitis and determine if there are additional individuals.

Most importantly, however, you then interview or at least review the records of these patients to determine their characteristics. What is it about them that might be common? Are they -- you know, this is the first thing you want to do. You want to find out everything you can just about the cases you know about because that will allow you to generate hypotheses that you can then test with your studies, with the study you're going to end up performing.

Q Okay. So you -- you go through that process.

A Right.

Q What would be the next logical step, then?

A Well, then because of the disease being non -- subclinical in a lot of cases, meaning people don't have any symptoms, they -- we would -- if we can focus in, in this instance you can usually -- you can focus in on two days, one a date in September and a date in July.

And so you then want to test all the patients who had procedures around that area to see if you can identify additional infections. Which the more cases you have, the more you have to analyze, the more robust, in essence, your analysis is, not with respect to the laboratory sequencing, but with the epidemiological analysis. And I'll explain that.

So we would go and focus in on what we think might be the exposure period and what was common to the patients, in this case it was those two days, and attempt to identify the

infection status of all the patients before, during, after to see if we could identify additional infections.

Q Okay. And once you start going through that process?

A After we've done that, and you never get everybody, after you do that then you start looking at the -- in this case since the only common factor among the original cases was -- were their procedures at this particular clinic, you're going to look at the clinic and what all of those patients had in common during their procedures while they were at the clinic.

And you -- and then you start thinking about, well, what exposures would cause blood-borne transmission? Remember, blood has to get into the blood stream of a susceptible individual. So it has to -- there are only certain ways that can happen. So it has to get through your natural barriers of skin or mucous membrane.

And so you start generate -- so you then -- you look at all the clinic's procedures and you observe the procedures that might be an issue or different exposures that might -- and you go through everything written, procedures, you interview the staff, you interview the patients, and you observe and you read the -- yeah, and you observe. And then that helps you focus your formal study, which will compare infected patients with uninfected patients to see what was

different. And that -- that's the essence of epidemiological methods. And can I give an example that might be --

Q Sure.

A A new drug, someone is developing a new drug to treat diabetes, let's say. So in order for the drug to be licensed by the FDA, they have to test it to make sure that it works and that it's safe. But let's just go to the work part. In order -- they need to show that if they treat people with diabetes with this drug they get better more often than if they're not treated with that drug, okay. But it's never 100 percent. I mean, in other words, no drug is 100 percent effective.

So let's say they treat people with a certain type of diabetes with this drug and 60 percent get better. But of the people who weren't treated with the drug, only 10 percent got better. Well, that's a pretty big gap. And, you know, it's a very simple explanation, but you can -- you know, that's in the news all the time about -- nothing is ever 100 percent is the point.

And so you can see that the drug actually did have an effect, even though -- on people who took it versus people who didn't with the same disease. So that's an example of what you are doing here. You are comparing the types of exposures patients who got infected with had versus patients who didn't get infected. What's different?

Q So what kinds of things in a -- and you know the setting that we're talking about.

A Yes.

Q An endoscopy clinic, outpatient setting, patients having basically two types --

A Right.

Q -- of procedures.

A So obviously you're going to look at the date of the procedure, you're going to look at the timing of the procedure compared with everything you know about the infection status of the patients who had the procedures during the time period of interest. You're going to look at specific procedures such as the type of procedure they had, what scope was used, what the -- what medications they received, how they received them, and the process of giving them the medications. You'll look at the staff members who were assigned to those individuals. You'll look at the timing of the cases relative to the potential source patient because presumably you had to have a source patient, someone who was infected in order to serve as a source for transmission to other patients.

Q Along those lines, I mean, do you -- when you look at various things related to -- and let's -- let's talk about an endoscopy clinic type thing, what types of things would you look at as possible modes of transmission in that setting?

A Well, the first thing people look at are the scopes themselves to see if they've been properly disinfected between patients. And -- as well as what type of procedure the person had. Because if you have an upper GI versus a lower GI, they're two different scopes. So someone who gets a colonoscopy has a scope that's completely different from someone who gets an upper -- an upper GI. So even if the records were not accurate, you would know that the same scope was not used. Plus, it requires time to perform high-level disinfection on each of the scopes that are used.

So basically the first thing you would do besides looking at the procedure for disinfect -- cleaning and disinfection of each scope is what procedures the patients had and compare the frequency, let's say, of colonoscopy in the infected patients versus the frequency with which uninfected patients had that procedure, the frequency of biopsy in the infected patients versus the frequency of biopsy in the control patients, and whatever else is involved, let's say, in -- you know, that might be unique to these procedures.

And what you're looking for is a -- well, when I say a statistically -- a statistical, significant -- significant statistical difference between the frequency in the infected and the frequency in the uninfected to point you in the right direction, point you in the direction of where the contamination might have originated.

In this situation it was not the scopes because the frequency of procedures, the different procedures were not different between infected patients and uninfected patients.

MR. SANTACROCE: Objection as to that conclusion. If she's making a personal opinion, that's fine. But if she's making a definitive statement as to the legal conclusion, I object to that.

THE COURT: All right. Well, I think it's clear it's her opinion as to --

MR. STAUDAHER: Yes.

THE COURT: -- based on reviewing the records.

Correct?

THE WITNESS: That's correct.

THE COURT: Okay.

BY MR. STAUDAHER:

Q And you're not here to make legal conclusions; correct?

A No, I'm here for science --

Q So you're just going to --

A -- and medicine.

Q -- tell us what you know based on your analysis and 25 years of doing this --

A Yes.

Q -- is that fair? Okay.

THE COURT: And, ladies and gentlemen, at the

conclusion of the trial when I give all of the instructions, there will be an instruction pertaining to this type of testimony, which will cover not only testimony you've heard from this witness, but, you know, other witnesses that we've heard through the course of the trial. And it will describe -- I'm not going to paraphrase the instruction because I get in trouble for doing that, or could get in trouble.

So, Mr. Staudaher, go on.

MR. STAUDAHER: Thank you.

BY MR. STAUDAHER:

Q So at least your opinion based on the issue of the scopes was that it was not the scopes in this case?

A From an epidemiological point of view, it was not the scopes.

Q Now, there were other areas. You mentioned biopsy forceps, things like that.

A There was no difference in the frequency with which the patients who were infected got biopsies compared with patients who were not infected. Now, often an overall comparison like that might not show you -- might not show anything. And based on observations and information that you get while you're there, you might say to yourself, well, I don't know, I don't feel like I've looked at this sufficiently and you might then want to, you know, cut it down into different categories like that morning, that afternoon, or the

next day, or by a certain person, you know, to see if these procedures, for example, either the scope or the biopsy had any relationship to the infections on a smaller scale or a different scale just to make sure that you've covered your bases.

Q Okay. Did you see anything along those lines that cause you concern?

A No.

Q So at least from that perspective the same analysis for the scopes and the snares, did that, is it fair to say, eliminated those as --

A Yes.

Q -- transmission possibilities?

A Yes.

Q What about the issue of cleaning? What if it was not what was believed to be the case?

A Well, despite -- even though they did cite some -- some small, minor deficiencies, their high-level -- their cleaning and disinfection of the scopes was according -- was very strictly followed.

Q So --

MR. SANTACROCE: I'm sorry. I didn't hear that. Very strictly what?

THE WITNESS: Followed.

MR. SANTACROCE: Followed.

BY MR. STAUDAHER:

Q According to the records and so forth that you reviewed; right?

A Yes.

Q What if that had not been the case? What if the scope cleaning had been less than, well --

A Optimal?

Q Optimal. That's a good word.

A Well, one, you would have made them change, and, two, you would have -- you're looking at it, but still you'd have to consider the epidemiological -- see, to me, that's very -- epidemiology is a very powerful tool all by itself. And if it's done right, when you can make that comparison of patient, the frequency of a procedure in -- in the infected patients versus those who didn't get infected and you see absolutely no difference, then even though disinfection may not have been ideal, you've got to look elsewhere. You have to look elsewhere for other types of exposures. And, in fact, I don't think we've ever had an actual outbreak related to -- of a blood-borne virus related to the scope itself.

Q Let me talk to you about the --

A At least hepatitis C anyway.

Q Since you've done this for -- for quite some time, are you familiar with the literature in the area?

A Yes.

Q And when I say that, I mean records of and reports of infections across the United States.

A Yes.

Q For many years?

A Yes.

Q Have you actually been involved in outbreak investigations pertaining to endoscopy type clinics or centers or transmissions in that setting?

A Yes.

Q Have you done a number of them in that regard?

A Yes.

Q Now, as far as the investigation, I mean, I imagine that over the 25 years that you were there that your role at least in the process maybe changed a little bit, supervisor, actually in the trenches, that kind of thing, is that fair?

A That's fair.

Q Did you actually go out and do investigative work at some stage of your career?

A Yes. Early in my career, which is true for everybody at CDC, you get to go out and actually do the investigations. And as you remain at CDC and keep getting promoted, then you're in a supervisory capacity and on the phone usually every day with your what we call epidemic

intelligence service officers who are sent out, you know, who are the ones you're supervising who are actually onsite doing the investigations.

Q So what is the purpose of that interaction that you have with the people that were actually in the field once you're in that role as a supervisor?

A Well, presumably we know more than they do because they're young and we're not, and we have a lot of experience. And so we're making sure that they are getting all the information they should be getting, they're drawing the proper conclusions, they're doing the types of comparisons that they need to do, that they've covered all the bases that they need to cover at each step along the way because you don't want to have to go back.

Q So if you are -- if you have somebody even that's relatively new in the field, a year or less, whatever, and you're having communication with that person, I mean, how does that -- how does that work? What do they -- what kinds of things do they tell you and then what do you respond as far as follow up?

A If they're listening to me or not?

Q Well, I mean, is there a way to determine if they listened to you? Do you follow up --

A If they're listening to me --

Q --and say did --

A -- then they --

Q -- you do that?

A Well, hopefully they're, you know, on the right track. They'll be telling me -- first they're telling me all about the cases, and they're going to be telling me how they're going about identifying the steps that I described earlier. I want to hear that they've done all those -- they've gone through all those steps and what the results have been, okay. And so if anywhere along the way I think that they need to delve further, I will tell them to do that.

Q And then do you ask them in follow up what was the result of that?

A Absolutely. And then as they start to -- when they generate -- for example, then they're going to have to design a question of some type. So they'll send it to us, email is a wonderful thing, and we will look it over and offer suggestions. And probably they've taken some examples of questionnaires used in previous outbreaks with them, as well as publications of previous outbreaks to help them, you know, along the way, and they'll revise it and, you know, use that. And then we'll decide upon it together upon a method of study, how the study will be conducted to determine the source of the outbreak, the extent of the transmission, and what we need to do to prevent it, either prevent it from continuing or prevent it from occurring someplace else.

Q Whether you've been in situation where you're a supervisor or actually in the field doing the actual investigative work, do you -- as part of your epidemiologic investigation, do you ever have a situation where you see something that is -- you know, you've got your, I assume, your likely causes, or the possibilities anyway for a situation like we're talking about here, correct, as far as how it would actually occur?

A Right.

Q If you see one of those things in practice, you're out there and you see them do something like that, do you stop there, or do you continue to look at other things to make sure?

A You continue to look at everything that could possibly be a cause. And this actually has been an issue between supervisors and young investigators. Because the young investigator who hasn't completed their training in epidemiology will say, well, it's so obvious, you know, it was this or that. And we'll say, no, you have to do the study. You have to show definitively that it was this or at least, you know -- you have to show that it was likely this versus something else in order for your investigation to be useful.

Q Is that invariable in all cases that you go through that process?

A Yes.

Q Okay. Have you ever been involved in a case where you did not go through that process, you just shortchanged it and --

A Not at the CDC, no. Not when the CDC was involved onsite, no,

Q Now, as far as the literature that you described or that you said that you have at least been aware of over the years, I mean, are we talking about one, two, three studies? I mean, how many studies are we talking about?

A That I'm aware of, hundreds, but that I've been involved in, many. But, you know, since -- especially in the last decade, 10 to 15 years because they've been increasing in -- there's been an increased reporting of these episodes of transmission in outpatient healthcare settings. So it's many. I don't know how many, but many.

Q Does that have to do with anything related to whether testing was available back then versus now?

A I think -- I think that for hepatitis C it is -- there's an increased awareness, and also I think a health department that identifies a case that tests positive may be -- and the only -- and someone without traditional risk factors might be more likely to call us and say we have this case that might have had a healthcare exposure, but we don't know. Whereas, now that we have the ability to go in and test people so we can determine the extent of the problem as

opposed to relying on just clinical symptoms probably makes it more likely that they will report it or recognize it.

Q With regard to those studies, have -- and I'm talking about the -- not necessarily just the ones you've been involved with --

A Right.

Q -- but the hundreds of studies that you've -- you've looked at over the years, have a number of those been in areas involving colonoscopy, endoscopy, that kind of thing, in a -- in a setting where those kind of procedures are done?

A Yes, a number have been.

Q Have you been directly involved in any of those?

A Yes, I have. In fact, directly involved in the first one we ever investigated for hepatitis C.

Q Can you tell us about that one?

A That one occurred in New York City.

Q And the year, roughly, if you know?

A 2001.

Q Okay.

A And it was actually interesting because four people developed acute symptoms of hepatitis, symptoms of hepatitis and were actually hospitalized. And they were middle-aged people without traditional risk factors. And it just so happens that the gastroenterologist on call that

weekend was their gastroenterologist and he recognized that all four of them had had procedures at his -- in his practice, at his private practice. And so he called the health department and reported it. And that was the initiation of the investigation.

And what we found is that these four patients had procedures over a three-day period. It was actually about 48 hours, but a span of three days. And so we -- in order to look for more patients in addition to existing data, like surveillance, etcetera, we chose that week before, during, and after those three days to find as many patients as we could and test them to determine if we had any other infections.

And to make a long story short, we did find a source patient. Someone known to be chronically infected who had the first procedure of the day on the first of those three days. And we found -- and then we found that all of the patients who became infected, newly infected, followed that patient, but also over a 48-hour period. So they began on different days. They had their procedure on different days, but consecutively.

And after an intensive investigation in which we compared all types of exposures, including the scopes and the injection practices, the anesthesiology, the sedatives, we couldn't identify a difference, something that stuck. Everybody -- the procedures and writing were correct, the observation of personnel actually performing procedures was

correct. There were some problems with the high-level disinfection, but nothing that would -- everybody had a different procedure, particularly the source patient had a colonoscopy and the next infected patient -- next patient to become infected did not.

So, you know, there were a lot of -- they just -- there was not commonality. And because everyone gets sedation from, you know, the same sedation, you really can't -- you can't compare them with respect to that. And so on the last day that the team was there it was suggested to them that they might want to look at the purchasing records for needles and syringes for the anesthesiologists. And they did.

And they found that while the IV catheters, number of IV catheters coincided with the number of patients who had procedures, not one to one, but close, however, the number of needles ordered compared with the number of procedures didn't even come close. So there were like 600 needles, new, you know, sterile needles ordered that attach to syringes compared with, I don't know, over 2,000 procedures.

And since we know that patients got multiple doses of sedation during their procedure, they should have been using a sterile needle, especially because they had multiple dose vials. In this case it was a different type of sedative than the one involved here which actually comes in multiple dose vials, but the anesthesiologist had denied reusing

syringes and needles. Well, this suggested that, in fact, that was not true.

And when confronted with the purchasing information, the anesthesiologist admitted to reusing syringes and needles on one patient, discarding the syringe and -- and going back into a multi-dose vial with the same needle and syringe that he used to inject that one patient with subsequent dosages -- doses of sedative, and then that multi-dose vial was then used for the next patient, with a new sterile syringe and needle. But that vial was now contaminated, presumably contaminated. And it turns out that they had just switched to large vials of this particular sedative.

And we were able to show that if -- if a new vial had been opened on the day for the first patient who was the source of the outbreak, it would have let -- given the average dose that the patients received of this particular drug, would have lasted the 48 hours or over the three-day period that the patients became infected. And -- and the procedure was that these vials would be used if they were -- if they were not used up at the end of the day, they were kept for the next day.

So it was actually only that way that we were able to determine that in fact there were unsafe injection procedures being used in the clinic that put patients at risk of -- of transmission. It was the only thing we could

identify, and, it turns out, is a common problem. Much more common than we'd like to believe.

Q So when you looked at that, I mean, that's 2001. I mean, that information gets published, I assume?

A Yes.

Q Okay. So 2001, fast-forward to you and this case today, did you see similarities, striking similarities between the two cases?

A This -- these practices of reusing needles and syringes or even just syringes and contaminating vials that are then used on subsequent patients is -- has been the source of many outbreaks, and continue to be primarily, but not exclusively, in outpatient settings.

Q So in the studies you've looked at in outpatient settings, just so I'm clear, this issue of contaminated multi-use vial being used on the next patient kind of thing is something that has been reported multiple times --

A Right.

Q -- before?

A Yes, it has.

MR. SANTACROCE: I'm going to object. Asked and answered. Your Honor, can we approach?

THE COURT: Sure.

(Off-record bench conference.)

THE COURT: All right. Mr. Staudaher, please proceed.

MR. STAUDAHER: Thank you, Your Honor.

BY MR. STAUDAHER:

Q And I'm not even sure where we left off, but I'll try to pick up. I was -- at one point I was asking you about the various studies related to these types of clinics. Are you with me again?

A Yes.

Q This type of thing, the 2001 study that you mentioned, as well as your review of this particular case, are there other like outbreaks that have occurred with similar results?

A Yes.

Q Okay. And in the studies that you have looked at over the years, I think if I -- I just want to make sure the -- the scope issue that you mentioned, has that ever been shown to be a source of transmission in any of those?

A No.

Q What about some of the other items that were -- that were looked upon by the CDC as possible modes of transmission?

A No. The only -- other than an infected healthcare worker who was abusing narcotics and therefore contaminated a multi-dose vial of a narcotic by self injecting

and then contaminating the -- you know, using the contaminated needle and syringe so that it was the healthcare worker's virus that was transmitted from patient to patient. Other than that, all of them have been the result of what we now refer to as unsafe injection practices.

Q Can you describe for us what you -- what you view as an unsafe injection practice?

A Well, anything that enters the body through your normal barrier, skin or mucus membrane, should be sterile. You would expect to go into an operating room and everything that they use would be sterile if it was entering your body, and injections are no different. And so once a needle and syringe have been used to access your blood, whether it be through IV tubing or direct, you know, through a vaccine injection or something, it's now contaminated. It's no longer sterile.

So if you reuse it on the same patient with the same medication, that's fine. But if you reuse it and any part of that is used on another patient, you've broken the barrier of sterility and that next patient is exposed to a non-sterile product.

Q In the -- in the literature and training and so forth, and I'm talking about primarily here nurses, nurse anesthetists, things like that, are you familiar with the training that those individuals go through on that issue?

A Yes.

Q Can you tell us about that?

A Nursing, when you go to nursing school, no matter what school you go to, they actually have in textbooks and in practice a curriculum that specifically addresses the safe way to provide injections or injectable therapy, whether it be directly, you know, into your -- you know, like by vaccine or through an intravenous setup of some type, and they're very specific about the fact that these practices must be what we say must conform to aseptic technique. Aseptic meaning the lack of any contamination.

Q So is it fair to say that in that information that you've reviewed, the textbooks and the like, is that part of the basic training?

A Yes, it's part of basic nursing training.

Q With regard to that, even though there are outbreaks that have occurred over time, is that information continuing to be disseminated on each one of these outbreaks?

A Yes, the information continues to disseminated.

Q So not only in training. I mean, I'm talking about the textbook kind of thing.

A I must -- I may have misunderstood your question. When you say after the outbreak -- when we do the outbreak investigation, we then disseminate the information

that unsafe practices are being used and this is what you should do. But in a continuing medical education you mean? Like yearly --

Q Actually, the first part is what I was asking. After an outbreak --

A We publicize in various ways what it is that people are doing and what they -- what they're doing wrong and what they should be doing.

Q So I want to ask you about another outbreak, if you're familiar with it. In August of 2002 in Oklahoma there was another outbreak of hepatitis C related specifically to actions of a CRNA. Are you familiar with that?

A Yes.

Q Can you tell us about that?

A Is this the pain clinic or the oncology clinic?

Q If there's a document that you need to refresh your memory, I can provide it to you.

A Just -- yes, would you mind? I'm just like -- right now I just --

MR. STAUDAHER: May I approach, Your Honor?

THE COURT: Sure.

MR. STAUDAHER: And, counsel, I'm showing the MMWR, Morbidity and Mortality Weekly Report, September 26, 2003, Volume 52, Number 38.

MR. WRIGHT: Thank you.

BY MR. STAUDAHER:

Q And this is page, I believe, 903 of that.

A Okay. It was the pain -- pain clinic.

Q If you -- if you need a moment to look at that you can do so and then I'd like to ask you a couple of questions.

A Oh, yes.

Q Okay. Can you tell me about this?

A In this instance the -- this was a pain remediation clinic where people go to get pain meds for chronic pain, like back pain and a variety of other maladies. And the individual providing -- who was providing the pain medication to these patients through a heparin lock, actually, which is -- you've probably already heard that described -- with a -- filled a large syringe with the pain medication, and then went from one patient to another with the same syringe and injected them with the appropriate amount.

I think the same needle, too. That I'd have to double check; regardless, from one patient to the next using the same syringe which was filled with the pain medication until it was empty. And they could trace the infections that were transmitted by virtue of who was there that day, what bed they occupied, etcetera.

Q So another unsafe injection practices

outbreak?

A Yes.

Q And in that same article, I can bring it up to you again if you need to, was there a dissemination of that information through the actual organization of CRNAs at that time?

A Yes.

Q I mean, nationwide dissemination?

A Yes.

Q Now, related specifically to some other articles that you may be familiar with, and the next article I want to ask you about is a entitled -- for counsel -- multiple clusters of hepatitis C virus infections associated with anesthesia for outpatient endoscopy procedures. And I think one of the officers is -- excuse me, authors, is a Bruce Gutelius?

A Uh-huh.

Q I don't know if I pronounced that correctly. Can you tell us what this is about?

A A case of acute hepatitis C was identified and, in fact, possibly more than one by the clinician, again, who noticed that the only commonality between the patients was procedures at this particular -- at actually two different gastroenterology practices. And when they did the investigation, actually, the transmission involved both

hepatitis B virus as well hepatitis C virus. So they had clusters in each clinic setting with both viruses.

And in this instance it was a similar scenario in which a -- they were reusing syringes, but needless. You know, they now have needless devices so that healthcare workers are protected from sticking themselves, essentially, and so you're only using the syringe.

And they put a vent -- they put a little spike in the multi-dose vial, although this might have been single-dose, but multi-dose vial and they stick the syringe in and then they pull out the medication and then they -- the IV may also be needless, in which you can inject just directly with the syringe. And the syringe was being reused on the same patient to get additional doses, and even though it was discarded and a new syringe used for the next patient, the vial was already contaminated from the source patient.

Q So -- and I've got the article here if you need to look at it. It appears as those propofol was the drug.

MR. WRIGHT: Where was that?

THE COURT: That is this article here.

MR. WRIGHT: Which -- no, I mean, which city?

THE WITNESS: New York City.

MR. WRIGHT: Okay. A different New York one?

THE WITNESS: Pardon?

MR. WRIGHT: A different New York one than the first one?

THE WITNESS: Yes, but a different one.

MR. WRIGHT: Thank you.

THE WITNESS: It occurred much more recently.

BY MR. STAUDAHER:

Q As a matter of fact, the date of this article is -- it looks like it was published in 2010, but it's talking about a report in 2007, March of 2007; is that correct?

A Yes.

Q And I don't want to -- if you need to look at it --

A No, it's -- usually there's quite a lag between.

Q Okay. So it's not unusual --

A But although, is that the -- no, you're looking at the actual publication. It was probably in an MMWR prior to that.

THE COURT: Why don't you show it to her so we can make sure --

THE WITNESS: Sorry.

THE COURT: -- that --

MR. STAUDAHER: It's okay.

THE COURT: -- it's correct.

THE WITNESS: No, that is -- those are the dates.

BY MR. STAUDAHER:

Q Okay. Yes.

A Yes, those are the dates of publication and when the outbreak occurred.

Q March of 2007 outbreak, publication 2010?

A Yes, in a peer reviewed journal.

Q Will you confirm that -- that it was propofol?

A Yes.

Q Yes, it was?

A Yes, it -- I'm sorry. I tend to be long winded, so I try and be short. Yes, it was a single patient use vial of propofol for multiple patients with reuse of syringes to re-dose patients.

Q So, again, some --

MR. SANTACROCE: I'm going to -- I need a clarification. If you're reading, I'd like to know what you're reading -- where you're reading from exactly.

THE WITNESS: Actually, right now I'm just reading from the abstract, but I just read this article again for the 10th time last night.

MR. SANTACROCE: Well, it appeared to me you were reading an answer from that document. If that is, in fact, the case I'd like to know which page.

THE WITNESS: Okay.

THE COURT: Is it the front page that --

THE WITNESS: The front page, first --

THE COURT: -- has the abstract?

THE WITNESS: -- page of the article, which is page 163 of this journal. And I was reading from -- not -- I was reading from the last sentence of the results.

MR. SANTACROCE: And, again, the article? The article name?

THE COURT: The name of the article.

THE WITNESS: Multiple clusters of hepatitis virus infections associated with anesthesia for outpatient endoscopy procedures.

MR. SANTACROCE: Thank you.

BY MR. STAUDAHER:

Q But in this particular case, the same type of sort of reuse is what we're talking about in --

A Yes. The only difference is it was needleless.

Q So a vent spike or something was used?

A Yes.

Q Why is that not protective to have a spike versus a needle going into the bottle?

A It's for protection -- these are -- have been put -- these are a variety of measures or technological advances have been developed and employed in healthcare settings to protect healthcare workers from accidental needle

sticks. So the less needles they handle, the less likely they themselves will get stuck with a contaminated needle. A lot of this resulted from HIV in the '80s, so -- concerns about transmission of HIV to healthcare workers in the '80s. So there have been a lot of these sort of technological advances in equipment use in order to reduce the amount of needle use by the healthcare worker. But it had to do with protection of the healthcare worker.

Q So the -- no difference in risk for vent spike versus needle?

A No. No.

Q If it's used in that way that was described?

A No. Presumably -- no.

THE COURT: Mr. Staudaher, I'm going to stop you. Some of the jurors need a break, so we're going to take our morning recess.

Ladies and gentlemen, we'll take about ten minutes for our morning recess. During the recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research, and please do not form or express an opinion on the trial. Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 10:29 a.m.)

THE COURT: I'll see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ma'am, before we let you take a break and we take our little break, out of the presence of the jury, Mr. Wright needs to ask you some questions regarding the basis of your opinions. Okay?

THE WITNESS: Okay.

THE COURT: All right. Mr. Wright, go ahead.

VOIR DIRE EXAMINATION

BY MR. WRIGHT:

Q Ma'am, have you read the Southern Nevada Health District report on this matter?

A Yes.

Q Okay. And the CDC trip report?

A Yes.

Q Okay. Any other reports on this one?

A There was a peer reviewed article published from the CDC in collaboration with the county health department.

Q Okay. Other than that?

A No.

Q Okay. And you're aware of the notifications, patient notifications that took place in this case?

A Yes.

Q Okay. And it basically went back four years and all patients who had been there who may have been exposed to this ongoing practice were sent letters and test -- and tested. And then there were results laid out, not in CDC's reports because this took place --

A Uh-huh.

Q -- after they had been here, after their trip report, but in Southern Nevada Health District's report. And do you, in reaching your -- the firmness of your convictions, let me put it that way, you've made a determination as to likely cause of transmission in this case; correct?

A Yes.

Q And that's the combination of unsafe injection practices and multi-patient use of propofol vial; correct?

A Yes.

Q Okay. Does -- does the later testing -- the -- the later patient notification and the results of that enter into your determinations?

A No.

Q Okay. Why do they do that if it has no basis whatsoever on --

A For the --

Q I mean, the correctness of my conclusion. Because I noticed in your New York case, in various cases like in the New York case when an anesthesiologist -- I think it

was the second one readily admitted to his behavior. And then letters were sent out, a couple thousand of them, and then other patients were found to -- to have been infected.

A Can I also tell you that in the first outbreak in New York -- New York has had actually quite a few -- and they also -- when they realized how long the practice had been going on with the one anesthesiologist, they also sent many, you know, patients over several years letters of notification to get tested.

Q Okay.

A Okay. Why do they do that?

Q Right. And -- and it seems to me, I'm not an epidemiologist, but it seems to me if certain conduct is going on and I believe it caused on two days these events occurred, okay, the transmission of hepatitis C and that the conduct has been ongoing for, say, a year, then I would look to the other 363 days of the year expecting to find other cases the same, other clusters, whatever you want to call it. Because if those were the two things on those two days that caused the transmission and the precise same thing was happening every other day of the year, it would seem to me I would find that on the other days of the year. And then that would confirm for me, bingo, I found the right thing and I -- what am I missing epidemiologically in my analysis?

A Well, the fact that they had sufficient

numbers of cases actually on one of those days to draw an epidemiological conclusion even separate from the laboratory sequencing, on the July date they only had one new case and the one source patient. And the only way to prove that that was the -- that they were related was by viral sequencing. I mean, if you only have two people -- okay. So wait, I'm getting there.

Q Okay.

A However, the purpose of the notification was knowing that this practice was going on for a long time and that many patients might have been exposed, it was the ethical -- the obligation of the health department to notify these individuals that they may have been infected and they should get tested.

Q I -- I got that. I --

A Okay. So for their own -- for their own purpose, the resources -- to be quite honest, the resources involved and then taking all of those patients and doing the same kinds of studies that were done on those two days was probably not available.

Q Okay. And I'm not --

A And that's true for most of the large notifications that are done. If you're not -- you know, in this -- in many instances now, even without evidence of transmission, if a hospital or a healthcare facility notices

-- finds that a practice is -- some practice has not been done correctly, they will send notifications, even though there's been no evidence of infection.

THE COURT: So in other words, the point of sending the notification had nothing to do with confirming their hypothesis or their theory, but it was to give patients notice so that they could be tested and get treatment or modify their behavior --

THE WITNESS: That's correct.

THE COURT: -- or whatever they were going to do. Is that --

THE WITNESS: That's correct.

THE COURT: Is that a summation?

THE WITNESS: Very good.

THE COURT: Okay. Thank you.

THE WITNESS: Yes.

THE COURT: Is that fair?

THE WITNESS: That's exactly correct.

BY MR. WRIGHT:

Q Okay. The problem with that is there's testimony to the contrary in depositions. Not -- not yours or anything, but of -- of the Health District and what they expected to find. I mean, I'm not faulting anyone --

A No, no, no, no, no.

Q -- for notification whether you found it or

not. My -- what I still don't have an answer to is if I'm the epidemiologist and I say here's two days out of a year in which hepatitis C was spread by this method of transmission and then I look and say -- and that identical conduct occurred on the other 363 -- 62 days, whatever, of the year, I would expect to see other -- the same conduct. In other words, I'd expect to see --

A I understand, the same set of circumstances. You would expect --

Q Right.

A But that -- in order to -- it may have been the initial intent to do that, but given the frequency of positives, hepatitis C positives in the general adult population, particularly in that age range getting, you know, GI studies, you're going to find a lot of positives. And I think it might -- and I -- now I'm speculating that while the original intent might have been to identify other clusters, the number that they came up with made it impossible for them to actually do that kind of investigation because, remember, you have to find the source patient, a source patient, you have to determine what the differences in -- they would have had to go through everything that they did for those two days just for -- for all those other positives.

And actually in New York, the first outbreak I investigated, that we investigated in 2001, they did the same

thing, and they went back four years. And they found a lot of positives for both B and C, but they could -- you know, I think they identified a cluster, maybe, but they couldn't do the same kind of analysis. But that's not the purpose of the investigation. The purpose of the investigation is to identify what happened, how it happened, and if it's -- it shouldn't happen, prevent it from happening in the future.

Q I -- I --

A Yeah, so --

Q I follow all that.

A Right.

Q I just still -- I told you --

A The purpose of -- the real --

Q -- I'm not an epidemiologist --

A Right. But that --

Q -- but it seems to me if -- if it happened this way and this is my conduct and then I did the identical thing --

A Yeah.

Q -- 100 times --

A Uh-huh.

Q -- and it's convinced because I did it this way it caused it to happen --

A Uh-huh.

Q -- then on the other 99 days I would expect to

see it again if that was truly the cause.

A You wouldn't necessarily see it every day. You have to have someone --

THE COURT: You have to have --

THE WITNESS: -- who is infected --

THE COURT: -- hepatitis to start --

THE WITNESS: -- as a source.

BY MR. WRIGHT:

Q Well, right. I'm saying --

A Okay. So -- yes, but how would you show that and how -- what amount of resources should the health department when they have many other things that they have to consider, dedicate to this? This is not for, no offense, legal reasons. This is for public health. So to protect the public they have done their due diligence by identifying the potential source, who was at risk, and notifying them --

Q I understand.

A -- to get tested. And that was the -- that's really the overall purpose.

Q This is a criminal case.

THE COURT: I think we're getting --

BY MR. WRIGHT:

Q And I understand --

A I know that, but I'm not --

Q Let me ask --

MR. WRIGHT: Pardon?

MR. STAUDAHER: Your Honor, I think --

THE COURT: Mr. Staudaher is objecting. I think we're getting beyond --

MR. WRIGHT: No, I --

THE COURT: -- the focus.

MR. WRIGHT: Just one wrap up question.

THE COURT: Okay. One more question.

MR. STAUDAHER: He can do this on cross-examination.

THE COURT: Well, no, there was --

MR. WRIGHT: I can't do it on cross.

THE COURT: Wait a minute.

THE MARSHAL: Counsel, enough.

THE COURT: There was a purpose --

MR. WRIGHT: I --

THE COURT: Excuse me. There was a purpose for allowing this questioning to go on and it was a limited purpose and I think we're getting beyond the purpose. And so, Mr. Wright, you say you have one more question.

MR. WRIGHT: Yes.

THE COURT: You can ask your final question. Again, because the questioning was dedicated to a particular issue --

MR. WRIGHT: I understand.

THE COURT: -- and I think we're getting beyond that. And so ask your final question and then we're going to

take a little break.

BY MR. WRIGHT:

Q As I understand it, if it was conclusively shown that over the four years all 63,000 persons were tested, okay, every one of them was tested and there wasn't any hep C, it turns out it was below the threshold level that would have been expected, okay, if I could show that no one in four years got hep C at that clinic it would make no difference to you in reaching your determination that for those two days the method of transmission was what you found; correct?

A That's correct.

Q Okay.

A But unlikely.

THE COURT: Okay. Well --

THE WITNESS: Unlikely that that would be the case.

THE COURT: All right. If you need to take a break, ma'am, just exit --

THE WITNESS: I'm okay.

THE COURT: -- through those --

THE WITNESS: Do you want me to just --

THE COURT: You can sit there if you want to.

THE WITNESS: Fine. I'm fine.

THE COURT: We're going to take a break.

(Court recessed at 10:42 a.m., until 10:46 a.m.)

(Outside the presence of the jury.)

THE COURT: Yes?

MR. WRIGHT: I just want -- I just wanted to tell the witness that that exchange was outside of the jury's presence. So when I examine you in the courtroom --

THE COURT: And ask the same things again --

MR. WRIGHT: -- we don't act like they've heard it.

THE COURT: -- don't --

THE WITNESS: Don't sound as if why are you asking me the same --

THE COURT: Yeah.

MR. WRIGHT: Right. We don't discuss it.

THE COURT: Sure. Yeah, so obviously don't say -- don't say as I just told you five minutes ago --

THE WITNESS: Yeah. Okay.

THE COURT: -- blah blah blah.

THE WITNESS: No, I appreciate -- I appreciate that. Really, I have to be reminded. I don't do this as a routine.

(Off-record colloquy.)

MS. STANISH: Judge, I'm on the phone with Nia Killebrew --

THE COURT: Okay.

MS. STANISH: -- and she's out and about. And I thought if we could just put her on speaker phone if you could make the order to her to reveal Mr. Meana's --

THE COURT: Okay.

MS. STANISH: You ready, Nia, or are you in the check out?

THE COURT: What, is she like at Vons or something?

MS. STANISH: Yeah, that's fine. Can we just -- just to put on the record --

THE COURT: She can call in. I mean --

MS. STANISH: Let's see if this works. Nia, can you hear me?

MS. KILLEBREW: I can.

THE COURT: Can you hear me? This is Judge Adair.

MS. KILLEBREW: I can, Judge. How are you?

THE COURT: Good, thanks. Basically, I need to direct you to disclose to all of us the amount that the Meana family received in settlement of the various claims and lawsuits they may have filed. So if you could do that. Hello?

MS. KILLEBREW: I can do that. I don't have the amount that I can tell you right now. I can email it or have someone bring it in an envelope to the Court today.

THE COURT: Okay.

MS. KILLEBREW: The only thing that I need, you know, is some minute order or some kind of documentation on the record that you're ordering me to do so --

THE COURT: Right.

MS. KILLEBREW: -- so my client's --

THE COURT: -- Ms. Husted is making that --

MS. KILLEBREW: [Inaudible].

THE COURT: Ms. Husted is making that part of the minutes right now. And you don't need to, you know --

MS. KILLEBREW: Okay.

THE COURT: -- rush it over today, as long as we get it, you know, by an email or something like that. We don't have to put that on the record today. So, you know, don't worry about sending over a runner or rushing back to your office or anything like that. You know, just sometime today or tomorrow morning if you get that over to the lawyers, that would be great.

MS. KILLEBREW: Okay. I'm out of town, but would it be easier for me to just -- I mean, my office is right across the street -- to have a runner bring it over in an envelope to your -- to your chambers?

THE COURT: Sure. That --

MS. KILLEBREW: Or would you rather have me disclose it to counsel?

THE COURT: Sure. That's fine.

MS. KILLEBREW: Okay.

THE COURT: All right.

MS. KILLEBREW: I'll just do that.

THE COURT: Okay.

MS. KILLEBREW: Not a problem.

THE COURT: Okay. Great. Thank you.

MS. KILLEBREW: Thank you so much.

THE COURT: Okay.

MS. KILLEBREW: Bye, everyone.

THE COURT: Bye.

MS. STANISH: Bye.

THE COURT: Okay. We can bring the jury back.

(In the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Mr. Staudaher, you may resume your direct examination.

MR. STAUDAHER: Thank you, Your Honor.

DIRECT EXAMINATION (Continued)

BY MR. STAUDAHER:

Q With regard to your review of the records in this particular case, we're talking about the Health District report. What else did you review?

A The trip report from the CDC, which is their initial follow up report right after they return from the investigation, and then their publication in a peer reviewed journal of their -- of the final analysis of the CDC's investigation portion.

Q So the -- in the chronology of things that you looked at, did you look at them in a particular order, did one

build on itself, that kind of thing, or did it matter? Was the trip report first and then the article, or vice versa?

A Oh, definitely. The trip report definitely because that comes out right after they return from their investigation, like within a short period of time.

Q Is it typical to have an outbreak investigation published in a peer review journal after such an outbreak?

A Yes.

Q So the trip report is -- how would characterize that report?

A Well, it's publicly available, but it is -- it is part of CDC's procedure that you summarize, even though they might be preliminary, the results of your investigation immediately upon return so that that's communicated back to the inviting state and they have everything that you have at that moment.

Q Is it fair to say that are there sometimes errors in those initial reports?

A Yes, probably. Yes.

Q When it gets to the stage where you actually publish the paper, though, in the peer review journal, does that go through some sort of vetting process with other investigators? I mean, how is the journal sent out before it's actually published?

A The draft or the manuscript, which is what we call the prepublication report is sent out to the co-authors on the -- on -- on the paper to read and make any suggested revisions. It doesn't necessarily mean that all errors, if there were errors, would be caught at that time, but hopefully everything that's in the -- in the manuscript is accurate as far as the co-authors know. In addition, when it gets submitted to a journal for peer review, which is a separate process, it is reviewed by individuals who were totally not related in any way to the -- whatever the study was that's being reviewed. So the journal sends it to its own peer reviewers to decide whether it's of importance and worthy of publication in the journal.

Q And once it finally gets published, it's been through that whole process; is that correct?

A Yes, including, I should say, clearance at the CDC level.

Q So in this particular case you looked at those particular parts of the -- that sort of detailed the investigation; is that correct?

A Yes.

Q Now, we've talked about some of your kind of conclusions about scopes and the -- or the biopsy forceps, things like that up to this point.

A Yes.

Q In general, looking at the results in this particular case, did you come to a conclusion as to how you believe the transmission occurred through the records that you reviewed?

A Yes.

Q And what was that?

A My conclusion is that the unsafe injection practices used routinely in this clinic resulted in contamination of medication vials, in this case propofol, with hepatitis C virus that was then transmitted to other patients.

Q Okay. Anything in the reports related to that that called into question that analysis or that conclusion? Any results that you saw? Anything in there?

A I don't know. I'm thinking.

Q -- in there?

A I just want to make -- no.

Q Have you ever heard of the term serial contamination?

A Yes.

Q Do you know -- can you tell us what that is, first of all?

A Basically you have a source and it's transmitted down the line. I mean, you know, it's transmitted to each subsequent individual who is exposed.

Q Have you seen this actually in your own

investigations?

A Yes, I have.

Q Have you -- I mean, is this something that has been around for awhile?

A The idea of it, yes, and having seen it in the context of hepatitis B virus because it's so infectious and so much more easily transmitted that we've seen it in a variety -- and we've been able to test for it for a much longer period of time and we've seen that in a variety of settings and done experimental studies to show that it can happen, but it doesn't have to.

Q Okay. What do you mean it doesn't have to?

A When you refer -- I'm assuming when you mean serial transmission that every single individual after the source gets infected?

Q No, not necessarily.

A Oh, okay.

Q And let's talk about that. Serial contamination meaning just people downstream of the source patient --

A Right.

Q -- are contaminated serially.

A Yes.

Q And do you know how that could happen in a situation like that?

A Well, if you have a common source of virus like a multi-dose vial or several contaminated vials of medication, then people who are exposed to that vial of medication downstream, so to speak, from its point of contamination will be exposed and potentially infected.

Q Is there a dilution effect that involves that sort of serial contamination that might have a play here?

A Yes, there is because, you know, there's a certain amount of virus that is in the contaminant, and as the vial gets used up, presumably the level of contamination will go down or you really don't have any idea which dose is going to contain virus and which isn't.

Q Now, in this particular case there were two specific days; correct? We're talking about a July date, July 25th and a September 21st date. Your -- go ahead. Did you want to say something?

A May I correct what I just said? It just occurred to me the question you're asking. I didn't answer the question you were asking about how the serial contamination might occur, whether or not you would get -- whether it would be different the further downstream. If you were -- if the source was in the same -- if you only had one source of virus, then presumably as the -- as the vial gets used up you'll have less contamination and lower infection rates the further out you go.

However, if it's from different vials, if multiple -- if you have multiple sources of potential contamination, then that might be difficult to see. In an experimental setting, however, that's exactly what happens is you -- because you have -- as you go along, downstream you have less and less, your infection rates start to drop.

Q So at some point you wouldn't expect there to be infection rate with a common initially contaminated source, or -- or can you --

A Presumably, but not always.

Q Now, on the two days in question that we're talking about here, and you've reviewed the information pertaining to those; is that correct?

A Yes.

Q You said that you believe -- if I -- I'm not trying to reiterate, but is it the same conclusion for both days?

A Yes.

Q And what do you base your conclusions off of?

A The only -- first of all, the only significant result that the CDC could find was that all of the patients who became infected received procedures on the same day as a chronic -- you know, as the source patient. And all of their procedures occurred after the source patient. In the September -- on the September day they have a few infections

that can actually look at it in an analysis using numbers and statistical techniques. On the July day, there is only one infection downstream from the source patient. So the only way to link those is by genetic sequencing.

However, the fact that the only -- the only technique or procedure that could be implicated, that they could identify as being inappropriate and not according to good aseptic technique was how the multi-dose vial -- how the anesthesia was delivered, essentially, and to multiple patients. And so since that had been occurring all along, there was no reason to believe that wasn't the source in July as it was in September.

Q Now, the source in July, let's talk about that day just for a second. You said there was just one infected patient from the source patient on that day. You said the only way that there could be a link is through genetic sequencing --

A Right.

Q -- correct?

A Yes.

Q Was that -- was that done in this case?

A Yes, it was, and they were -- they were genetically related.

Q And are you -- I mean, you've -- I assume since you've been at CDC you've seen that kind of analysis

done in the past, is that right, where they do linking?

A Yes.

Q Is there any issue with regard to the methods or procedure that you saw employed in this particular study for that work, for the sequencing work that called into question the results?

A No, it only gets better as time goes by.

Q Okay. Now, on the 25th date, the July 25th date, were you aware based on the records that the CRNA involved on that day was the one who administered the heplock and administered the medication?

A Yes.

Q Is there -- although the infected patient on that day did not fall under the same category, it was a nurse that put in the heplock initially --

A Yes.

Q -- at least according to the records, is there any issue there with regard to, you know, potential error in what the transmission was or the source of the transmission based on that information?

A I don't -- I don't think so. The reason being that the procedures that the nurses use to put in the heparin locks were correct, and they were observed to be correct, they routinely were correct, and so there is no reason to believe that the placement of the heplocks were related. They

certainly didn't find that in September, and when they investigators were onsite observing the staff, one of the CRNAs continued to administer anesthesia in the same way, in an unsafe way by using -- you know, reusing a syringe on a single patient and then using that vial on multiple patients.

Q Were you aware that a communication was made to a second CRNA about that same practice?

A Yes.

Q And you were aware of the results of that, the admission of the reuse there?

A Yes.

Q Those two things combined, those are different, if I understand you, that in that New York 2001 study where you didn't have any observed mechanism by which you could see or determine transmission?

A Until -- that's correct, until we looked at the purchase records.

Q So that's what led you to your conclusions?

A To confront the person who had been denying the unsafe practices, yes.

MR. STAUDAHER: I pass the witness, Your Honor.

THE COURT: All right. Cross.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Good morning. My name is Richard Wright. I

represent Dr. Desai. You did not participate -- let's see, you left CDC in 2006.

A Yes.

Q And so you had no participation in this investigation in Las Vegas in January?

A Other than talking to Brian Labus over the phone

Q Okay.

A Over the telephone.

Q Okay. And the -- when did you talk to him?

A It was in the middle of the investigation, just before they -- just before they went public to -- did the public notification.

Q Okay. So that would be -- I mean, we know from dealing with all the dates here in the courtroom it went public February 27. It went public and notifications went out to patients February 27, 2008. So prior to then; correct?

A Yeah, like the day before.

Q Okay. And you -- you had received -- were you contacted by lawyers from the clinic to consult with them? I read that.

A Let me think a minute, only because I do get contacted a bit. Yes, I think so. Yes.

Q I -- I read somewhere of efforts to reach out to you by civil litigator -- civil lawyers for the clinic at

the time seeking to use your expertise --

A You're absolutely --

Q -- and consult.

A Thank you. You actually brought it back. Yes, that's correct. And, in fact, because I knew nothing about the outbreak at the time, it was early on, they did -- they were referred by a colleague and I turned them down when I -- when they described the situation. And then I immediately called my contacts at CDC to see what was going on because it sounded, you know -- sorry, from an epidemiologist's point of view, it was quite exciting.

Q I -- I read --

A I'm sorry.

Q I read the articles you forwarded. Okay? All of these articles and the Morbidity -- what's that thing called?

A Morbidity and Mortality Weekly Report. It's CDC's public health notification of important events.

Q It sounds like a Halloween magazine. But it is really dry reading.

A To you.

Q Correct.

A The rest of us can't wait to get our hands on it, and it's embargoed, too.

Q The -- I mean, this is esoteric stuff we're

dealing with. The -- I read your article about, and I had nightmares, about the testing the chimpanzee dried monkey blood to see how long the virus lives in dry chimpanzee monkey blood. And the results were how long does the hepatitis C virus live outside, like when it's -- some blood is left on an instrument. What's the results?

A The results were that the -- the only way you can demonstrate infectively is with an animal model because you really can't do it in -- in the laboratory, so -- and only non-human primates. So the results were that we had three time points to look at, 16 hours, four days, and seven days. And only the 16-hour sample was infectious. So we know that it persists for at least 16 hours outside the human body. It could be dried on a surface, not visible to the human eye, and still cause infection.

Q Okay. And the three-day old -- three-day old blood, using my --

A Four-day.

Q -- layman's terminology --

A It's okay.

Q Four-day?

A Four days.

Q Four days the -- it was no longer infectious, the virus had died.

A Right.

Q And the same with the seven-day?

A That's correct.

Q And -- and that's -- learning from your article, that's different than the hepatitis B, where that -- it -- the hepatitis B virus survives when exposed to the environment for --

A It was only looked at for seven days, okay, because of the limitations of doing these kinds of studies. So its infectivity was demonstrated seven days, but it's a very hardy virus. It's easy to kill, you know, if you use disinfectants on it, bleach does a great job, but it survives a long time. And when people ask -- actually ask our opinion, if they call and say, you know, I've had this thing with blood on it for two years, should I consider it infectious with B? We would probably say, yes, you should just consider it infectious. They've actually found evidence of the virus, not necessarily its infectivity, seven years after it was dried. But unknowing -- you know, we don't know if it's infectious.

Q Okay.

A Hepatitis C clearly does not survive that long because you have to combine your experimental work with reality and what you see in terms of transmission patterns. And it was clear from transmission patterns that hepatitis C was not like HIV, which does, once it leaves human body, it -- it's no longer infectious. But because of its transmission

patterns, we suspected it had to live for some period of time outside the body, and that's why we did the experimental study.

Q Okay. As -- as a hepatitis expert, I contract hepatitis C today, and the odds are like seven out of ten times I will have no symptoms, asymptomatic. Is that what it's called? Is that right?

A Yes.

Q Okay.

A Right.

Q Like three out of ten times I will get the classic symptoms that we've heard about testified here, jaundice --

A It'll send you to the doctor.

Q Right. Okay. And so I may not -- I may not know I even have it --

A Yes.

Q -- seven out of ten times.

A That is correct.

Q And the -- how -- how quickly -- and I guess once I'm past six months and I'm most -- once I'm past six months, I just acquire it today, six months from now, assuming I knew I acquired it, six months from now it's quite clear I'm not going to get the classic symptoms; is that right?

A That's correct. I mean, the classic symptoms

-- the incubation period is short. It can be as short as 14 days, supposedly as long as six months. But likely within two to three months of exposure, if you haven't become symptomatic you're not going to be for the first phase of infection, the new phase of infection.

Q Okay. So once -- and then the -- we've heard testimony here in the courtroom, I'm past six months so it's what we've called -- we're calling chronic hepatitis C. And chances are I will end up dying of old age and not hepatitis C.

A From an odds point of view, absolutely.

Q From a what?

A From an odds -- look where we are. From an odds point of view, yes.

Q Okay.

A Likely you will.

Q Okay.

A It depends on a variety of factors.

Q Okay.

A Whether you drink, you know, do other things that might harm your liver that all of that potentiates.

Q Okay.

A You know, it puts different risks on it, but, yes, that's correct.

Q Okay. And if I contract it today, the -- like

what do -- what do the studies show or what's your analysis of how quickly I may develop cirrhosis of the liver from hepatitis C?

A Presuming you're over 40?

Q That I am.

A Age --

Q And drink.

A Age -- well, if you had hepatitis C your doctor would tell you not to drink at all, but -- except maybe champagne at your daughter's wedding. But depending on your age and a variety of other factors, you're male so it increases your risk, as well, and that you can't do anything about. So all other factors being equal, you could develop cirrhosis in 5 years, 2 years, 20 years, or 40 years.

Q You just don't know.

A No. I mean, there's an average.

Q What's the average?

A 20, 30. 20 we'll say. And that most of those -- that -- that's -- also includes a range of -- you know, averages always have ranges. So that's the average, but it can be much shorter, and I've observed that directly.

Q Okay.

A In my follow up studies that I conducted at CDC. So -- but it has usually -- often, in moist people it has a long what we call latent period where nothing happens

and you don't know you have it until you have that yearly physical. The doctor finds you have liver -- elevated abnormal liver enzymes, meaning your liver is inflamed. They test you for hepatitis C, and you just found out you have it.

Q Okay. And if I have it and I didn't know I had it, I had a blood test and the doctor says you've got hepatitis C, and I don't have any symptoms at all from it, didn't even know I had it, I could still undergo the treatments we've heard about here in the courtroom, which is a 48-week interferon and ribafarbon (sic) or something.

A Ribavirin, yeah.

Q Okay. I -- I could do that even if I had chronic and no symptoms?

A Actually, that makes you a better candidate for --

Q Okay.

A -- resolving your infection. However, there are guidelines for treating people and the guidelines have to do with the severity of your liver disease, which may not be manifest or clear based on your lack of symptoms. So they do laboratory testing, possibly imaging studies, possibly a liver biopsy to determine the stage of your liver disease. And people with mild disease may not have been treated in the past. They may be more likely to be treated now because some of the drugs -- because the treatment is more effective and

can be shorter. But in general you have to sort of show that you're progressing in your liver disease to be treated. On the other hand, some physicians treat everybody.

Q Okay. Have you heard of Dr. Richard Perrillo, a neuropsychologist?

A I know a Robert Perrillo who is a hepatologist.

Q Nope, this is Richard Perrillo.

A And he's a what, neuroscientist?

Q Neuropsychologist.

A Neuropsychologist, no.

Q Okay. He testified here in the courtroom about hepatitis being neuroviral and attacking the brain and causing -- hepatitis C causing dementia which he distinguished from brain fog.

A You mean like the rest of us have.

MR. SANTACROCE: I'm sorry. I didn't hear you.

THE WITNESS: It wasn't a scientific comment. Can I take it back?

MR. SANTACROCE: No.

THE COURT: No.

THE WITNESS: Like the rest of us have.

THE COURT: Oh, okay.

BY MR. WRIGHT:

Q He testified that he reached this conclusion

of hepatitis C causing dementia, as well as the treatment causing dementia. And he based it upon he had seen 19 patients with hepatitis C and they had dementia. Do you -- are you familiar with any -- any of his work or studies or does any of that ring a bell with you?

A No.

Q Okay. The --

A But I can comment.

Q Give me your comment.

A Okay. This is a common misconception, particularly by physician researchers. I don't know if he's a physician, but they look at cases only and they don't end up doing a study. They look at case reports or just people with the disease and they see that they all have this in common, whatever it might be, in this case hepatitis C and dementia, and they come to a conclusion about the cause or some association. But you can't. Case -- case reports can be very useful because they can -- you know, they can show that further study might be necessary in that area, but they can't -- you can't draw any conclusions from cases, just looking at cases.

Q And that's the difference between association and cause and effect.

A No.

Q No?

A Association --

Q Well, let me -- let me ask it this way. I mean, the way it was explained to me the -- why an association doesn't prove cause and effect, let me put it that way. I was told in the late 1940s before there was a polio vaccine, that there was an anti-polio diet put out by the government that you should not eat ice cream or soft drinks because everyone that had polio had been eating a lot of ice cream when they caught polio. They were eating a lot of ice cream and soft drinks. And so ultimately it turned out that polio was transmitted in the summer when it was hot, and so the -- they had misinterpreted. There is merely an association. Everyone caught polio when -- when it was hot and that's when you eat ice cream and drink soft drinks.

A Actually, I'm sorry if I interrupt. That is not an association. That's actually -- it's called an ecological fallacy in scientific terms and from an epidemiological point of view. I'm sorry. That's exactly what it is. It's like there are more telephone poles in -- or people -- there's a higher risk of getting -- or a higher rate of cardiovascular disease in places that have more telephone poles. Why is that? That is not an association. It's an ecological fallacy.

People who have -- who don't live in -- well, when this was used as an example, telephones were not exactly as

common as they are now, and in urban areas where people had less exercise and ate -- and had worse diets had more cardiovascular disease than in rural areas where they worked out, worked on the farms or whatever, and had fewer telephone poles. It's an ecological -- it's a misinterpretation.

THE COURT: So it would be a coincidence that has --

THE WITNESS: It's a coincidence.

THE COURT: -- no bearing on actually the cause of disease or the symptoms of --

THE WITNESS: That's right.

THE COURT: -- the disease or anything like that. Okay.

THE WITNESS: And as a scientist an association has the same implication as a cause and effect if you use it -- if you use it in the same way. Like something is associated with infection, a particular event or -- means in epidemiological terms that there is some kind of cause and effect.

So when you do studies that can't establish a cause and effect, what we do is say we found a characteristic related or associated with positivity, testing positive, which is a little -- it may be -- it may be a very obscure kind of -- but it's very important in our line of work to be very clear about what we consider studies that can demonstrate real associations with getting infected or getting a disease and those that are just a characteristic of populations, for

example, with the disease. I know it sounds esoteric, but it's important.

BY MR. WRIGHT:

Q And some -- some of the statistical -- do you -- do you all compute it like statistically, the probability that it was this or that?

A Yes, after having done an appropriate study. So the study methods have to be just as appropriate as the analysis. And bad data in, bad data out. You know, good data in, hopefully your results are valid. But there have been -- there's a lot published, not necessarily in hepatitis C, that's not valid.

Q Okay. The -- Brian Labus stated in -- in his -- in the report that the likelihood of getting hepatitis C --

THE COURT: Keep your voice up.

BY MR. WRIGHT:

Q The likelihood of getting hepatitis C for a patient who went to the clinic on September 21, 2007, was 38 million times the likelihood of a person who didn't go to the clinic on September 21, 2007. Okay?

A Uh-huh.

Q What does that show?

A I've read the sentence, too. I don't know --

Q I mean, I presume --

A -- what calculation --

Q -- it's true.

A I agree. I -- no, I read the sentence, too. I don't know what calculation he was making or the report was making, what calculation that was based on.

Q Okay.

A And it wasn't explained.

Q It -- it is fair to say that you -- you simply read the reports and you concur with the conclusion of CDC?

A Yes.

Q Okay. And their conclusion was that the most likely cause was the combination of unsafe injection practices with the multi-patient use of propofol vials?

A Right, which is also considered under the overall phrase of unsafe injections.

Q Oh, okay. That -- that -- somehow I was viewing an unsafe injection as the actual --

A No, it also involves the reuse of a vial for a multiple -- or the reuse of the vial for multiple patients.

Q Okay. And the --

THE COURT: Keep your voice up.

BY MR. WRIGHT:

Q Your -- on that New York, your first case of New York 2001, was that your first colon --

A My first -- the first investigation of an outbreak of hepatitis C in a GI practice.

Q Okay.

A Private GI practice, yes.

Q Okay. And that -- and was that an anesthesiologist?

A Who was reusing syringes and needles. Reusing needles and syringes and on the same vial and going back into a multi-dose vial, actually.

Q Okay. And was he -- was it a he, the anesthesiologist?

A It was.

Q Okay. Was he using -- reusing needles and syringes between patients or simply to re-dose a single patient?

A Simply to -- to re-dose. He was discarding between patients.

Q Okay. The -- and --- and he had denied it?

A Yes.

Q Okay. And then ultimately admitted to it?

A Yes.

Q Okay. And the Oklahoma case you talked about, the one you talked about here, that was a reuse of syringes -- reuse of needle and syringes on multiple patients?

A That was taking one syringe, filling it with enough medication for ten patients, and going from bed to bed administering the medication.

Q That's what I'd call serial.

A Yes, that's serial.

Q Okay. And so that -- you all call that overt syringe -- needle and syringe reuse? I saw that in one of these articles.

A Oh, you mean like direct versus indirect contamination?

Q Right.

A Yeah, that would be direct contamination of the syringe as opposed to indirect. Indirect being through -- through the vehicle of a multi-dose, like contaminating the medication vial. Right.

Q Okay. And you -- you were asked about serial contamination. And what does that mean to you?

A It means that a line of people, so to speak, or patients, have received -- have been exposed serially.

Q Okay.

A You know, in --

Q I got it. And the --

A -- a sequence of some time.

Q Okay. And I think it was your New York investigation there was a multi-dose common vial and that appears to have been contaminated with hep C by a source patient, and then that -- that one vial was used over three days and that one vial, which was contaminated, thereafter

transmitted hepatitis C to other patients getting out of that same vial, is that fair?

A That's correct. Although, there were some patients in sequence who did not become infected.

Q Okay. And the -- here, and I'm unsure if it's that clear in the Southern Nevada Health District report, but Brian Labus testified that he had two theories by which the transmission, talking about September 21st, could have occurred where it went from room to room because there were two different procedure rooms.

And he said it could have been a single -- theoretically it could have been a single 50 cc contaminated vial, one vial of propofol contaminated because if you add it up, all of the dosage for all of the infected patients and you just gave them each like their first dose out of the one vial, there was enough total that it could have all happened through one vial. That was one theory he testified to. Second theory dealt with contaminating multiple vials because the -- and having open multiple vials at the same time. And he called that serial contamination of vials. Okay?

A Uh-huh.

Q Okay. Have -- have you, in the cases you have seen and studied, have you come across serial -- using that definition of serial contamination of vials? Did any of your cases involve that?

A I'm thinking.

Q Take your time.

A I don't think so. I don't remember that being the case, but the practices at this clinic of having multiple vials open at the same time in the same procedure room and some of the -- and their techniques in general were pretty, well, unfortunate. And so, you know, there is really no reason to have multiple vials open at the same time, particularly if you don't have more than one anesthesia person in the room at the same time. So -- but my understanding is that they did. And --

Q Okay. Well, where do you get that understanding?

A From the report of the observation --

Q Okay.

A -- of what they were doing at the time the investigators were there.

Q Okay. Well, that was Linda Hubbard. I mean, you don't know that, but Linda Hubbard was not there on September 21st or July 25th. And she --

MR. STAUDAHER: Objection. Mischaracterizes the evidence. She was present on July 25th.

THE COURT: I'm sorry?

MR. STAUDAHER: July 25th.

MR. WRIGHT: Okay.

THE COURT: All right. So --

MR. WRIGHT: Okay. I didn't remember her being there. I'll accept that --

THE COURT: And the jury --

MR. WRIGHT: -- clarification.

THE COURT: -- will recall --

MR. WRIGHT: Okay.

THE COURT: -- what it recalls. And that's what it's important, what the jury remembers.

BY MR. WRIGHT:

Q Okay. Linda Hubbard wasn't involved with the source patient or infected patient on July 25th, and Linda Hubbard was not involved on September 21st. Other CRNAs did not testify to you opening multiple vials. They -- they have testified to pre-loading, for lack of a better word. I mean, in the morning drawing up out of one 50 cc, filling five syringes, and other than that simply using a vial until it's empty. Multi-patient, I'm not arguing that, but if you take that open vials out of the equation on September 21st, meaning having more than one vial open at the same time sitting there, do you follow this serial contamination of the vials theory?

A I don't think I understand the question --

Q Okay.

A -- actually.

Q Okay.

A If you don't have more than one vial, then --

Q Open.

A Open? Well, you can serially -- you can contaminate it if you open another vial and use a contaminated syringe. Or if you use a new syringe, withdraw some -- some, you know, whatever is left in the contaminated vial into a syringe, and then go into a new vial to get a little more.

Q Okay. The --

A But, you know, these are all hypotheticals, and my understanding was that, you know, the vials, multiple vials were open at the same time. I mean, there's no reason why either of those scenarios couldn't have happened. I don't know if they did. They also --

Q Right.

A They may carry, you know, their own -- I mean, it's common in some settings. I'm not saying this one. But, you know, you put what you drew up in your pocket when you change rooms.

Q Okay.

A Or a vial, you stick the vial in your pocket that you're using and you change rooms and you then use that vial as opposed to whatever is in that room available.

Q The CDC trip report noted that there was no -- based upon observations and interviews, they didn't haul propofol room to room.

A That's true. However, that may not be the case.

Q Right. We're -- we're --

A I'm just saying a --

Q Right. I mean --

A It's possible.

Q It maybe had --

A I don't know.

Q Okay.

A I don't even know if they had pockets.

Q I don't either. We've heard about tackle boxes, but not pockets.

A Fanny packs I've seen now, you know.

Q So you were -- you're aware of no published articles or cases involving serial contamination of vials, and the evidence in this case --

A In which -- what are you -- tell me again your definition of serial contamination of vials?

Q Having multiple vials get contaminated by all with the virus of the original source patient, and that's how it moves from room to room into later in the day.

A I don't --

MR. STAUDAHER: Objection, Your Honor. That mischaracterizes --

THE WITNESS: Yeah.

MR. STAUDAHER: -- Brian Labus's testimony.

THE WITNESS: It's --

MR. STAUDAHER: -- about that.

THE WITNESS: It's not serial contamination of vials in my mind.

BY MR. WRIGHT:

Q Okay. The -- the evidence in this case has been that Brian Labus in March 2009, before -- still having not written his report in December 2009, contacted CDC to ask them if there was any case or any published literature that could document serial contamination of vials as he presumes happened in Las Vegas. And the response was --

MR. STAUDAHER: Objection, Your Honor. Hearsay.

THE COURT: Well, overruled. She's testifying as an expert.

Mr. Wright.

MR. STAUDAHER: So hearsay is allowed?

THE COURT: Well, Mr. Staudaher, that's enough. I said she could answer the question.

Mr. Wright, state your question and be mindful to speak into the microphone --

MR. WRIGHT: Okay.

THE COURT: -- because you start off strong, and then you start drifting away and we -- we're having trouble hearing you.

BY MR. WRIGHT:

Q Brian Labus contacted CDC in March 2009 asking if they had any articles or cases in the published literature that document serial contamination of vials as we presume happened in Las Vegas. And the CDC responded that they didn't have any such thing other than one pooling incident, and the CDC stated that they thought there was enough information from your investigation that this is clearly a plausible explanation.

THE COURT: Is there a question?

BY MR. WRIGHT:

Q Does -- would you concur with that response from CDC?

A What I would concur is that they were using practices that would -- could result in contamination of medication vials with a blood-borne virus, and that that virus could serve as a source for transmission to multiple patients.

Q Okay.

A So why couldn't -- I'm -- I still don't understand exactly what definition we're using for serial contamination.

Q We -- these are -- this is Brian Labus's --

A I know. But I -- I don't know what he meant, either, so --

Q I don't either.

A Well --

Q Six years later.

A I -- you know, there -- I don't really know what you're asking. I don't see why multiple vials, if they're out, couldn't have become contaminated if they use the same -- either pooled them into a contaminated syringe or -- or used -- reused a syringe on a different vial that was open.

Q Okay.

A But I don't know what you -- that's the --

Q What I'm asking, and I'll ask it again.

A Okay.

Q Their response was there is no case like it, and there is nothing in the published literature regarding his presumed contamination of vials by serial contamination. Do you agree with that?

A I agree with I can't think of a published study involving a specific contamination of different vials --

Q Okay.

A -- in the same place. However, I can say that we have had an out -- we -- that there have been serial transmission from a common source to multiple patients downstream.

Q Right.

A But I can't -- I don't know why -- I don't -- or -- or contamination of medication vials from blood

splatter, which would have contaminated multiple medication vials, even if they weren't being reused.

THE COURT: Would the contamination of, say, multiple vials all have had to come from the source patient, meaning the source patient --

THE WITNESS: Yes.

THE COURT: -- contaminated all the vials --

THE WITNESS: Given the --

THE COURT: -- as opposed to --

THE WITNESS: -- incubation period --

THE COURT: -- patient to patient to vial to patient to vial to patient? Do you understand my question?

THE WITNESS: Say it again.

THE COURT: Would the single source patient have had to contaminate all of the vials in your theory?

THE WITNESS: No.

THE COURT: Okay.

THE WITNESS: One vial could have contaminated another.

THE COURT: Okay. As long as you're using the same syringe from -- or mixing the two vials together.

THE WITNESS: With the same way that you breached the sterility of the product --

THE COURT: Okay.

THE WITNESS: -- by using something for one patient

on another, yes. So one vial could have served as a source for another vial.

THE COURT: If you mix the dosage or the syringes.

THE WITNESS: Right.

THE COURT: Okay. I get it.

BY MR. WRIGHT:

Q So a fellow named Priti with CDC --

A A woman.

Q Oh. I'm sorry. A young lady named P-R-I-T-I --

A Patel.

Q Okay. Responded that there are no articles or cases like it, but you're theory seems to be a plausible explanation.

A It could happen. I don't really see --

Q Okay. I'm just --

A -- whether it's -- you know, it could.

Q Okay.

A Given how --

Q And that's a plausible explanation as to what --

A It's a plausible scenario for contamination.

Q Okay.

A Is the best --

Q And plausible means?

A It could happen.

Q It could happen. Okay. Now, on -- on 7/25, July 25 -- I don't understand why we don't look at the two events separately like what happened on July 25th and what happened on September 21st.

A Is there a question? Are you asking me?

Q Yeah, why -- why -- if September 21st hadn't even occurred and we're just investigating July 25th where there was a source patient, there's genetic connection sequencing, in other words the victim, the infected patient received the hepatitis of the source patient; correct?

A Yes.

Q And the -- we conclude that it must have been unsafe injection practice.

A Okay. So you're asking me how we -- well, first of all, they did the same kind of investigation that they tested patients to see if there were any other infections around the same time. So they conducted the same kind of investigation separately. I mean, clearly, two different time points. And -- but they didn't -- they only had the one infection, which from an epidemiological point of view, you wouldn't have been able to, quote, associate it with the source patient unless you did genetic sequencing.

Q Okay. But then it happened that it was connected.

A Yes.

Q Okay.

A So how could that happen? Well, there has to be some break in technique for a blood-borne virus to go from one patient to another. And having been able to associate the -- or having observed the unsafe injection practices which were ongoing at this clinic, it would stand to reason that the July 25th incident had the same -- was likely to have been caused by the same mechanism as the September incident --

Q Okay.

A -- transmission episodes.

Q But it -- it could have happened that way.

A Yes. You can't prove it, but, yes --

Q Okay.

A -- it makes perfect sense. And from a public health point of view, that's what -- it's important to know what it is that needs to be changed or communicated to prevent it from happening in the future. That's the purpose of the investigation.

Q Okay. And it -- and it's not a -- have you ever participated in a criminal investigation?

A No.

Q Okay. And you all -- you all, meaning you healthcare epidemiologists, CDC, are going in and you want to as quickly and thoroughly as possible find out what is

occurring so that you can both stop it, correct it, and notify anyone who is potentially at risk; correct?

A That's correct.

Q And are -- are you aware that Brian Labus -- you testified on direct about the importance, especially with the new investigators, the newbies who were out there in field, don't jump to conclusions, don't -- don't zero in on one cause, or likely cause, and stop. You have to do everything; correct?

A Yes.

Q Brian Labus has testified that the investigation started at the clinic on Wednesday, the 9th of January, late in the afternoon, and the next day on Thursday they did chart review, they meaning CDC and Brian Labus and BLC and all these team members.

A Uh-huh.

Q And the next day on Friday they knew of the propofol multi-patient use and observed reuse of syringe on patient to redose, and by Friday evening, two days into the investigation, he had determined the likely cause. Does that make sense?

A That's the question, does it make sense, or did it --

Q Yes.

A -- is it -- could it have -- did it happen

that way? I can't --

Q Okay.

A I don't know. Since, I can see that that's happening -- that happening, especially given the history of consistency of these outbreaks being due to the same cause over and over and over again. However, the CDC did do a complete analysis of all the other kinds of exposures that could have occurred regardless of what his conclusion was on Friday afternoon.

Q Okay. His -- I mean, he testified that he had determined that --

A I can't -- I can tell you that in their publication they presented the data showing the other types of exposures that they looked at and ruled out because there was no association between those other exposures and getting -- and acquiring hepatitis C.

Q Okay. Now, the -- the unsafe practices that keep going on and on and on in the literature and in real life practice, here the evidence has been that the -- the -- on Wednesday afternoon when the -- Mr. Labus and Dr. Fischer and Dr. Schaefer went in, the clinic told them they are multi -- they are injecting with multi-dose propofol, multi-dose vials, whatever the terminology was, multi-dose --

A Single-dose vials used on multiple patients --

Q Correct.

A -- is actually what they were.

Q And is -- is what they acknowledged and exactly what their practice was. And this -- and the evidence has been here in this courtroom that that was a common practice throughout this community in outpatient settings.

MR. STAUDAHER: Objection, Your Honor. I don't believe that's the testimony or evidence as it is right now.

THE COURT: Don't spin the evidence, Mr. --

MR. WRIGHT: I'm not spinning the evidence.

THE COURT: Mr. Wright.

And, ladies and gentlemen, once again, it's your recollection of what the testimony was and how you interpret that in terms of, you know, common --

MR. WRIGHT: Okay.

THE COURT: -- uncommon. It's up to you. Again, I'll remind you.

That's what I meant, Mr. Wright.

BY MR. WRIGHT:

Q Keith Mathahs is a CRNA, okay, who was observed, and he testified here in this courtroom that it was the same practice at Sunrise, it was the same practice at Southwest, it was the same practice everywhere he was involved.

MR. STAUDAHER: What practice are you referring to specifically? That's the point that I'm --

MR. WRIGHT: Multi --

THE COURT: Can you be more specific in your questioning, Mr. Wright.

MR. WRIGHT: It was specific before he said --

THE COURT: All right. Well --

MR. WRIGHT: -- it wasn't --

THE COURT: -- Mr. Wright --

MR. WRIGHT: -- the evidence.

THE COURT: -- state your question again.

BY MR. WRIGHT:

Q We are talking about using a single-dose propofol vial on multiple patients, acting like it's a multi-dose vial rather than single-dose vial.

A The problem, if you just look at it that way, is bacterial contamination and has nothing to do with serial virus contamination.

Q Okay.

A Because a single-dose vial, something labeled for single-dose has a very short period in which it can be opened and used. It has no bacteria static preservative in it to prevent contamination and when it's -- after it's been opened. So it's bacterial contamination that is intended, a multi-dose vial that's -- excuse me, a vial that's labeled as multi-dose versus single-dose. And I think -- and the package insert is very clear about this for propofol. But not every

outbreak has involved propofol, and some have involved vials that are labeled for multi-use. The issue here is the re-dosing with the same syringe.

Q I'm going to get to that.

A Well, yes, but --

Q Okay. Well, I just --

A Okay.

Q No --

A Okay.

Q We'll get -- we'll get where you want to go.

A But it isn't -- it isn't necessarily the -- I mean --

Q Well, I'm --

A Well, that might not --

Q You're not going where I'm going.

A Well, okay.

Q I'll drive, and then you can get what you want. And if you think I'm asking unfair questions or something, I'm -- I'm trying to focus in on this why this lack of recognition, this lack of understanding, this lack of awareness in the community of the danger involved in using like a 50 cc propofol vial as multi-dose. Okay? I mean, do you understand that just -- the things just keep going on despite your -- all -- all the best efforts to say don't do it? Do you agree with that?

A What I -- you're not in isolation. Well, you shouldn't use a single-use vial unless you use all of it at once. You shouldn't use it for, you know -- you shouldn't have it open for more than the time. It has nothing to do with -- I mean, it has very little to do with the fact that it's labeled for single-use in terms of virus transmission.

Q Is that --

A Then it has --

Q -- part of --

A -- more to do --

Q -- the confusion?

A Well, you can't take it -- in my opinion it's not -- you can't take that as an isolated event, reusing the vial.

Q I'm not isolating it.

MR. STAUDAHER: Your Honor, I'm going to object to letting -- I would like him to let her finish her answer before he --

THE COURT: Were you -- okay.

Were you finished with your answer, ma'am?

THE WITNESS: Yes, that I can't -- that his -- the question is not answerable in that way.

BY MR. WRIGHT:

Q Okay. As part of --

A It has no significance.

Q Okay. The significance I'm asking is -- is why do these -- we've had a CRNA in this courtroom, Mr. Sagendorf, who is presently a CRNA practicing in California for two large outpatient clinics and he testifies right here within the past month that they still use propofol as -- single-use on the label, they use it as multi-dose in their clinics. They use it for multiple patients.

A Uh-huh.

Q Okay. And I --

A I'm not shocked.

Q You're not shocked. I'm not shocked either. And -- and we understand best practices. We've heard all about best practices. And all I'm focusing on, we'll get to the needles in due course, but the -- somehow, and this may be the confusion between the multi-dose and single-use has to do with the preservatives and how long it can last once it's open; is that fair?

A Yes.

Q Okay. Because, I mean, you talk to practitioners and they say I'm using it quickly. Once I open propofol, it -- it says right in there if you read everything that it's good for six hours. And if I am using it all within that time frame, there is no harm in me using it all up. Do you understand what I'm saying?

A Yes, I understand perfectly.

Q And they -- and if you read the propofol vial --

MR. WRIGHT: Where is our propofol vial? It's an exhibit.

BY MR. WRIGHT:

Q We've had witnesses testify that it's safe to use it if once you open it, if you use it all within six hours. And none of that -- none of it -- if you can --

A See it?

Q See it. None of that is explained on that label. Is it?

A I have to read the label.

Q Okay.

A However, anyone who uses a drug, any drug, should be -- a professional who uses a drug, any drug, should be fully familiar with that drug.

Q Agreed.

A Okay. So --

Q Best practices. I agree.

A Now, the other issue is I think in my opinion there is confusion regarding multi-use and single-use vials and how they contributed. This outbreak could have just as easily occurred with a multi-dose, a vial that was labeled for multi-use. Because the issue wasn't so much that it was a single use vial. It's that they contaminated the vial and

then used it on multiple patients. And that could just as easily have occurred with a vial that's labeled for multi-use. Okay.

Q Okay. I agree. But why -- why do we have -- we had another CRNA testify in here named McDowell. McDowell, I don't remember his first name. But he wanted to argue with the investigators --

A I bet he did.

Q -- when they told him you use that 20 cc, and then you throw it out and you can't use it on another patient. And he literally argued that as long as I am using aseptic technique and I use a new needle, new syringe every time I enter that vial, there is no way on Earth you can ever show me I will contaminate a patient. And he wants to argue with them to -- to use the vial up and not throw any away. And so why doesn't it sink in?

A I have no idea why it doesn't sink it.

Q Okay. But --

A I have no knowledge or data --

Q Okay.

A -- to tell you why it doesn't sink in.

Q Who in CDC --

A It says single patient infusion vial. That's what it says.

Q I found it on there, but I needed a magnifying

glass.

A I can't believe I can read it myself.

Q I can't either. But --

A It does say it. And the package insert is -- it says it in big letters.

Q But no package inserts come with this.

A No.

Q They come in flats of 20 with no --

A However, if you were a physician or a nurse and you were using this routinely on patients, you would hopefully have looked it up in the PDR and know everything about it.

Q I don't disagree with best practices.

A I'm just saying. However, the issue here, in my opinion, is not the fact that this says it's for single patient infusion. It's the fact that they contaminated it.

Q We're going to get to the --

A But, you see, it's irrelevant epidemiologically --

Q Epidemiologically, but --

A -- and scientifically.

Q -- this is a criminal case --

A I know --

Q -- okay --

A -- but I'm science.

Q -- and people's knowledge matters. It matters whether they are mistaken in their judgment or are they consciously, knowingly doing something they're not allowed to do. So I understand epidemiologically it may not matter, but --

A Well, then that wouldn't -- that also would not -- if they didn't know that they were doing something wrong, then it would apply to whether it was -- they were -- it wouldn't matter if it was single-use or multi-use, they would still be contaminating the vial.

Q Right. Because I may think I am engaging in proper practices. Let's move on to your favorite, the contamination. Okay. Needle and syringe usage. What was observed here? Keith Mathahs is the fellow who -- who is in the report who was observed by Dr. Fischer. In the clinic, in front of the CDC inspector with her little -- I don't want to call it her badge, her little plastic badge on, knowing there is a hepatitis outbreak, she is observing his practice.

And this CRNA takes a new propofol vial, I'm presuming he wiped the top off, you know, with the alcohol, all of the aseptic stuff, inject the patient, procedure is ongoing, patient needs another dose. He takes the same needle and syringe, holds it up, takes off the needle, puts it in the Sharps container right in front of the CDC inspector, gets out a brand new sterile needle, puts it on, and redraws out of the

same propofol vial.

A Uh-huh.

Q Procedure ends, Dr. Fischer steps in, interviews Keith Mathahs, and her testimony is he was not aware that his practice was risky or dangerous. And he believed that he was being aseptic by changing the needle. Okay. Why does -- where -- why does he think something like that?

MR. STAUDAHER: Objection. Speculation, Your Honor.

THE COURT: Yeah, that's sustained. You need to phrase that --

MR. WRIGHT: Okay.

THE COURT: -- a different way. If there's anything in the --

BY MR. WRIGHT:

Q Why do those instances like him -- I mean, have you seen a situation like that during your investigations where the person just wasn't cognizant, aware, understanding of the improper behavior the person was engaging in?

A Yes. Not this specifically, but other investigations --

Q Okay.

A -- involving unsafe practices, we'll say.

Q Okay. And you're dealing with Keith Mathahs, got out of CRNA school before Dr. Fischer was born in the late

'60s. Okay.

A But not before I was born or graduated. And I can tell you that his -- his original nursing degree is based on a practice taught to him in nursing school, and that practice routinely involves -- or the curriculum routinely involves aseptic technique for -- for giving injections, for preparing and administering injectables.

Q Right. But those techniques have evolved.

A No.

Q Well, in the late '90s, in these articles I've read, in the late '90s, 1990s, you still had between 20 and 35 percent of the practitioners believing you could multi-use a needles and syringe on multiple patients if you change the needle.

A I know. It's unbelievable, isn't it?

Q Right. And -- and what were the standards then?

A The standards have been the same all this time. I cannot -- the standards -- aseptic technique is not something that has evolved over time. Although, obviously, disinfection and sterilization techniques have changed, the term and what it implies, asepsis, you know --

Q Clean.

A -- has not changed. Okay. So the fact that they believe that by changing the needle they are maintaining

a sterile connection, I don't under -- I have no idea why they believe that.

Q Well, who in the CDC -- I mean, you keep putting out -- I'm talking not you --

A It's okay.

Q -- but the CDC --

A I'm used to it.

Q -- puts out these common myths, puts out posters on misperceptions, and -- and keeps trying to drive this in to the practitioners, and it still persists. And so who is studying the why it doesn't trickle in to the perception of the practitioners? I mean, something is wrong in the teaching, something is wrong in the delivery of the message. I mean, I can't believe that like -- I'll show you a study where 28 percent of the --

A I saw the --

Q -- practitioners --

A -- same study --

Q -- still believed it was okay to reuse needle and syringe on -- on the same patient. All I'm doing is reusing needle and syringe on same patient, and then threw it away. 28 percent of the practitioners.

A Actually, you can do that. You can reuse a needle and syringe on the same patient.

Q Not CDC. We heard best practices was you go

in, you use it once, once, once, and it's gone. That's what we heard here from Dr. Fischer and -- and Dr. Schaefer.

A Once only.

Q Okay.

A It all -- it's a package. It's not -- you're isolating the events. They're referring to a package. They are trying to drive home a point or a practice and they're trying to make it simplistic. And, you know, I'm -- what we used to say, and still do, is you have two choices. You can either keep your -- if you want to use a multiple-dose vial on multiple -- on more than one patient, or a single-use vial, whatever, you better keep it separate from the treatment area so that people cannot go back into it with a used syringe or needle. You keep it separate in a centralized medication area. What, they're going to walk out of the room to get another dose? I don't think so. So -- or you don't reuse. That's the bottom line and has been for -- since the -- well --

Q Okay.

A -- since I came to CDC. So we've been pushing this home and dialysis centers forever. And the only -- that is one area where I do know, or I can speculate, rather, why staff are not carrying out appropriate infection control practices that have been recommended since the 1970s.

Because there -- the cohort of personnel who were

there in the '70s, '60s and '70s and early '80s who saw all these transmission episodes that are now being -- that were then prevented by good infection control practices, as well as a little vaccine, have never seen an outbreak because they were prevented. So they don't understand the need for some of these recommendations that are made for that specific setting, okay, which are very -- much more extreme than for other settings.

And that was the only -- I mean, they just are -- it's like parents who don't want to vaccinate their children against childhood diseases. They have never seen a case of polio or a case of measles and don't know how severe it can be. And, therefore, they would -- you know, they can't appreciate what vaccines to, you know, for the population. It's somewhat of a familiarity. On the other hand, would you operate with an unsterile -- well, yes, actually, I've seen that, too.

Q Okay. Well, I get --

A I've seen that, too.

Q I understand.

A Where a surgeon thinks that if he washes it in the sink, his instrument, with soap and water, he can use it on the next patient because it's his instrument and he's very attached to it, he/she. So I -- it's -- I can't explain why it doesn't get through.

Q But -- but -- maybe I'm Pollyanna-ish, but I just don't think 28 percent of the healthcare providers in this one study appreciated the risk. I mean, I misstated that. 28 percent of them, I think, misapprehended, misunderstood the behavior they were engaging in, as opposed to 28 percent of them were just saying hell with it, I don't care if I'm going to harm someone.

A That I can't say. I have -- I don't know the rationale for reusing. I just know that they did. When they surveyed outpatient surgical centers, 28 percent were reusing.

Q It was shocking.

THE COURT: Can I see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ma'am, we're not going to finish with your testimony at a reasonable time before lunch.

So, ladies and gentlemen, we'll just go ahead and take our lunch break now. We'll be in recess for the lunch break until 1:30.

During the lunch recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Do not do any independent research by way of the Internet or any other medium. And please do not form or express an opinion on the

trial.

Notepads in your chairs, and follow the bailiff through the rear door.

(Court recessed at 12:22 p.m., until 1:34 p.m.)

(In the presence of the jury.)

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

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q Doctor, one of the articles you forwarded, U.S. Outbreak Investigations Highlight the Need for Safe Injection Practices and Basic Infection Control. In -- in talking about the practitioners continuing to utilize single-dose vials as multi-dose vials despite best practices recommendations, what -- I'm going to read you a portion of this article and then ask you if you agree with it. Okay?

Transmission potential is magnified when facilities use vials or bags of medication and infusates that contain quantities in excess of those needed for -- for routine single patient use. Although these medications are often labeled as single use, i.e., single dose, the large volume in the container may lead to the perception that they are suitable for multi patient use. Do you agree with that?

A Yes.

Q Okay. And that -- that was a long -- I'm not sure of the infusates and all of the words there, but when it comes in a big package, like 50 cc and it's utilized in an outpatient setting where you normally use 10 to 20 ccs for a procedure, having that big vial invites the belief that you can use it for more than one patient; is that fair?

A The belief? I don't know if I agree with that, or rather misperception.

Q Okay. The misperception that it can. And in this case, the evidence that has been introduced thus far was that 20 cc vials of propofol were initially being purchased, and then the purchase person, a fellow named Jeffery Krueger, the charge nurse, talked to a Baxter representative who said, hey, we have 50s, do you want some of those. Okay? And 50s were then introduced to the clinic. Had -- had that not happened and they just kept with 20s, that would have decreased the opportunity for something like this to happen?

A If 20 milliliter vials were used up on a single patient, then the opportunity for contamination of the vial for the next patient would not be there.

Q Okay. And I think, as you made clear this morning, if I just stuck to using one vial per patient and throwing it away, or if I just stuck to using one needle and one syringe one time, either of those -- this -- this type of transmission wouldn't occur; correct?

A Likely not.

Q Okay.

A Correct.

Q Okay. Most likely this -- this type --

A Yes.

Q -- of transmission. And you, I think, agreed that using the same needle and syringe to redose the same patient for propofol would be okay as long as that propofol vial is then thrown out?

A That's correct.

Q Okay. Now, is part of the confusion that continues to manifest itself by lack of following best practices in the practitioners, is part of the confusion due to the varying definitions of single patient use, single use and single-dose vials?

A No.

Q No?

A I don't believe so.

Q Okay.

A In my opinion it's not the vial that's the problem. The vial -- we're human. Sometimes we actually make policies because we're human. And so we might go a little further with our policy in order to prevent human error, okay, from affecting a particular procedure --

Q Okay.

A -- knowing that we're human. So it isn't the fact that the vial -- this would still have happened even if the vial was labeled multi-use given their other practices.

Q Correct.

A Okay.

Q I mean, but -- I'm with that. The -- I mean, because if you had simply tossed the vials at the end of each use for a patient, no problem. If I had reused syringes on every patient and tossed the vials, no problem; right?

A That's correct.

Q And if -- if I use the vials as a multi-dose vial, despite what it says on it, and I used a new needle and syringe every single time I entered it, every single time I dosed a patient, no problem; correct?

A As long as there wasn't blood splatter, yes.

Q Right. I'm just giving it a -- okay.

A Yeah. All things being equal, yes.

Q Okay. And the -- my -- I'm -- I'm more confused about the interchangeability of calling a vial single dose, single use, and single patient use. Okay?

A Uh-huh.

Q And maybe I'm too literal and I'm not a healthcare practitioner, but I -- I read something and I see distinctions between a dose and a patient use. Do you?

A No.

Q Okay. Well, see, I do. When I think of something as a single dose, to be used once, that means I take it -- I take out a dose, I throw it away, and I use it. And if the patient needs another one, I get out another one for another dose. Am I wrong?

A You're interpretation, yes, is incorrect.

Q Okay. Okay. Because dose and use are synonymous --

A In this instance.

Q -- in CDC land?

A Yeah, in -- no, in medicine In this instance in medicine. Remember, the FDA approved this packaging.

Q For good or bad.

A I'm just pointing that out. I mean, they approved the wording that is on these kinds of pharmaceuticals. So I'm just telling you what we -- that's -- that's the interpretation.

Q Okay. Because I'm going to show you an exhibit. But now maybe it'll make sense since a use is the same as a dose. Do you recognize that?

A No.

Q Okay.

A I mean -- I mean, I haven't been on the website recently to look at their recommendations.

Q Okay.

A So I have no idea when it went up, but I know they have a major campaign on their website.

Q Right. This is off the CDC website --

A Yeah. No, I can see that.

Q -- last night. And tell me if everything on there look -- looks accurate.

A Okay.

Q Does that look accurate?

A It's an -- it's actually preventing human error. It's a little -- in other words, one could look at this and say that I was incorrect when I said on the same patient you could reuse that needle and syringe on that -- with that medication vial, for example, as long as you threw it out.

Q Okay.

A Okay. That not what this says. This says you shouldn't do that.

Q Okay. I wasn't --

A No, no, no. I know. I didn't mean --

Q Okay.

A I didn't mean anything by that. And all I'm saying is what they're trying to do is reduce the opportunity for anyone to -- to -- reducing the opportunity for human error by making it just one policy and that's it.

Q Okay. The --

MR. WRIGHT: I'm going to move its admission.

MR. STAUDAHER: No objection.

THE COURT: All right. What number is that, or letter and number?

MR. WRIGHT: What exhibit?

THE WITNESS: S1 or -- S1.

THE COURT: S1. That would be right.

(Defendant's Exhibit S-1 admitted.)

BY MR. WRIGHT:

Q The part that throws me is the single dose, this differentiation between multi and single, okay. And as I read this, this is a patient safety threat syringe reuse. And it says a single-use vial is a bottle of liquid medication that is given to a patient through a needle and syringe. That part I get. Single-use vials contains only one dose of medication and should only be used once for one patient using a clean needle and clean syringe. Okay? See, I -- I read that literally as meaning --

A I would --

Q -- a single-use vial has only one dose in it. And after I use one dose, I toss it, which is inconsistent with the label; correct?

A The label on -- well, the label doesn't really say, does it?

Q What's it say?

A I'm sorry. I'm not laughing because -- because I can see the -- I mean, I don't happen to agree with that statement. I don't know if it's correct. Because, let's face it, why would you make a vial that contains -- you know, that's not consistent because you don't give all of this at once.

Q Right.

A You might give it twice or three times in the course of the procedure. So you could then draw it up. But -- and it says it's okay for 12 hours. It says use strict aseptic technique. It says single patient infusion vial.

Q Okay. Single patient infusion vial.

A I'm telling you, if my computer was working, I would boot it up -- which it isn't somehow. I don't know. I must have -- I left it on. I would boot it up, I would go to the FDA, and I would see what their definition was. I think -- I mean, I can't honestly address the veracity of this statement --

Q Okay.

A -- because we know this contains more than one dose. In other words --

Q Right.

A -- you're not going to give them, the patient, all of this at one time probably, unless maybe they weigh 300 pounds. Okay. So --

Q See, when I looked at the --

A No, I -- so I see your point. And the only reason I can, you know -- again, I'd like to see what the FDA, what their definition is. But also, as I said, sometimes in relooking at policies or recommendations, I mean, this wasn't a CDC recommendation to begin with technically. It's an aseptic practice that's part of -- should be part of routine medical care, but anyway. We go -- we -- CDC will go a little more to the extreme to, as I said, prevent human error. On the other hand, that is a definition. And that's why the only way I would know is if I looked it up.

Q Okay.

A And I actually don't think of it that way myself. So -- but on the other hand, you know, I think they're trying to make it so simple that no one has to think about it.

Q Right. And it's -- and it's -- what you think is simple is confusing when you --

A Right. I understand that, but when you find that people are not following a procedure that's been in place for 50 years, then you have to decide what is it you need to do to make sure that they follow it, even though you might be going a little more -- a little overboard, so -- in some people's minds. Maybe they just want them to think single, single, single, and that's it.

Q See the -- see the next definition of multi-dose says a multi-dose -- a multi-dose vial is a bottle of liquid medication that contains more than one dose of medication. Now, if I'm applying this CDC directive, I would look at that propofol vial there as a multi-dose vial because it contains more than one dose. Agree?

A That's your -- see, but -- I can't comment.

Q Okay.

A Because I can't comment. It's a single -- it's a single -- because I don't know the -- as I said, I need to find -- I would need to know how the FDA -- you know, this is an FDA approved label, otherwise it wouldn't be licensed. And it says single patient infusion vial.

Q Okay.

A So but I honestly don't -- don't know why you couldn't give multiple doses in a short period of time to the same patient from this vial.

Q Okey-doke.

A But there's a lot of pooling going on with a lot of medications in different settings.

Q The -- your -- not your, but one of the articles you sent that talked about the New York -- 2010 article about the New York outbreak.

A The -- oh, yes, the later one.

Q Yes.

A Uh-huh.

Q Multiple Clusters of Hepatitis Virus Infections Associated with Anesthesia for Outpatient Endoscopy Procedures. The conclusion of it, if I may go through with you, outbreak similar to the one described here -- of course it's talking about the second New York outbreak --

A Right.

Q -- you commented on. Outbreak similar to the one described here would not have been possible if intravenous anesthesia medications were not administered from a single vial from multiple patients; correct?

A True.

Q Absolutely. Black and white. For this reason we advocate, now that's the authors of this; correct?

A Yes.

Q For this reason we advocate eliminating use of all multi-patient vials for anesthesia medications to the greatest extent possible, and educating clinicians on the risks associated with their use. Would you agree with that?

A Yes, and it's been stated in many previous publications, even while I was at CDC.

Q Okay. And so one thing to do was just plain no multi-use vials at all for anesthesia. That's just taking out human error and misperceptions.

A Uh-huh.

Q And educating clinicians on the risks associated with their use; correct?

A Correct what?

Q That that's -- that's something that needs to be done.

A Yes.

Q Even in --

A Yes. Yes.

Q This is three years later, three years after the events in this case and still in June of 2010, it's still a lack of understanding on the part of clinicians. Is that fair?

A Well, tactfully, yes.

Q Tactfully?

A Tactfully.

Q Okay. This can be accomplished by more clearly labeling medications, e.g., propofol as single patient use only. Would you agree with that?

A It is labeled as single patient use.

Q Okay. Well, this says this can be accomplished. I mean, you may disagree with --

A Those are the --

Q -- these authors.

A Well, I'm just saying that, you know, they're offering suggestions, but that is what this vial says and --

Q Okay. And improving pricing of unit dose single patient use medications to encourage their use. What did that mean?

A I can tell you exactly what that means.

Q Good.

A Multiple-dose vials are much more economical than single-dose vials. The larger the quantity, the cheaper it is per dose, the less expensive it is per dose. And, in fact, that's somewhat how they came to be multiple dose. Larger vials can be used for multiple doses. But it also then led to this problem, contamination, when used along with improper preparation techniques.

Q Okay. So improving pricing of unit dose single patient use medications to encourage their use.

A Right. Because, actually, when we -- when I was still there we -- you know, we said, you know, wouldn't it be great to get rid of all the multi-dose vials. But in -- in the absence of that you have two choices. You know, two things that you can do is restrict them to a centralized area where you can't go back into those, or -- you know, with a used syringe, or, you know, just not use them at all. So the first works quite well, but it's much more economical, particularly for large corporations, to purchase the multiple dose vials.

Q Why do you think that?

A Why do I think that?

Q Yeah.

A From my experience working in hemodialysis settings where I did a lot of very specific activities. It's an area of high specialization, particularly in terms of preventing transmission, and there are a lot of issues with economics in those settings, and that is part of the reason for purchasing large amounts of very expensive drugs that aren't supposed to be reused.

Q Okay. How about -- I mean, this is a propofol case.

A I know, but --

Q No, I mean --

A -- really, aren't economics --

Q No, I meant --

A You know --

Q Okay.

A -- but that is -- it is an economical issue --

Q Okay. Do you --

A -- I think.

Q Do you --

A In many cases it is less expensive per dose to buy in large volume than in small volume.

Q Do you -- do you have any -- do you believe like 50 cc propofols are cheaper by volume than 20 ccs?

A I have no knowledge in that area.

Q Okay. One article I didn't get from you, but you may be familiar with,

A Yes.

Q Okay. It's called Injection Practices Among Clinicians in United States Healthcare Settings.

A First off, that's from the place called the Premier Safety Institute, so it's a private organization.

Q I can't find where these things are from.

A I can tell you.

Q Melissa Schaefer is one of the authors.

A The first author is Gina Pugliese. The journal is American Journal of Infection Control. It's aimed at nurse -- infection control nurses in the healthcare facilities.

Q Bedside reading for --

A Well, for --

Q -- your kind.

A -- some of us.

Q This study or survey in 2010, or at least it was published December 2010, study during --

MR. STAUDAHER: Could I at least see the article?

BY MR. WRIGHT:

Q -- May and June.

MR. STAUDAHER: I'd like to see the article, if I

could.

THE COURT: I'm sorry? Oh, you want to see it.

MR. WRIGHT: I'm sorry.

BY MR. WRIGHT:

Q May and June of 2010 is a survey of approximately 5,446 clinicians, 90 percent of whom were registered nurses. Okay?

A Uh-huh.

Q The -- and it was a survey dealing with injection practices, syringe reuse, and multi-use of vials. The respondents reuse -- I'm going to ask you a question after this -- reuse syringe for additional doses from the same multi-dose vial. Did you follow that?

A Uh-huh.

Q Okay.

A Yes.

Q A total of 797 respondents, 15 percent, indicated that they are sometimes or always reusing a syringe for additional doses from the same multi-dose vial for the same patient. Okay?

A Yes.

Q And then of that group they were then asked -- that was 797 respondents -- were then asked about reusing the vial that they had just reused the syringe on. In our study, 797 respondents, 15 percent, indicated that they sometimes or

always reuse a syringe for additional doses from the same multi-dose vial for the same patient. They were then asked to indicate the disposition of the multi-dose vial. 51 of the 797, 6.5 percent, who answered the question on disposition of the vial indicated that they save the vial for reuse on another patient. Okay?

A Uh-huh.

Q So that -- that's 51 of the practitioners in this survey in 2010 did the double -- double danger; correct?

A Yes.

Q Okay. And that -- and that double danger being not -- not only did they reuse needle syringe, same patient, to redose, they then put it together with using the remnants, the leftover in the vial on the subsequent patient; correct?

A That's 6 percent of those whose said that they reused, or is that 6 percent of the total?

Q No, no, 6 percent of the 15 percent.

A Okay.

Q 51 -- no, I'm -- 51 out of what I told you, 5,446.

A Actually responded to the survey.

Q Right, that's the --

A Is that the number of respondents?

Q Yes.

A And of those 15 percent said they sometimes reused syringes to go to -- to back into a multi-dose vial.

Q Right.

A And of those 15 percent, 6 percent said -- said what they had done with the multi-dose -- but they reused the multi-dose vial.

Q Right. So that would work out like 1 percent --

A Right.

Q I mean, 51.

A Right.

Q I mean, there's 51 practitioners in 2010, I mean, still mixing together these --

A That's 1 percent.

Q Yes.

A Uh-huh.

Q Does that surprise you?

A It surprises me that it's that low.

Q Okay. Because?

A Because injection practices are so bad in -- in the places that we do the investigations that -- I shouldn't actually -- I shouldn't say that it surprises me in -- if these are general hospital based nurses, then I should say it doesn't surprise me. It should be low. It's never going to be -- I mean, I would be surprised if it was zero.

Then I would be suspicious. But it's a small number.

Q Well, it's -- it said the --

A No, we should be happy with that result. Well, zero is not -- you know, as much as --

Q Okay.

A -- people would -- as much as we would all like things to either be 100 percent or zero percent, that's not reality. And I think that the fact that it's 1 percent is quite good.

Q Okay. Where -- where would you think those infractions were, outpatient or in the hospital?

A It could have been either.

Q You're right. It said although non-hospital settings --

MR. STAUDAHER: Your Honor, I'm just going to move to admit this if we're going to read from the whole document. I mean --

MR. WRIGHT: I'm not --

MR. STAUDAHER: -- I don't have a problem with that.

THE COURT: Well, he can ask her specifically from the document, or he can speak to admit it without your opposition.

Go ahead, Mr. Wright.

BY MR. WRIGHT:

Q Our data indicates that some of the most

flagrant -- flagrant infractions, syringe reuse on multiple patients with only a needle change and reentry into the multi-dose vial, leaving it for reuse on another patient, are being reported at least half of the time by professionals in hospital settings. So it's about what you thought; correct?

A I said it could be either.

Q Right.

A That's what I said. It could be either.

Q Now, it identifies mistaken beliefs that account for this failure of appreciation of the risks, and I want to go through a couple of them. There are a number of mistaken beliefs about the risks associated with syringe reuse and aseptic technique when handling injectable medications during preparation and administration that likely contribute to many of the outbreaks of healthcare associated viral infections such as hepatitis B and C. For example, there is a belief that contamination is limited to the needle portion when a syringe and needle are used together as a unit. Has that been your experience that there is this mistaken, this misapprehension out there?

A Yes, which means there's something wrong with our education, medical education system.

Q Okay. And there is also an incorrect belief that the syringe does not become contaminated if the plunger is only pushed to inject, and not pulled to aspirate or

withdraw. What's aspirate mean?

A Withdraw.

Q Oh, okay. Okay. So they're -- they're -- this is an ongoing misperception or myth --

A Or ignorance. I mean, I really don't know what to say that -- I don't know what to call it, but I will tell you that I -- yes, I agree that they say -- they will say that. And they will say, well, there's no blood in the tubing. Well, you know, the germ theory of disease was discovered by someone who was trying to explain that just because you couldn't see it didn't mean it wasn't there. And it's -- I honestly do not know why they believe this. They really should know better.

Q Despite the availability of guidance on best practices from CDC and other groups, it remains a lack of awareness and implementation of these recommendations by may clinicians. Agree with that?

A Yes. I don't think the -- yes.

Q Hold that thought. Have you seen M-1?

A Not recently.

Q Okay. You've seen it before?

A In different formats.

Q Okay. And is that -- well, you tell me what that -- that's dealing with the persistent myths and what the truths are to try to address the people who still aren't

onboard.

A That's correct. It's part of the campaign, the one and only campaign.

Q Yeah, that's --

A One needle --

Q -- the name on it.

A -- one syringe, only one time.

Q Okay. Thank you very much.

MR. WRIGHT: I have no further questions.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: May I proceed?

THE COURT: You may.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Doctor. I represent Mr. Lakeman back there, and I'm going to ask you a few questions and try to clarify some of your direct testimony. But before I do that, I'm trying to understand exactly what the purpose of your testimony is here today as you understand it. We've had three epidemiologists testify in this case. All of them have participated physically in the investigation of this outbreak. And as I understand it, you haven't done that; correct?

A That's correct.

Q So what did you understand the purpose of your testimony to be here today?

A I'm one of the world's experts on the epidemiology of hepatitis C, and in particular it's transmission patterns and in particular in healthcare settings. And my understanding was to speak to those issues as they relate to this particular outbreak.

Q And is this part of the consulting business that you said you have?

A You might -- a business? It's like -- yes, I suppose, except that I agreed to do this in 2008.

Q Okay. So while you were still employed at the University of Texas?

A Yes, I was contacted by the sheriff's office

Q Clark County?

A Uh-huh. Yes.

Q And you were contacted in 2008 by the Metropolitan Police Department?

A Yes.

Q Who contacted you?

A I would like to be able to tell you who it was and, unfortunately, I can't remember his name.

Q Okay. And then in 2008 --

A Don't tell him.

Q I won't tell him. Well, is he sitting here?

A I have no idea.

Q Did you ever meet with him face to face?

A Did I meet -- no, actually, I didn't. Someone else from -- they had a task force, I think, and someone else came to see me at the university. Again, it would have been at least a year later because Hurricane Ike occurred in between.

Q Was it after the CDC had conducted their investigation and issued their initial findings?

A Presumably.

Q Well, they did that in January of 2008. Was your visit --

A It would have had to have been after January 2008.

Q And did they contact you and say, you know, we have this theory. We have this theory as to the mechanism of transmission and want you to validate that theory?

A No.

Q Okay. What did they want you to do?

A They wanted me to provide -- to be an expert, a source of expertise in this area in hepatitis C transmission in this setting.

Q So did they contact you throughout their investigation from 2008 forward? Did they contact you --

A No, actually, I didn't hear from -- I then talked to the -- Mr. Staudaher, who explained, you know, that sort of what the -- my guidelines should be in terms of other

people calling me to discuss the case. The only thing I knew about it were the things that I directly read. Actually, they didn't tell me anything. They did not approach me with any particular -- any particulars, the police.

Q Okay. Well, I'm still unclear as to what you were to do for them. They contact you and they tell you we want you to be an expert in this area because --

A You are an expert.

Q -- you're renowned for that. What did they want you to be an expert to do? Did they give you anything written, instructions, or here's a theory?

A No. They wanted me, I think, as an outside observer and whose expertise is specifically in this area, and I'm very experienced, to provide either -- to provide information or --

Q Okay. And we don't --

A -- on this outbreak.

Q And what information did you provide to them.

A I provide to them directly?

Q Yes.

A The articles.

Q Okay. Well, the article I have -- one of the articles I have from you was downloaded three days ago. So, I mean, when did you provide it to them. When I --

A Three days ago.

Q -- mean them, I mean --

A Those articles.

Q -- Metropolitan Police Department.

A Then there were -- did I send that -- you have to understand that our -- actually, there could have been several years that went by between my first contact with Mr. Staudaher and my next contact. I knew that until I was told differently that there was the possibility that I would be an expert witness for this case.

Q Okay.

A But it, obviously, went on quite awhile and I just went on about my business.

Q How many contacts did you have with either the District Attorney's office or the Metropolitan Police Department either telephonically, emails, or person to person?

A A handful.

Q A handful? Six? Five? Six.

A Want me to look? I can look on my phone and see how many emails I have. There are not many.

Q Okay. So a few?

A Well, that's a handful to me.

Q Depends on which hand your using.

A I know. I know, but really it's -- there weren't that many. In fact, there weren't that many. They provided me with, you know, the final reports, which one of --

which are all public anyway. And --

Q When did you get those reports?

A Well, I already had them, but the District Attorney's office provided them to me in the last few months. I want to say maybe -- well, earlier this year. Okay. I'm sorry, I just --

Q So earlier this year you get the trip report from the CDC from the District Attorney's office.

A From their office. I already had everything.

Q And then you get from their office what else?

A The Southern Nevada County -- the district report.

Q Okay.

A And -- and 18 exhibits or 25 exhibits, or whatever all the exhibits were that had been filed at that time.

Q Did you get the report, statement of deficiencies from the BLC, the Bureau of Licensing and Certification?

A I remember it being mentioned, I mean, in my reading. But I don't -- if it was an exhibit, then I got it. If it isn't -- wasn't, then I didn't.

Q Well, I'm asking you what your recollection --

A I know. Well --

Q -- of what you received.

A -- I don't remember seeing the report and -- I don't remember seeing the report.

Q Okay. You need to let me finish my question before --

A Sorry.

Q -- answer, okay? Because --

A Yes, I --

Q -- we're recording.

A -- apologize. I apologize.

Q You're doing it again. We're recording this, okay. And the record has to be very clear. Okay. Was -- were you being compensated for this by the District Attorney's office or Metro or citizens of Clark County?

A Since I no longer work for the government, I do have -- I am going to be compensated, but I haven't been compensated as yet. I haven't even submitted a voucher.

Q Okay. But you're getting compensated for your testimony here today?

A Yes.

Q And for any work you did previously on the case?

A For the number of hours that I did to review the documents, yes.

Q And -- and what is your compensation that you're receiving? How much is it?

A For today, I don't know. But for -- you can see I'm a real business person. My hourly rate for reviewing documents or writing reports is $450 an hour.

Q And what is your fee for testifying in court?

A This is the first time I've done it as a private citizen, so to speak, and so I have no idea.

Q Okay.

A Well, I shouldn't say I have no idea, but --

Q Well, what's the idea you have?

A Well, let me put it to you this way, okay. Well, we have -- we didn't agree on anything. To be quite honest, I still think of myself as a public service.

Q Well, let's surprise them right now and tell them --

A Well, what I'm going to --

Q -- how much.

A -- let me tell you that I looked up what other -- what physicians do who have to take off, you know, and it's -- it's so far above what I would even consider that -- you know, they charge 5,000, $6,000 a day for testimony. And if it's out of town it's more. We're not even --

Q Are you from out of town or do you live here now?

A I'm from out of town.

Q Well, where -- where do you reside?

A I reside in Galveston, Texas.

Q So you were flown in here today for your testimony?

A I flew in last night.

Q Well, it's safe to say you're not going to be charging less than $450 an hour for testifying here today; right?

A Yes, I am, probably.

Q Oh, you are?

A Well, I would do it as a lump sum. I didn't count the number of hours, you know, in the day. I'm not going to charge them by hour since I left home. I just can't.

Q I might get --

A I'm just not --

Q -- into contract negotiations --

A -- that way.

Q -- after this career is over.

A I told you. It's not a business. It's just, you know --

Q Okay.

A It's something that I do when I believe in something.

Q All right. So let's get back to what you -- you were supposed to do here. You reviewed certain documents from the CDC, from the Health District, and from someplace

else. I don't know where else, but some articles or something?

A Well, I -- in the course of my career, I've read or reviewed almost all of the articles that are currently in the literature since I've written reviews and editorials and --

Q And so now you have -- at some point you have the Southern Nevada Health District Report and you have the CDC trip report?

A And their publication in -- and their publication in the journal.

Q And then from that, you read all of that, and you came up with an opinion, or you validated their opinion, one or the other. Which was it?

A I don't know. I -- I -- it was already -- I guess I validated their opinion.

Q Okay. Now, did you review or look at anything else other than what you've told us here today?

A You mean other than the literature, the publications and the literature and the major reports from the CDC and the Health District --

Q Right.

A -- and the exhibits that were on file, which, you know, were line listings of specimens and patients and things. I don't think so --

Q Okay.

A -- to the best of my recollection.

Q And your opinion was basically supporting the CDC's opinion that the mechanism of transmission in this particular case was the unsafe injection practices at the clinic; is that correct?

A Yes, that's correct.

Q And what methodology did you employ to come up with that opinion?

A I reviewed the methodology for both the epidemiologic investigation, the -- as well as the laboratory, as well as the virus sequencing performed in the laboratory, and then for which I had the results to determine if I agreed with the methods that were used and the conclusions that were drawn from those methods.

Q Okay. Were you aware when the CDC conducted their investigation that they were not sure as to which patient was in which room at which time?

A I was -- I am aware from reading the reports that it was -- that the records were very inaccurate.

Q Okay. How many --

A That's all I can --

Q How many procedure rooms were at Shadow Lane on July 25, 2007?

A Two. I don't know.

Q Is that a guess?

A Yes, that's a guess.

Q How many procedure rooms were at Shadow Lane on September 21, 2007?

A I know that they did 65 procedures.

Q And the question I asked you was how many --

A I'm sorry.

Q -- procedure rooms.

A I don't know.

Q Okay.

A Or don't recollect.

Q Okay. So my question was were you aware that the CDC did not know which rooms the patients were in and at what times when they conducted their investigations?

A No.

Q You were not aware of that?

A Well, no, not specifically at the time they conducted their investigation, no.

Q Were you aware that they didn't know that information when they issued their initial findings?

A No. What I was --

Q That's -- that's all I need to know. Were you sent copy of Exhibit -- State's Exhibit 156 and 157 as part of your examination?

A Yes.

Q So you looked at these?

A Yes.

Q And when did you receive these documents?

A In the last couple weeks, sometime in the last couple of weeks.

Q Okay.

A Like three weeks ago, maybe, four weeks ago.

Q When did you reach your conclusion or concur with the CDC's finding?

A After reading the reports. It had nothing to do with this.

Q It had nothing to do with this. So you reached your conclusions before you saw these two exhibits?

A That's right because I reached my conclusions based on the epidemiological investigation.

Q Were you aware that the CDC did not interview the RN that administered the heplock on September 21, 2007?

A I don't know.

Q Were you aware of the cleaning practices for the endoscopes and the biopsy forceps for September 21, 2007?

A I read the methods that were used in -- in the reports, they were quite detailed, for the scopes. The biopsy forceps were apparently -- they talked about some reuse of disposables, I guess, that -- a practice that had been stopped. But regardless, there was the investigation. The

results of the investigation indicated that there was no association between getting infected and those pieces of equipment.

Q Okay. Tell me what you understood the cleaning procedures to be for the endoscopes.

A It was a very long -- it was a very long and detailed explanation that involves the cleaning of the scope, the rinsing of the scope. Manual cleaning is extremely important. You have to get all of the organic debris that might be in there out before the disinfectant can work. Because organic matter like blood and things can prevent the disinfectant from getting to the actual scope or germs that might be left there, something that a lot of people don't appreciate. And then they had a -- they have a machine that then reprocesses the -- these scopes for high level disinfection.

Q What's the difference between disinfection and sterilization?

A High level disinfection actually kills everything but bacterial spores. Sterilization also kills bacterial spores.

Q And how was the clinic cleaning bite blocks and biopsy forceps on September 21, 2007?

A The biopsy forceps, I'm not sure. The cleaning blocks -- I mean, I'm sorry, the bite blocks I'd have

to look at the report. I just -- again, while I was aware when I was reading these reports, it's the epidemiological methodology they use to look at exposures associated with infections that I was -- that I'm focused on and whether or not they considered sufficient -- you know, they considered the issues of importance in that -- in the setting. That's what I was looking at. I'm an epidemiologist. That's what my expertise is in this disease area.

Q Well, Doctors Langley and Schaefer testified that prior to coming to Las Vegas they had a theory or hypothesis that the infection was transmitted through unsafe injection practices.

MR. STAUDAHER: Objection. Mischaracterizes their statements, Your Honor.

BY MR. SANTACROCE:

Q But they didn't rule out of other mechanisms.

THE COURT: And that's -- that's overruled. And, of course, I've told the ladies and gentlemen of the jury if anyone, you know, prefaces a question with a statement of what the testimony was and that's not your recollection of what the testimony was, it's your collective recollection that's important, not something the lawyers may say or something that I may say as to what the testimony was.

BY MR. SANTACROCE:

Q So they looked at other mechanisms of

transmission.

A That's correct.

Q Okay. One of those mechanisms was scopes; correct?

A Yes.

Q And you -- you ruled out that theory because they ruled it out; correct?

A I ruled out the theory by looking at the data they generated to show that there was no association.

Q Okay. What data did they generate?

A There's -- they showed the frequency with which, you know, the -- the use of the scopes, you know, depending on whether you got an upper GI or a colonoscopy, they looked at the frequency of the specific procedures and those people who got infected versus those people who didn't. That's -- that's how you --

Q I'm talking about the cleaning of the scopes.

A Hold on. You asked me how I drew that conclusion.

Q Right.

A Okay. That, in addition -- that was most important. But also I thought that regardless of a few deficiencies cited as like the detergent used --

Q And you thought those deficiencies were minor?

A Actually, from the point of view of

blood-borne virus transmission, yes.

THE COURT: Mr. Santacroce, we're going to need to take a break now --

MR. SANTACROCE: Okay.

THE COURT: -- so I'm going to interrupt you.

Ladies and gentlemen, we're going to take a brief recess. During the brief recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, or listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research. And please do not form or express an opinion on the trial.

Notepads in your chairs and follow the bailiff through the rear door.

(Jury recessed at 2:37 p.m.)

THE COURT: What do we have to look forward to for the rest of the day?

MS. WECKERLY: Well, we have Dr. Lewis and then we have the --

THE COURT: And that's Ms. Grueskin's physician; correct?

MS. WECKERLY: That's correct.

THE COURT: So we have to do him today, which I'm good with.

MS. WECKERLY: Okay. And then we have an insurance person, and then --

THE COURT: Well, Ms. Stanish says she has all the records, so that should go smoothly.

MS. WECKERLY: She's good with this one.

THE COURT: Yeah, so that should go smoothly.

MS. WECKERLY: And then -- well, we have -- we have -- I mean, one thing we could do is we have Bob as the witness, but I have a doctor for tomorrow, so I can --

THE COURT: Is that Romie?

MS. WECKERLY: No, Jurani.

THE COURT: That's his name Romie Jurani.

MS. WECKERLY: I thought it was Patero.

THE COURT: Well, I think it's his nickname.

MS. WECKERLY: Oh, okay. Maybe.

(Off-record colloquy.)

THE COURT: In any event. Does that mean we're done?

MS. WECKERLY: You mean for tomorrow, then?

THE COURT: Right.

MS. WECKERLY: Well, with Dr. Olson, and then part two of the other --

THE COURT: Right. And then that's it?

MS. WECKERLY: That's it.

THE COURT: So you're not calling Dr. Jurani at all?

MS. WECKERLY: No, because he doesn't really --

THE COURT: Okay.

MS. WECKERLY: I mean, he doesn't say anything that -- that I don't think we've covered.

THE COURT: Okay. All right.

MS. WECKERLY: And another GI tech. Just kidding.

(Court recessed at 2:39 p.m., until 2:55 p.m.)

(In the presence of the jury.)

THE COURT: All right. Court is now back in session.

And, Mr. Santacroce, you may resume your cross-examination.

MR. SANTACROCE: Thank you.

BY MR. SANTACROCE:

Q You were talking about what you described as insignificant lapses in the cleaning of the scopes. Were you aware that the BLC actually observed the cleaning of the scopes, ma'am?

A I know that the cleaning of the scopes was observed.

Q Do you know that the BLC was part of the investigatory team, along with Southern Nevada Health District and the CDC?

MR. STAUDAHER: Objection --

THE WITNESS: Yes.

MR. STAUDAHER: -- Your Honor. That's not actually correct. They weren't part of the investigatory team. They investigated separately.

THE COURT: Well, okay. They -- they were involved in investigating. Is that your understanding?

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Well, they were present when groups were represented.

THE COURT: Okay.

BY MR. SANTACROCE:

Q And you understand that they issued a summary statement of deficiencies; correct?

A I saw the statement of such, yes.

Q Okay. Well, I'm going to show that to you now as Exhibit 80 E-3. This is their statement for the Shadow Lane clinic. And it notes that on January -- I'm not sure if it's a 6 or an 8, 2008. The GI technician was asked to describe the measured amount of EmPower with what amount of water. The GI tech stated add two to three pumps, not sure of the capacity of the basin, I do not have an answer to that. Were you aware the GI tech didn't even know how much sterilizing fluid to use, the ratio between the water and the sterilizing fluid?

A No.

they should be scheduled in the practice?

A Not that I was aware of.

Q This was the sort of the format that you had?

A That's how he specifically wanted it, that's how I specifically wrote it.

Q And when I asked you the question about PacifiCare, were you under any -- during anytime that you were there, did you become aware of sort of an order that PacifiCare patients had to be done?

A Not until later.

Q When you talk about later, are we talking about -- well, let's use as a benchmark the investigation. You know -- and I'm talking about the CDC investigation.

A Mm-hmm.

Q Was it after they came or before they came?

A After.

Q So this was something that you implemented at his direction but you didn't -- did you understand what -- what the implications were?

A No. I was very busy. And I don't mean to be disrespectful.

Q I'm going to move forward now to a couple things, and I just want to -- those -- those records that you showed, those were things that you've seen before in the clinic, those documents and memos and so forth?

A Yes, sir.

MR. STAUDAHER: And I want to move for their admission at this point, but I know counsel's still looking through them.

BY MR. STAUDAHER:

Q With regard to the 30-minute issue, did that ever become a problem at some point? And I'm talking about before the investigation at CDC, at any time was there any issue with that that had arose, but before January of 2008?

A Actually, yes. In 2007, Dr. Carrol had been sued by a patient, Rexford. And in that lawsuit I was deposed, the CRNA was deposed, and Dr. Carrol, of course, was deposed. So one of the things they were questioning was the CRNA time. I don't remember which CRNA it was. So it kind of happened simultaneously. The lawsuit was later part of 2007, the testimony happened in 2008, and the CDC thing happened in 2007.

And then there was a moment where, I don't remember which CRNA, Dr. Carrol came screaming up to my office, by this time I was located upstairs, saying and showing me one of the papers that one of the CRNAs -- I can't -- I don't remember which one, prefilled out an anesthesia form. He was livid. He was screaming. It was a mess. So he --

Q Before that happened, did you have any indication that there was any problem like that beforehand?

A We did have one with the nurses, the RNs. Katie and Jeff had brought up an issue of the RNs precharting something in their chart. We did bring that to Dr. Desai, Katie, Jeff and myself.

MR. WRIGHT: Foundation.

THE COURT: When did that happen? And again, you know, we don't expect you to say, oh, that was, you know, July 15th at 11:45. We get, you know --

THE WITNESS: I want to say 2007, 2000 -- 2007, early part of 2007.

THE COURT: So Katie and Jeff came to you with their concerns, and then the three of you went to Dr. Desai?

THE WITNESS: Yes.

THE COURT: Okay.

BY MR. STAUDAHER:

Q So what happens in that meeting?

A Dr. Desai was very angry, I mean, first of all that we were questioning him and what took place and so forth. So he proceeded to yell. Everything calmed down and the precharting stopped.

Q So the concern was brought to Dr. Desai. Did he seem surprised by what you were bringing him, or just angry?

MR. WRIGHT: Could I have foundation as to the conversation --

THE COURT: Well, can get there.

MR. WRIGHT: -- what the precharting --

THE COURT: Overruled. I mean, some of this you can follow up with on cross, and some of it Mr. Staudaher, you know, may get to the specifics.

THE WITNESS: I don't know exactly what they were precharting. I think, if I remember correctly, it could have been vital signs or something like that.

BY MR. STAUDAHER:

Q So you go with Katie and Jeff to tell Dr. Desai about this?

A Right. Because Katie brought it to my attention. Jeff was there. It was always better to approach him with three or more.

Q So when you say he was angry, was he angry because he was outraged about what was going on, or was he angry because --

A Because he thought it was a small --

MR. WRIGHT: Objection, Judge.

THE COURT: That's sustained. Only --

MR. WRIGHT: Just what was said.

THE COURT: I sustained the objection, Mr. Wright. If I sustain it you don't have to --

THE WITNESS: Dr. Desai --

MR. WRIGHT: They caught me off guard.

THE COURT: Wait, wait, wait. When an objection is

sustained, that means you can't answer the question. What you can say is if Dr. Desai said something, you know, I'm angry because or, you know, you can tell us what he said. But don't like speculate as to what he was thinking or what was going on in his head unless he tells you. That's basically --

THE WITNESS: It's very obvious when Dr. Desai is angry. The voices get loud. The voice tone got loud. We were wasting his time.

THE COURT: Was that said to you?

THE WITNESS: Yes.

THE COURT: Okay.

BY MR. STAUDAHER:

Q So he was mad because you were wasting his time?

A [No audible response.]

Q Was he angry at all because of what you were bringing him, the actual information you were bringing him?

A No.

Q Now, with regard to the 31-minute issue again, or 30-plus minute issue, whatever it was, when you have essentially Dr. Carrol coming up to your office, beside that one instance with charting and so forth with Katie and Jeff, had there ever been an issue to your knowledge about any kind of 30-minute time period that was being billed?

A No.

Q Were you aware -- well, I think you had

testified before that Dr. Desai told you that that's what it needed to be though, correct?

A From the start time to the end time.

Q And that that was this --

A It should be around -- he didn't give -- he never gave specific like time frames.

Q But didn't you testify that he said it should be greater than 30 minutes?

A It should be -- yes, the more than 30 minutes, but he didn't say 30, 31, 35 or anything like that.

Q Just more than 30?

A Mm-hmm.

Q Now, when -- when that occurs -- that's the policy you said was in place forever, since the CRNAs started essentially?

A Mm-hmm.

Q Now, when this issue comes up when Carrol comes up to your office and he's got this anesthesia record, had any other doctor ever raised this to you before?

A No.

Q So when he brings it to you, what do you do?

A First I tried to calm him down, because he was -- like I said, he was livid. I called up the CRNAs from downstairs, had them come up, and they --

MR. WRIGHT: I would interpose an objection, and just

give us a time frame.

THE COURT: Was this the --

THE WITNESS: Within ten minutes --

THE COURT: Okay.

THE WITNESS: -- after he calmed down.

MR. WRIGHT: Just this meeting.

THE WITNESS: I mean, he's this short little Jewish guy. He was extremely mad. I mean, he was livid because of the Rexford case and couldn't believe all this with the CDC thing. So got him calmed down to some extent, brought up the CRNAs.

I can't -- I know it was -- I think it was Vince Mione, Vinnie Sagendorf, and maybe one or two others, whoever was on the floor downstairs. And he reiterated and I reiterated to them that their time had to be absolutely accurate. He also got on the phone with Dr. Mason --

BY MR. STAUDAHER:

Q Is he still angry during this whole time?

A Yes, he's still angry.

Q So he gets on the phone --

A But he's composed more. He's a little bit more composed.

THE COURT: So Dr. Carrol gets on the phone with Dr. --

THE WITNESS: Dr. Phone -- Dr. Carrol picks up the

phone on my desk, calls over to Dr. Mason and tells him what he finds, and he wants him to make sure that that's not happening at Desert Shadow Endoscopy.

MR. WRIGHT: Can we have a time frame for this? I missed it.

THE WITNESS: The whole thing took about 35 minutes.

MR. WRIGHT: I mean when did the 35 minutes take place?

THE WITNESS: Sometime in February.

MR. WRIGHT: Of 2008?

THE WITNESS: Of 2008.

MR. WRIGHT: Thank you.

THE WITNESS: So the CRNAs just, they listened, they said okay and they went back downstairs. Dr. Carrol was still upset. He went downstairs to Dr. Desai's office. I followed him downstairs to Dr. Desai's office, which is in the corner of Shadow Lane building. He starts yelling. Dr. Desai starts yelling. Dr. Desai tells me get the hell out of the room and close the door.

I got out of the room, but I did stand there because I didn't want the staff outside the door. They continued their conversation, or disagreement. Dr. Carrol left upset.

THE COURT: Could you hear the -- don't say what was said, but could you hear them yelling through the door?

THE WITNESS: Yes, I could. I think everybody in

the -- the rooms were this way [indicating].

THE COURT: It was loud?

THE WITNESS: It was very loud.

THE COURT: Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q So after, after Carrol leaves, what do you do?

A After Carrol leaves, which was about ten minutes, maybe not ten -- I don't know. It seemed like forever. After Carrol left, I went back to go talk to Dr. Desai and he dismissed me, and he was mad and didn't want to talk to me really, said, Don't worry about this. And I -- of course, I was upset to see them like that.

That's really how it was left. Dr. Carrol left. Dr. Desai was in his office. He was upset.

Q So let me ask you this. I'm going to stop there for a moment and go back upstairs with when Dr. Carrol confronts you with this anesthesia record and tells you what he's seen. Did that -- I mean, when you heard that, saw the record, was that a record that you used in your billing company?

A Yes.

Q When you saw and heard what he was saying, did that affect you in any way?

A Absolutely. It's --

Q How so?

A Well, we processed what they wrote down, and so obviously I'm thinking if they're pre-doing this, this stuff that we're not processing is not accurate and correct.

Q So you knew --

A Yeah, and I'm upset.

Q Did you know what the implications of that were?

A Of Medicare and Medicaid fraud, yes.

Q So you --

A Insurance fraud, yes.

Q So you knew that that was going to an insurance company though?

A Yes.

Q After this all takes place, you get dismissed from the clinic, do you stay in the clinic that day?

A I think I left as well. I think I was in shock and like I said, Dr. Carrol and Dr. Sharma -- I mean, Dr. Carrol and Dr. Desai, they've had arguments, but never to that extent. I was probably shooken up, because I knew what implications it would be for me personally in my company. So I'm confident that I did leave the facility that day.

Q Where'd you go?

A Either to a meeting or home. I can't remember.

Q When was the next time you spoke with or saw Dr. Desai?

A I can't remember exactly when. Two to three

days later.

Q Was this in person or on the phone?

A In person.

Q Did he ever call you at any time during that window period to talk to you?

A I don't remember.

Q So when you see him again, tell us how that goes.

A I go down and I see him and I tell him, you know, what my concerns were. I mean, I respected him and I -- it was a different relationship. I told him what my concerns were, you know, and the whole thing with Dr. Carrol and so forth. And he would say, Darling, it's taken care of, there's no problem, the times are right to the start time, to the end time, so forth.

Q When you told him your concerns, what did you actually tell him? What were your concerns when you were in this room?

A There was two meetings.

Q Okay. Let's talk about the first one. What time period are we talking about?

A Two to three days afterwards.

Q Okay. So two meetings. Did they occur the same day --

A No.

Q -- or were they separated?

A No, they didn't.

THE COURT: Had it been a weekend or something that you didn't --

THE WITNESS: I think it was like a Thursday --

THE COURT: Okay. And that's why --

THE WITNESS: -- to be honest with you.

THE COURT: -- it was a couple of days to --

THE WITNESS: Right. I think it was like a Thursday or something like that. I can't remember the exact date. But I want to say it was a Thursday because it gave Dr. Carrol time to calm down when he came back Monday, you know.

BY MR. STAUDAHER:

Q Okay. So let's talk about the first meeting. Where --

A The first meeting that I had --

Q -- does it take place?

A -- with Dr. Desai when I was scared, or when I thought all this stuff was going on?

Q Yes. Where did it take place?

A In his office. We often met in his office downstairs.

Q And this is the two to three days later?

A Two to three days later.

THE COURT: So would that have been on like a Monday

after the weekend, or...

THE WITNESS: Monday or Tuesday.

THE COURT: Okay. So there's the -- kind of the blow-out between Carrol and Desai, you go home, and then it's a few days, maybe a weekend, and then you meet with Dr. Desai early the next week?

THE WITNESS: Yes.

THE COURT: And that would have been in Dr. Desai's office?

THE WITNESS: Mm-hmm.

THE COURT: Is that yes, for the record?

THE WITNESS: Yes. I'm sorry.

THE COURT: And it's just the two of you at this first meeting?

THE WITNESS: Yes. I mean, I talked to him a lot by myself.

THE COURT: No, just to make it clear.

THE WITNESS: Yes, it was.

THE COURT: All right. Go on, Mr. Staudaher.

BY MR. STAUDAHER:

Q So tell us what the concerns were that you voiced to him at that time.

A I voiced to him, you know, the concerns of, you know, the precharting and making sure the times -- and he reassured me. He goes, Tonya -- he used to call me darling or

he'd call me other endearing names sometimes -- don't worry. He goes, It's okay, they'll write the time down, they'll write what needs to be done, we're fixing anything that needs to -- and that was it.

Q So at that point, I mean, you had mentioned you were concerned about insurance fraud, things like that. Did you voice that to him at the time?

A I did. I did voice it to him.

Q What was his response?

A That the times were accurate. And he went back to the time they start interviewing and the time that the patient was safe, because they were still in the care of the CRNA, that the CRNA was responsible for that patient, if I had a problem that CRNA would be the one reviving me. So I felt a little bit more comfortable at that point.

Q That's what he's telling you though?

A That's what he was telling me.

Q So you said that there was a second meeting later on.

A There was a second meeting which didn't --

Q Well, wait. Before we get there, your billing company at this point, do you try to find out what's going on with that with regard to the records that are coming over from the Endoscopy Center to your company to be billed?

A Yeah. I mean, obviously as the owner of a

company, I went over to make sure my billers were putting exactly what the CRNAs put their start time, end time and made sure, and it did match. What had happened though, is one of my data entry clerks and my billing manager contacted me after this whole blow-out with Dr. Carrol, Dr. Desai, and the anesthesia time went from eight minutes, ten minutes, 12 minutes, from 30, whatever, 20, 30, 31, 35 minutes.

Q So you say it went from eight to 30?

A No. It went from high number, 30, 35, down to eight, ten, 12 number.

Q So less than 15 minutes?

A Yes.

Q Okay. Does that give you concern when you hear that?

A Absolutely. I told Brian --

Q Before we go any further, the records that are coming in, is this just an isolated one or two, or how many of these are coming over in that way?

A I would say a significant amount that where a new employee noticed the difference.

Q And called you?

A And called myself and the manage -- my billing manager. And I told him bill whatever time is on the sheets. The next -- the next day I went in early, because Dr. Desai would do his prayer in the morning or whatever and I knew he

would be early. And I went in there and I showed -- and I talked to him. And I told him that the times are significantly different. I told him that he's putting my family at jeopardy, my business at jeopardy and so forth.

Q How does he respond to this?

A That conversation he was very angry, and I don't know if it was because of everything else that was going on with the CDC. He started cussing. He started swearing. He was just extremely upset.

Q Did he deny it at all, that that was a problem?

A No.

Q Did he acknowledge that what you were saying was accurate?

MR. WRIGHT: Could I have foundation, what was said?

THE COURT: I think she already said, so overruled.

BY MR. STAUDAHER:

Q Was there anything else said?

THE COURT: I mean, I guess the question would be what did Dr. Desai say.

THE WITNESS: What, you mean his cuss words?

THE COURT: No, no. It might be entertaining, but no, that wasn't my question. When Mr. Staudaher said did he acknowledge something, and I guess, you know, what did he say?

THE WITNESS: He didn't address my concerns because I have never been that upset with him. I -- I actually cared

about him. So when this all came across, it was very overwhelming because of the hepatitis C thing, then this. So -- can I just take a minute?

THE COURT: Sure, of course.

(Pause in proceeding.)

THE WITNESS: I worked for him for a very long time, and the whole idea is -- oh, anyways. Go ahead.

So the -- so I was very upset because I knew what the problem was going to be, and he was very angry and I know that it had to do with all the stresses that he was under.

BY MR. STAUDAHER:

Q So when you say you knew what the problem was going to be, what are we talking about?

A Well, obviously if -- if we were getting information from the CRNAs 30 minutes, 31, 35, 20, these high numbers, and then within one week of Dr. Carrol's meeting the anesthesia time went in less than half, there's a problem.

Q What is that problem?

A We weren't processing accurate times. They must have been precharting. I don't know.

Q When you said that you were -- you confronted Dr. Desai and you said that, if I have it correctly, you put me at risk, you put my family at risk, my business at risk, what is the risk that you're talking about?

A Well, exactly what -- I can't go into there. So

I mean, obviously he put --

Q Were you worried about your own liability in all this?

A Well, yes, because I'm the billing company. I'm the one who's relying on the information given to me by the licensed professionals. If somebody said they had gall bladder removal and I had a surgeon give me a gall bladder removal, I would bill a gall bladder removal.

Q So you were assuming what was given to you was accurate?

A Yes, absolutely.

Q Now, after -- after he yells at you and the like, I mean, how does this end?

A We agreed not -- I told him I -- I couldn't do his billing anymore.

Q So you're going to stop doing his billing?

A Yes.

Q Did you do that?

A Yes. He told me I had to finish up what I started, at the end he would get it changed over, get it over to Ida. And I was fine with that.

Q So what's the next thing that happens after that?

A Well, the facilities were getting shut down. The business licenses were getting yanked. There was a lot of

things going on with that. So the billers boxed all the information up, and I couldn't tell you what happened after -- I know we stopped doing the billing.

I mean, I think that was like it was happening in February. So maybe March is when we were finished and he paid us the residual money that we worked for and finished that out, and I just continued with my other doctors that we performed services for. We laid the staff off.

Q So you did billing for other doctors?

A I did.

Q Was this ever an issue with any other doctor you worked with?

A No.

Q Now, as far as your interaction with Dr. Desai after that time period, when things are shutting down and after this sort of blow-up meeting that you have with him, the second one, did you have further communication with him about anything?

A Yes, I had communication with him. I mean, I helped him shut down -- I didn't quit working for him until 2009. I helped him shut down his facilities. I helped him reset up an office for his billing department, and helped him get the medical records and worked with the attorneys to get medical records for patients.

MR. SANTACROCE: I'm going to ask for a cautionary

instruction at best, not to the jury, but to the witness.

THE COURT: Okay. Again, don't get into, you know, conversations with the lawyers.

I'll see counsel up here. You meant for like the civil loss?

MR. STAUDAHER: I'm not going to ask anything about lawyers, Your Honor, so.

THE COURT: Okay.

THE WITNESS: I was just getting the medical records ready.

THE COURT: Okay. So for if --

THE WITNESS: They were like medical requests we had.

THE COURT: From the civil lawsuits, when people --

THE WITNESS: There were seven staff members.

THE COURT: -- wanted their medical records?

THE WITNESS: Right.

THE COURT: Okay.

THE WITNESS: Or legal counsels, when they wanted stuff too. I will get those --

MR. STAUDAHER: My question is --

THE COURT: Right. You would help -- somebody sent the request for a patient, you know, John Doe's records, you would help to get that together; is that what you were doing?

THE WITNESS: Or if the corporate attorneys or any other attorneys wanted information --

THE COURT: Can I see counsel at the bench.

I'm sorry.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we need -- apparently some of the jurors need a break. So we'll just take a quick break, ladies and gentlemen.

And during the break, you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, person or subject matter relating to the case, and please don't form or express an opinion on the trial. Notepads in your chairs. Follow the bailiff through the rear door.

And Ms. Rushing, if you'd like to take a break, you can exit through that door, but don't leave yet. Do not discuss your testimony with anyone else during our break. Okay.

(Jurors recessed at 4:34 p.m.)

THE COURT: How much -- Mr. Staudaher, how much --

MR. STAUDAHER: I'm just going to -- I have one question left and that's it.

THE COURT: Okay. They -- the jury told the bailiff they needed a break. That's why we took the abrupt break. There is a juror question up here. You guys can look at it. It looks okay to me. I'm going to take a break.

(Court recessed at 4:35 p.m. until 4:41 p.m.)

(Outside the presence of the jury.)

THE COURT: Mr. Staudaher, you said you just have one question?

MR. STAUDAHER: I actually don't have any.

THE COURT: Okay.

MR. STAUDAHER: I'm just going to move to admit those documents [inaudible].

THE CLERK: Can you be specific? Eighty-one -- or I mean, 179 to 208?

MR. STAUDAHER: Yes.

THE CLERK: Okay. And then you mentioned 81. Are you --

MR. STAUDAHER: Eighty-one is already admitted.

THE CLERK: Oh. Well, that's not what I have.

MR. STAUDAHER: That's not what you have?

THE CLERK: No. She left me a list --

MR. STAUDAHER: Do you have a big red sticker?

THE CLERK: -- of --

MR. STAUDAHER: That was one of the --

THE CLERK: Well, okay.

MR. STAUDAHER: That was one of the earlier ones.

THE CLERK: So you have the top part that we need to take off, right?

MR. STAUDAHER: Yes.

THE CLERK: And then we're going to get the red one?

MR. STAUDAHER: And that one is the copy [inaudible].

(Pause in proceedings)

THE COURT: We're waiting for Mr. Wright and Ms. Stanish, and I think the jurors are about ready.

(Pause in proceeding.)

(Tonya Rushing resumes the witness stand.)

(Jurors reconvene at 4:48 p.m.)

THE COURT: Court is now back in session.

Mr. Staudaher, do you have any more questions for the witness?

MR. STAUDAHER: No, Your Honor. The only issue that I have is with the exhibits that I proffered or proposed, and I'd move for their admission again. I know that counsel's now looked at them and --

THE COURT: Any objection?

MR. WRIGHT: No.

THE COURT: All right. And Mr. Santacroce, any objection?

MR. SANTACROCE: No.

THE COURT: That was exhibit what?

THE CLERK: 179 to 208.

THE COURT: All right. Those are all admitted.

(State's Exhibit 179 through 208 admitted.)

THE COURT: And Mr. Santacroce, are you ready to

proceed with your cross-examination?

MR. SANTACROCE: Yes, Your Honor. Thank you.

CROSS-EXAMINATION

BY MR. SANTACROCE:

Q Good afternoon, Ms. Rushing. I'm going to ask you some questions about your direct testimony today, okay?

A Mm-hmm.

Q The first thing -- one of the first things you were asked today was whether or not the State had given you immunity from prosecution, and I'm talking about the State. Did -- and I believe you answered no. Was that your answer?

A They gave me a proffer in the very beginning, and I have had no immunity or anything else given.

Q As you testified today, do you have state immunity from prosecution?

A No, sir.

Q Do you remember giving testimony in front of the grand jury?

A Yes, sir, I do.

Q I'm going to show you page 55 of that transcript. I'd ask you to read this portion, please, to yourself.

A From here?

Q You can read as much as you want, but I'm just directing your attention to here.

A Okay.

Q Have you read that?

A Yes.

Q Do you remember Mr. Staudaher asking you --

MR. STAUDAHER: Your Honor, I'm going to object to the display of the transcript. He can certainly ask the question --

THE COURT: That's sustained. You're on the overhead.

MR. SANTACROCE: Oh, okay. I'm sorry.

BY MR. SANTACROCE:

Q And Mr. Staudaher asked you, "And that out of the abundance of caution, although you were not a State target in this particular case and you have made proffers that you have in the past, out of the abundance of caution we are telling you today from the State's perspective that you in fact are not going to be subject to prosecution by anything you say during this proceeding today, correct?" And you answered correct.

Was it your understanding at the time that you gave testimony before the grand jury that you had immunity from the State for prosecution?

A It was my understanding that I had a proffer, that what that meant to me was that I could talk and describe and answer the questions, but there was no guarantee of them

not using anything or any -- either the State or the other one, against me.

Q Have you been charged by the State for insurance fraud?

A No, sir.

Q Have you been charged by the State for theft?

A No, sir.

Q Have you been charged by the State for obtaining money under false pretenses?

A No, sir.

Q You testified that, I believe, back in 2003, you started doing billing for the Endoscopy Center; is that correct?

A In 2003 was when Rebecca Duty and myself were introduced by Dr. Desai, and Rebecca's company subcontracted the work to my company, so our company let her company do the billing.

Q Prior to that time you had worked for Larry Preston, correct?

A Correct.

Q And Larry Preston had a medical billing company, correct?

A Medical billing and consulting.

Q And what did you do for Mr. Preston?

A Practice management.

Q And Mr. Preston's company did the billing for Dr. Desai at that time, correct, prior to 2003?

A I think it was Lizmar and Larry's company.

Q And the first nurse anesthetist was Ms. LoBiondo, correct?

A Correct.

Q And when did she come to be employed, do you know?

A I can't recall the date. I would assume 2000.

Q 2000?

A I would assume there or very close to.

Q And when did her billing become your responsibility?

A You mean Healthcare Business Solutions?

Q Is that your company?

A That was my company.

Q Healthcare Business Solutions?

A Mm-hmm.

Q Were you a sole proprietor?

A I was an LLC.

Q And who were the managing partners of that LLC?

A Well, I owned it 100 percent, and then I -- like I said, I didn't do the billing, the physical billing until Rebecca quit in 2006. So Rebecca's company was subcontracted to do all the data entry, all the claim processing and

everything else, because she had experience with billing.

Q So tell me how that works. You have a company, Healthcare Solutions. She has Paragon.

A Right.

Q And how does the flow --

A There was a contract --

Q You need to let me finish the question.

A Oh, sorry.

Q How does the flow from the CRNA billing get to Paragon?

A She had a runner.

Q No, I don't mean physically. I mean what is the business procedure. How does it go through Healthcare Solutions to Paragon?

A Paragon had a subcontract contract with Healthcare Business Solutions, which --

Q You?

A Yes, which Rebecca owned a 10 percent ownership in.

Q Okay. Let me stop you there. So you had a contract with the Endoscopy Center?

A Rebecca and I did.

Q Well, Healthcare Solutions --

A Healthcare Business Solutions, which was owned by Rebecca Duty and myself, and Rebecca Duty signed the

initial contract for health -- on behalf of Healthcare Business Solutions to do billing. Healthcare Business Solutions then had another contract between her company, because it was her employees and stuff like that, to go ahead and process the billing, because she's already been doing that for a few years.

Q And that occurred in what years?

A Initially right off the bat, off the contract.

Q Okay. So after you left Larry Preston's company --

A No. Yes, 2003. I'm sorry. You're right.

Q So you left Larry's company --

A And I went to work for Dr. Desai.

Q Went Dr. Desai. Then there came a time shortly thereafter where you formed Healthcare Solutions, and you went into business with Rebecca Duty?

A Correct.

Q And how did you and Rebecca share the profits at that time?

A Rebecca owned 10 percent, and she would invoice Healthcare Business Solutions for the staffing, supplies or whatever else they used in the billing for their billing staff. And then they would do -- I think we would just do disbursements or whatever.

Q I want to focus primarily and solely upon the

CRNA billing, okay?

A Mm-hmm.

Q So there came a time in 2006, when Rebecca left and you did the sole billing for the CRNAs?

A Correct.

Q When I say you, I mean your company.

A Correct.

Q Of which you're a 100 percent owner?

A Correct.

Q And what third party payors did you have at that time for the CRNA billers?

A The CRNAs were credentialed and contracted through Gastroenterology Center of Nevada. So whatever contract they were on, Blue Cross Blue Shield, Culinary [phonetic] or whatever it was.

Q Okay. Well, I want you to give me a list of those, okay?

A Okay.

Q Go ahead.

A The CRNAs were credentialed through Gastro on all the Gastro contracts; Culinary, Medicare, Medicaid --

Q You need to slow down. I can't write that fast.

A Sorry.

Q Culinary. Who else?

A Culinary, Medicare, Medicaid, Blue Cross Blue

Shield, PacifiCare --

Q Hold on.

A Sorry.

Q Blue Cross Blue Shield. Who else?

A Culinary, Medicare, Medicaid, Blue Cross Blue Shield, PacifiCare. HPN, which would be all Sierra products. There's a ton of them. Tri-Care, Tri-West. Gastroenterology Center was contracted with every payer. I can't even begin to tell you what payers. They were not excluded from any payer.

Q I'm talking solely about the CRNAs.

A The CRNAs were on the Gastro contracts.

Q So let's talk about these ones here. Okay.

A Mm-hmm.

Q For a anesthesia process or procedure, how much did Culinary pay?

A I can't remember what they paid from back then.

Q How much did Medicare pay?

A I'm -- I don't remember. I know it was like probably $500.

Q How much did Medicaid pay?

A I don't remember.

Q How much did Blue Cross pay?

A I can't remember from 2006. I don't know what the payers paid. I'm guessing.

Q Okay. You're telling me you don't know any of

what these people paid?

A Not now.

Q Blue Shield?

A Not now.

Q PacifiCare, HPN, Tri-Care, Tri-West?

A I mean, it would depend on how many units were billed and what the contract said. They could vary.

Q Well, you testified that they billed 31 minutes or more than 30 minutes.

A Right. But some of them were flat rate too.

Q Okay. Who's flat rate?

A I know the cash pays were flat rate $150.

Q Who were they?

A Anybody who was uninsured.

Q Okay. I'm talking about third party payers.

A I couldn't give you an accurate answer. I mean, it's been six years, five years.

Q Well, how much percentage -- and I'm assuming you received a percentage of all billings collected, correct?

A Receipts, yes.

Q And how much did you receive?

A Nine percent.

Q Did that ever go up?

A It did.

Q How --

A To 10 percent.

Q So in what years were you earning 10 percent?

A I think the last year.

Q What were you earning in 2007?

A It would have been the 9 percent.

Q And so you --

A I'm guessing at what time frame that was.

Q Your company received 9 percent of all the CRNA billings; is that an accurate statement?

A Yes, of receipts.

Q So if the billings were increased, you would stand to earn more money, correct?

A Correct.

Q Okay. And conversely, if they went down you would earn less money?

A Correct.

Q How much money did your company earn from the CRNA billings in 2007?

A I would have to look at a document or something to tell you the truth, or a tax return.

Q Did your company file a tax return in that year?

A Yes, we did.

Q How many procedures a day did the clinic do in 2007, your best guesstimate?

A Forty-five, 45 to 50 a day.

Q So up to 50 a day. And what would you say the average third party payer would pay? You've identified Medicare 500 bucks. Would they all be around the same?

A I would say probably.

Q So 500 times 50 is how much, do you know? I come up with -- and I'm not good at math, so do you have a number?

A No.

Q 25,000?

A Mm-hmm. Probably --

Q Is that right?

A Probably around there.

Q And there was two procedure rooms, correct?

A Well, there was --

Q Or is there a total of 50 patients?

A No. There would be also the Burnham location too.

Q So you would get money from Burnham?

A All the CRNAs.

Q Okay. So let's just talk about Shadow. The 50 patients, was that for both rooms or for one room?

A For Shadow, that was the whole facility.

Q Okay. So from the CRNAs you made 25,000 -- or billed $25,000 per day; is that correct?

A It sounds correct.

Q And if you multiply that times five -- I mean, they worked five days a week, right?

A Sometimes six.

Q Okay.

A They pulled Saturdays every once in a while.

Q So if we bill times five, is that -- can that be possibly right; is that $125,000 per week?

A I don't remember ever getting a check for that amount.

Q Well, you wouldn't though, because you would have billed that and you would have gotten -- well, you would have got 10 percent of that, correct, 9 percent?

A Nine percent or 10 percent.

Q So you would have received about $12,500 per week from the CRNA billings; is that correct?

A It sounds correct. Without seeing the numbers, I couldn't tell you.

Q Okay. You testified that Dr. Desai set up a CRNA fund, correct?

A Not fund. An account.

Q And he had sole control over that account?

A Yes. He would use it at his discretion.

Q So when you made the billings in this amount of money per week -- and did you bill per week to the third party payors?

A Billed every night. Every time the claim was in, it would go out every night.

Q And then would you get a check from the -- would your company, Healthcare Solutions, get a check from these third party payors?

A No, sir. They paid directly to Gastroenterology Center of Nevada.

Q And which account would they go into?

A Gastroenterology Center of Nevada, I believe, or the CRNA. I can't remember which one.

Q And your commission came from which account?

A Gastroenterology Center of Nevada.

Q So Dr. Desai would pay you out of that account for your percentage of the CRNA billings, correct?

A Yes. The CRNAs were employed from Gastroenterology Center of Nevada.

Q I'm talking about how you got paid.

A Yes. Gastroenterology.

Q And how often would you get a check? Would you get it weekly, monthly?

A Monthly.

Q Monthly?

A Mm-hmm. At the end of the month they would run the reports.

Q And that check would come out of the CRNA

account, or the Gastro account?

A As I stated, I can't remember which. I'm sure -- more so sure that it came out of the Gastro account.

Q Okay. You were the manager of the Shadow Lane clinic, correct?

A Correct.

Q And you were the COO?

A Correct.

Q Chief operating officer?

A Correct.

Q Are you aware that the CRNAs never got one dollar out of that CRNA account?

A They would be paid out of Gastroenterology Center.

Q So the answer would be yes, you're aware that they didn't?

A They were employed, so yes, that would make sense to me.

Q And you're aware that they got a salary, correct?

A They got a salary and then they got a bonus.

Q And there's testimonies that at some point those bonuses stopped; is that your understanding?

A They did for everybody, yes.

Q So the CRNAs were on a salary?

A Yes, sir.

Q So unlike your company, Healthcare Solutions, the CRNAs, it didn't matter if they did one patient or 50 patients a day?

A Correct.

Q Now, you testified that you took, or the CRNAs would, I guess -- let me just strike that.

How did you get the anesthesia records to bill for the CRNAs?

A At the end of the day there was a bin, and the CRNAs would have filled out their charge ticket, like I said, with all the patient information and so forth. The front desk person at the Endoscopy unit would attach the insurance information and everything else, put it back in the bin in an envelope, and the runner would come by and pick up the envelope from that facility.

Q Who would attach the documentation?

A The front desk person would attach to the charge ticket the patient's copy of the patient's insurance card, a copy of the patient's driver's license, and I think the financial policy of gas -- of Endoscopy Center.

Q So the CRNAs would drop off the anesthesia records in the bin, correct?

A Right. After they were done filling them out.

Q And that was the end of their responsibility as

far as billing was concerned?

A Right. Because they put their start time and end time, that's all they needed to do.

Q Did you ever view any of those anesthesia records when they were in the bin for the three, four, five years that you were doing this?

A I'm sure I did.

Q Did you ever view any of the EOB cards?

A I am sure I did.

Q And it's your testimony here today that the first time that you are aware of the CRNAs billing 31 minutes was when Dr. Carrol came to you after the Rexford case?

A When the precharted record was done, that is the first time I've heard of that.

Q And if Anne LoBiondo told you that when she testified that when she started working you told her to bill 31 minutes, she'd be wrong?

A Yes. I had -- I can't oversee CRNAs.

Q Well, according to the organizational chart, you are overseeing CRNAs. Isn't that you here?

A Right. And they have a direct line to the physicians and the physician staff up to Dr. Desai. As I stated earlier, they would coordinate with Mr. Lakeman for their schedule and their covering. I would dissonate that schedule and that covering.

Q So the only thing Mr. Lakeman did as far as -- was scheduling the CRNAs?

A Right. He would coordinate. If they would take off vacation days or whatever, they would communicate it to him.

Q And how long did he do that?

A I would say probably about a year and a half, two years.

Q And he had nothing to do with ordering supplies or anything of that nature, correct?

A No, sir. There was only one incident that I can remember that he had an argument with Katie --

Q Okay. I don't want you to tell me about that, because that's hearsay from Katie.

A No. I was there.

THE COURT: Well, it's -- that doesn't matter.

BY MR. SANTACROCE:

Q So other than that one instance, whatever it was, he didn't have any control over -- he didn't order propofol, he didn't order syringes, he didn't order Chux, he didn't order --

A No. He didn't order --

Q -- K-Y Jelly?

A No. No, sir. He did not.

Q Okay.

A He wanted a specific drug.

Q All he did was schedule the CRNAs as to what their work schedule was for about a year?

A Coordinate it, yes.

Q Yeah, coordinate it. And you said that he had a direct line to staff physicians. He also has a direct line to the COO, you.

A Mm-hmm.

Q Okay. Is that fair estimate of the chain of command here?

A Yes. He would turn in those sheets and he would turn in his vacation requests and so forth.

Q And who would approve them, you?

A No. Dr. Desai would approve or the doctors.

Q So Dr. Desai would approve every single week of what CRNAs were scheduled; is that what you're telling us?

A Absolutely.

Q Okay. And he would oversee all of the other things that you mentioned and still be able to do 50 procedures a day?

A Like I said, he was quite remarkable. Yes.

Q He was quite remarkable.

In your direct testimony you talked about a meeting that you had with the CRNAs; is that correct?

A I'd have to remember it. If you could bring it

and let me remember it.

Q I believe it was in February of 2008, when Dr. Carrol came to your office about the precharting. Was that '08 or '07?

A It was '08, like in February of '08.

Q And you testified that you called the CRNAs into the office.

A Right. Dr. Carrol, he's a partner, came up, had the --

Q I don't need all that explanation.

A Yes.

Q You called the CRNAs up, correct?

A Under the direction of Dr. Carrol, I would definitely call the CRNAs up, yes.

Q And you testified that you called -- you can specifically remember calling Vinnie Mione and Vinnie Sagendorf up, correct?

A Couldn't remember the others, yes.

Q Didn't Vinnie Mione and Vinnie Sagendorf work at Burnham?

A They could rotate.

Q Do you remember if this meeting took place at Shadow or Burnham?

A Shadow.

Q You also in your grand jury testified that you

called up Vince, Linda, Linda Hubbard and Keith Mathahs. Do you remember that?

A I -- if I -- I guess.

Q Well, let me show you the transcript.

MR. STAUDAHER: Page, Counsel?

MR. SANTACROCE: I'm sorry. Eighty-five.

THE WITNESS: Eighty-five? Okay. Yes, and I also state here if I can't remember the other Vinnie was there or not, so obviously I might not have gotten all the names right. Whoever was on the floor at Shadow Lane was called up to the office.

BY MR. SANTACROCE:

Q Well, one thing is for sure is that Mr. Lakeman wasn't called up, correct?

A I didn't remember Mr. Lakeman being called up. I don't know if he was there or not.

Q Well, he left your -- the employment in October of 2007, and you're telling me this occurred in February 2008?

A Then he wouldn't have been called up.

Q So the meeting that you had in Dr. Carrol's office with you and the CRNAs did not include Mr. Lakeman; is that a fair statement?

A That would be a fair statement.

Q Now, you talked about a time when your company started to grow and you took on other doctors, physicians,

correct?

A Yes, sir.

Q When was that?

A I want to say 2005, approximately. I can't give you the exact date. I don't have the books in front of me.

Q And what other physicians did you take on?

A We took on Dr. Michael Gunter.

Q What is his area of practice?

A Internal medicine.

Q Okay.

A Dr. Bhatnagar, who is a surgeon.

Q I guess I don't want to go through the names. Tell me if there were any other CRNA billings in any of those.

A No, sir, there was not.

Q So the Gastro was the only CRNA billings you did?

A Yes, sir.

Q And you talked about when you found out about the 31 minutes you confronted Dr. Desai; is that correct, or you went to Dr. Desai?

A Yes, sir.

Q And you expressed your concern to him and he said, Darling, honey, whatever he said, don't worry about it because the procedures start from the preop area to discharge?

A Correct.

Q Were you aware that that's how Larry Preston was billing the CRNA time as well?

A No.

MR. STAUDAHER: Objection. Speculation.

MR. SANTACROCE: He testified to that.

MR. STAUDAHER: It's not what he testified to.

MR. SANTACROCE: Well, that's my recollection.

THE COURT: All right. Well, she --

BY MR. SANTACROCE:

Q Okay. So your answer's you were not aware of that?

A No, I was not aware.

Q Okay. Let me put it -- let me state it this way. Were you aware that Larry Preston believed that the anesthetist's time started when he first made contact with the patient until the patient was discharged?

MR. STAUDAHER: Objection, Your Honor.

THE COURT: Sustained.

THE WITNESS: Can I answer, or no?

THE COURT: No, no, don't. Don't answer.

MR. SANTACROCE: No, you can't.

BY MR. SANTACROCE:

Q You never did any CRNA billing when you worked for Larry Preston?

A Never.

Q Did you see any of the CRNA billings when you worked for Larry Preston?

A Never. I was always in Dr. Desai's office.

Q You were shown that memo about the insurance companies, and specifically about PacifiCare.

MR. SANTACROCE: I think it's 179.

MR. STAUDAHER: It's, I believe, 79 or 81.

MR. SANTACROCE: Let me see 180, please. I'm sorry. It's actually 185.

BY MR. SANTACROCE:

Q You were asked about why PacifiCare was spaced this way.

A Yes, sir.

Q And what was your answer?

A At that time the memo was written, I just wrote it and followed orders.

Q Is that your whole take on this thing, that you just were following orders?

A On that specific memo that you just showed me, yes.

Q What sorts of things at the clinic did you have direct control and authority over?

A Like I said, I answered to the partners and I answered to Dr. Desai.

Q When you answered to the partners, the partners

are Dr. Carrol, Dr. Carrera, Dr. Desai?

A Mason, Dr. Herrero, Dr. Faris. There was a ton of them.

Q And what sorts of things -- were there regular meetings with all of those folks?

A Only when Dr. Desai had called them. I mean, he was the one who called the partner meetings. He was very specific on his agendas of what he called them for. He didn't allow us to socialize or have outside conversations like that.

Q Well, were you in attendance in those meetings?

A On some occasions, and some occasion I was not.

Q And so what sorts of things that were in your control did you bring to those partner meetings?

A I did not bring much to the partner meeting other than attend. Dr. Desai would have me bring down Medical Manager reports, which showed the productivities of the physicians. He would have us discuss opening new facilities. He just -- he would discuss when a new doctor, like a doctor who had already done three years' time and was getting ready to become partner.

Q Well, I guess I'm not quite understanding this. You told us over and over how busy you were at the clinic, correct?

A Mm-hmm.

Q I want to know what you were doing that kept you

so busy.

A I would go see referring physicians, drop off referring physicians, referring physician pads, make sure that people were happy. I would do for errands for him, as well as something else if somebody else needed it. I would write letters if he needed letters written. I would build facilities. When I got there, there was only two, three locations. And we revamped the whole Shadow Lane office.

So I'd work with the contractors, buy furniture, help him redo like the phone system. Because when we first started we had a very adequate bad phone system in each office. So then he had to put a central phone system, so I'd work with those. I would work with check-in to make sure that they were getting all the patient demographics and all that stuff in, in checking the patients in.

We developed patient satisfaction surveys. I mean, whatever he needed. I mean, if it was, you know, set up a dinner with him and somebody, or a doctor with somebody, or attend a meeting, or decorate his office, decorate the offices that they had there. I mean --

Q And what -- how much time did you spend overseeing Healthcare Solutions then?

A I would go there either an hour in the morning or I would go there three hours at night, two hours at night. Sometimes I couldn't make it there depending if we had a

function.

Q And when you oversaw the activities at Healthcare Solution, did you review any of the billing records, the CRNA billing records?

A No. Because Healthcare Business Solutions didn't do just billing. We also did credentialing, startups, that type of thing for physicians. So that took -- that's where I concentrated on. I had billing managers. I had billers that went to school for billing, and then Ida would address if there was any concerns.

Q And those billing managers, who are they?

A Ida Hansen was one of them. Kim Taylor [phonetic] was one of them. Tammy Davidson [phonetic] was one of them. Sheila Seefus [phonetic] was one of them. I mean, there was a few of them.

Q And those were all employees of Healthcare Solutions?

A Yes, sir.

Q And during that time period of 2006, when you started that until you closed down, or until the Gastro closed down --

A I didn't close down when Gastro closed down.

Q No, no. I'm sorry. That's not what I was inferring. Let me restate that. From the time you started Healthcare Solutions in 2006, until the billing practices from

CRNAs changed at some time in 2008, not one of those billers came to you and said, hey, all of these guys, these CRNA guys and girls are billing 31 minutes? That didn't raise a red flag to anybody?

A No. I mean, they did the same thing. They did a colonoscopy and an EGD in the facilities. It's not like they did different things. They were always the same.

Q So that never triggered a red flag to you?

A No. And from my understanding, it was the same at Lizmar. I mean, I don't think any of our practices changed, and I don't think the CRNAs' practices changed.

Q Who's Ryan Cerda?

A Ryan Cerda was an entry level data entry person that we hired at Healthcare Business Solutions.

Q Did Ryan Cerda ever come to you voicing concern about the CRNA billings?

A After the conversation with Dr. Carrol and they dropped, like I said, to eight, ten, whatever minutes, I can't remember if he came to me directly. I think he may have, or he came to Tammy, and then they brought it to my attention. Then I went and brought it to Dr. Desai.

Q You realize then or at some point that you had some liability because you were the one that was pushing the buttons, sending this information to the third party payors?

A I realized that I am responsible for all my

staff, and yes, I realized that I had some liability.

MR. SANTACROCE: I have nothing further. Thank you, ma'am.

THE COURT: Thank you, Mr. Santacroce. Can I see counsel at the bench.

(Off-record bench conference.)

THE COURT: Ladies and gentlemen, we're going to go ahead and take our evening recess. We'll be in recess for the evening. 9:30 tomorrow morning.

During the evening recess, you are reminded that you're not to discuss this case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

Notepads in your chairs. Follow the officer through the rear door, and we'll see everyone back here at 9:30.

And Ms. Rushing, once again, I must remind you that during the break you're not to discuss your testimony with anyone, all right?

THE WITNESS: Mm-hmm.

THE COURT: Thank you, and you're excused.

(Jurors recessed at 5:25 p.m.)

THE COURT: Somebody had a dental appointment on the jury. That's why we're starting at 9:30, so.

MR. STAUDAHER: No, that's fine. I just --

MR. SANTACROCE: I want to bring something up. Are we --

THE COURT: Okay. Is this back door --

MR. SANTACROCE: Are we on the record?

THE COURT: Yeah, we can be on the record.

Oh, Ms. Rushing, you're excused.

TONYA RUSHING: Yeah. I'm waiting for...

THE COURT: Okay.

MR. SANTACROCE: I just want to bring up to the Court's attention that every time Mr. Wright makes an objection, this juror in the back row on the left where that shawl is makes an audible gasp, and it's getting very frustrating to me. And I want to bring her in here and ask her if she's already made a decision in this case as to the guilt or innocence of Mr. Lakeman and Dr. Desai.

No one else is making those audible grunts, groans, moans and gestures every time, and it only happens when Mr. Wright makes his objections that she makes those gasps and moans. So I'm very concerned about it and it's my request that we be allowed to ask her if she has formulated an opinion as to the guilt or innocence of these two people.

THE COURT: Well, I don't know that that's

appropriate, because there's already been how many weeks of evidence. So of course she's forming preliminary opinions and, you know --

MR. SANTACROCE: I'm not asking about preliminary assessments of the evidence.

THE COURT: Do you see what I'm saying? I mean, it's -- they're not allowed -- you know, they don't have to -- I mean, we tell them -- I mean realistically, of course they start forming opinions. And, you know, with all due respect to Mr. Wright, maybe she doesn't like Mr. Wright. I mean, that's not reason --

MR. WRIGHT: Well, I want to examine her about that.

THE COURT: Well, no. I mean, you know, as long as she didn't start out not liking you, if you have earned her dislike over the course of the trial, and that sounds facetious, but by that I mean, you know, if she for whatever reason, you know, just doesn't, you know, just doesn't like you, you know, I don't know that that's grounds for anything as long as she didn't start out not liking you.

But if she doesn't like you because she thinks you take too long or make too many objections or something like that, I mean, we tell them at the beginning don't hold it against the lawyer. But as long as --

MR. SANTACROCE: It might be just my perception. I might be completely off base here. I don't know if anyone

else has observed or heard it. But I'm just bringing it up because I'm very concerned. We tell the jurors, don't make a decision as to guilt or innocence until all of the case is presented. The defense hasn't presented anything, and I'm just concerned because of these, you know, these gestures and gasps and moans. And I might be off base, but I want to raise it.

MS. WECKERLY: My perception of some of the jurors is when it seems like the testimony or -- even on direct, the direct or the cross is repetitive, then there's, you know, some sort of reaction. And I mean, we're all sort of -- you know, we do that at our peril. And I don't think it's proper at all to inquire into her mental processes. I mean, yawning or making a -- you know, she hasn't done anything improper and so -- or none of her conduct.

MR. SANTACROCE: Am I crazy?

MS. WECKERLY: I mean, she's allowed to react.

MR. SANTACROCE: Am I the only one hearing it?

THE COURT: No. I think she may be doing that, but even let's just assume that she is gasping and moaning and sighing and, I mean, part of that could be boredom.

MR. SANTACROCE: Well, I'm not --

THE COURT: And, you know, like I said, I mean, part of it may be she just doesn't like Mr. Wright or she thinks his cross-examination takes too long.

MS. WECKERLY: She's done that when we're up too.

THE COURT: And you know what I mean. Frankly, Mr. Wright and Ms. Stanish take longer in cross. You know, you're more pithy, you get right in there, you know, tend to have a joke or two. And so I'm not -- you know, I don't sense that with them. Ms. Weckerly is shorter on direct than Mr. Staudaher.

So basically, you know, I think it's more Staudaher on redirect and Wright -- Mr. Wright, and I think it has to do with the length of their questioning and going over the same material. And just because someone becomes exasperated or bored doesn't mean that they're not fit to be a juror.

MR. SANTACROCE: Okay.

THE COURT: I mean, that's my assessment. And so, you know, I just -- as I said, as long as, you know, that was an opinion formed during the course of the trial, you know, we can't, you know, say, oh, well, all the jurors have to like the lawyers equally, or they have to think that the lawyers are doing a good job, or that the lawyers aren't, you know, being redundant. That's not the standard.

As long as they start out and don't have a preconception about the lawyers, you know, then -- you know, people are people and they're going to form opinions and they're going to like some lawyers better than other lawyers. It's just the reality of the situation. And, you know, like I

said, as long as that's based on something that's happened in the courtroom --

MR. SANTACROCE: Well, she might be doing that to everybody. I don't know. I'm just telling you my perception. If someone else has a different perception, fine. I accept the Court's analysis of it.

THE COURT: I don't -- I don't think it's a different perception. The issue is, okay, if that's true what do we do about it.

MS. STANISH: Your Honor.

THE COURT: Yes.

MS. STANISH: Just for the record, a few times already I have tried to make a record of this very same juror who moans and groans when we, the defense, are put in an objection -- or I'm sorry, put in a position to object repeatedly about what elementary rule of evidence foundation. And then we all have to scurry up to visit Your Honor, where you engage in an Evidentiary 101, and explain to the -- Mr. Staudaher how to properly lay a foundation.

And it's happened numerous times throughout this trial. And that's what I had -- my concern was and we've stated this, I believe, on the record, certainly up at the bench when visiting Your Honor on this issue, that we felt it was going to be held against the defense attorneys that we were delaying the trial because we were making these

objections to prevent this ongoing issue with lack of foundation, which Your Honor even addressed today and lectured about foundation at the bench.

THE COURT: Well, I mean, here's the thing, you know. I mean, I think Mr. Staudaher did better today laying a foundation now that he under -- now that I think it's clear what the defense wants and the Court, which, you know, a couple times said when did this meeting happen, who was at the meeting, a couple of things like that.

I'm happy, as you know, a standard instruction is to tell the jury that it's -- you know, I don't remember exactly verbatim, but it's the duty of a lawyer to object to evidence that the lawyer thinks may not be admissible. Please do not be prejudiced against the lawyer or client if the lawyer makes objections on behalf of the party he or she represents, et cetera.

I'm happy to remind them of that objection -- of that instruction if you want me to do that. I mean, I don't see, you know, a big deal about doing that. If that's something that's requested, I'll do it. But again, you know, to reiterate, just because a juror finds it tedious and may make, you know, sighs or gasps or expressions of frustration or boredom or whatever to me isn't grounds for removal or any kind of discipline or anything like that.

So I don't know what the point is to ask her the

questions if there is nothing we can do about it. And in fact, if we drag her in and ask her the questions like, well, it really appears that you're gasping when Mr. Wright asks a question, then to me now what have we done? We've really alienated her, because she's going to know, oh, they're dragging me in here because somebody complained about me sighing or gasping or whatever.

And so because the remedy is -- in my view isn't removal, what's the point of asking the question? All to me we'd do is create the possibility that now she's tainted, or now she becomes alienated against somebody if in fact before she wasn't. It's like I said, she's going to wonder, well, who -- you know, who complained.

I mean, I can, you know, finger Kenny for it and say he complained that you were sighing, you know. But still, I just don't know what would be --

MR. SANTACROCE: I didn't mean to -- I don't want to make a big deal about this.

THE COURT: -- accomplished.

MR. WRIGHT: I like that one.

MR. SANTACROCE: I'm not going to make a big deal about it.

THE COURT: Well, there's other behind the scenes issues going on there.

MR. SANTACROCE: There's bigger fish to fry and I'm

not here to make a big deal about that, but I wanted to raise it because it was a concern to me, quite frankly annoying to me, and I didn't know if it was just something that I was misperceiving or not.

THE COURT: And I'm hearing, which I heard today, you know, Dr. Desai's family members making noises and gasps and, you know, so I'm more aware of that. And I know Kenny, you know, it's the bailiff's job to maintain --

MR. SANTACROCE: Well, we can advise them right now. Don't make gasps and noises, okay.

THE COURT: Yeah. It's the bailiff's job to monitor and maintain control of the courtroom. He did inform me that he went over and told them to do it because I said, I just heard then, they made like, I can't remember the noise, but it was in response to a foundation question or something against Mr. Staudaher.

I don't remember exactly what happened, but I sustained the objection, or I said we need to do it this way or something, and then we heard something. And apparently it's been going on. So, you know, that can also be, you know -- I think they're making noises and I think probably the gal in Seat 14 is making noises.

MR. SANTACROCE: Okay. Well, we fixed this [indicating]. We fixed this problem.

THE COURT: So, you know, yeah, because --

MR. SANTACROCE: That one we can't fix.

MS. WECKERLY: Yeah. You can't say anything to her.

THE COURT: I just don't -- yeah, because whatever, you know, again, as long as she wasn't biased against anybody to start, then, you know, so what. You know, she thinks Mr. -- I'm just speculating, you know, she thinks Mr. Wright is boring. Well, that's not grounds for removal or, you know --

MR. WRIGHT: I'm not so sure about that. No. I don't want her holding -- if she does not -- if she decides --

THE COURT: Yeah, but -- no, no. As --

MR. WRIGHT: If she decides my behavior is offensive and inappropriate and takes it out on my client, I'm concerned about it.

THE COURT: Well, but you're making a big --

MR. WRIGHT: And I don't care if she makes the judgment here in the courtroom.

THE COURT: No, no. You're making a big leap from her -- if that's even it -- from her thinking you take too long on cross to somehow holding it against your client. And again, there's an instruction. I'm happy to give it. I'm happy to add to the instruction, you know, and I think it's already part of it, you don't hold it against the party he or she represents, number one.

And again, you know, frequently in closings, that's

one of the first things lawyers often say, you know, I hope I haven't done anything to offend you or to annoy you, and sometimes I may be tedious and sometimes, you know, I'm redundant, but please, you know, don't hold it against my client, you're free to say that.

And that's, as we all know, said all the time, you know, don't do any -- don't take anything I may have done as a lawyer, you know, I'm doing the best I can, I've made mistakes, what have you, you know, you're free to do that if you think it's an issue. But like I said, just because she might --

I mean, okay. Let's be real here. It is long. It is boring. It is tedious. It is uncomfortable. It is incredibly repetitive. And so if she's thinking all of those things, to me that is a normal reaction, not something that causes inquiry for some kind of misconduct or something like that.

MR. SANTACROCE: Well, as long as she's not directing it toward the defendants because of what we the lawyers are doing. That's my only concern.

THE COURT: Well, and I can remind --

MR. SANTACROCE: She can hate me all she wants.

THE COURT: And I'm happy to remind her of that as I said, if we stipulate to adding to the stock instruction. I'm happy to, you know, ad lib a little bit and say, look, this

has been a long process, we've all been tired, we've all been hungry, you know, you may think the questioning went on too long or there were too many objections.

I just want to remind everyone that you can't hold it against the party the lawyer represents, whether that be the State or whether or not that be the defendants, because you don't like something a lawyer may have done or you don't like, you know, that lawyer. I'm happy to do that if you ask me to do it. I'm happy to do that.

MR. SANTACROCE: I ask you to do it.

THE COURT: All right. Well, let's make sure Mr. Wright and Ms. Stanish are on board --

MR. WRIGHT: Yep.

THE COURT: -- and the State. And as long as I direct it towards both sides, that -- you know, they may not -- you know, I don't know. They may not like Ms. Weckerly.

MR. SANTACROCE: Oh, I don't believe that.

MS. STANISH: Oh, no way.

MS. WECKERLY: I think that's true in the sense, you know, we've heard like, oh, why do they keep asking the same things over and over. And of course we'd like to say, look, you know, we have this really big burden, we want to make sure you get this straight. I mean --

THE COURT: Right. Well, the other thing I can tell

them, if it's fine with everyone -- again, these are suggestions. I'm only going to do it if we all agree to it, is something like look, the questioning becomes repetitive, unfortunately the lawyers -- and this is another thing often lawyers, as you know, say. Unfortunately we can't all say, hey, does everybody understand, by a show of hands do you understand, so they have to ask the questions to make sure you're understanding hearing the evidence.

Something like that, I'm happy to give it if we all think that that would be better. And, you know, again, a lot of times this stuff is addressed in closing. But I can tell them, you know, look, we don't have the benefit of saying does everyone understand the testimony, did everyone get that. We have to, you know...

MR. SANTACROCE: Well, I think, given the length of the trial and at this juncture of the trial it might be appropriate.

THE COURT: Like I said, as long as it focuses on both sides and is fair to both sides, I'm inclined to do that.

MS. WECKERLY: Sure. Sure.

MS. STANISH: Well, and too, and especially since it sounds like we're going two weeks beyond what the jury was told, it might be a good time to at some point soon talk to the jury about scheduling and give some instructions.

THE COURT: Well, the jury has all asked for letters,

and I just --

MR. WRIGHT: What's that mean, letters?

THE COURT: Well, we give letters. You know, we told them in the jury selection if you need a letter for your employer. What happens is one or two will ask for a letter, and then everybody wants a letter. And now they've asked for new -- one or two asked -- not to me personally, but to Kenny. And then one or two want letters to their employers and then they all want letters to their employers.

And originally we wrote the letter and we said three to four weeks, and I couldn't bear to sign the letter frankly. And so I said, Sharry, don't do it today, we're going to see where we're going to be. So Ms. Weckerly, realistically you think the 27th -- or I'm sorry, the 24th?

MS. WECKERLY: But I mean, I don't mean -- I mean like maybe we would have evidence on that day, but be done around that day.

THE COURT: Right. And so then for the defense, maybe July 1st, which would give you --

MR. WRIGHT: 2000 --

THE COURT: No. Which would give you -- so that's basically another three weeks. I mean, if you had four days the last week of June, and Monday, July 1st, we could do closings the 2nd and the 3rd possibly, and then the 4th, of course, is a national holiday. And we also have a juror

leaving for vacation for ten days -- or no, more than ten days, which he told us about during jury selection. But of course we all said, oh, no, it's never going to go that long, don't worry about it.

MR. SANTACROCE: Oh, no. I didn't say that.

MS. STANISH: Well, we didn't say that.

MR. SANTACROCE: There's only one person that said that.

THE COURT: Well, no. You said about eight weeks and we're well over that, we'll be over that. So in any event, I mean, do we think we can finish Wednesday the 3rd -- well, then he can't deliberate. But as long as we make it to there with more than 12, we can call in an alternate.

MS. WECKERLY: Is the defense case really --

MR. SANTACROCE: Who is the juror that has the --

MS. WECKERLY: -- going to take three weeks?

THE COURT: It's the guy, Juror No. 6 -- 7. I'm sorry.

MR. SANTACROCE: Who is that?

THE COURT: It's the guy that works for the school district.

MR. SANTACROCE: Oh, this guy on the end over here [indicating]?

THE COURT: Yeah.

MS. WECKERLY: So three weeks from now?

THE COURT: Right.

MS. WECKERLY: Okay. But I mean, the defense case -- yeah, I guess that's right.

THE COURT: Right. Tomorrow's the 15 -- I'm sorry. I'm looking at the wrong -- tomorrow is the 12th.

MS. WECKERLY: Yeah. I miscalculated, I think.

THE COURT: So I mean, it kind of depends on how much time we need for the defense case, and basically we can stay late one day. Dr. Desai doesn't have to be here. We can settle jury instructions. And, you know, maybe this is something you folks can start doing over the weekend or whatever. But State -- sorry. State, do you have your proposed jury instructions done?

MS. WECKERLY: Not done. Started, but not done.

THE COURT: Okay. Well, you're the youngest one in the group, so.

MS. WECKERLY: I can -- I can try to have a proposed packet on Monday. Is that --

THE COURT: Okay. And get it to the defense.

MS. WECKERLY: Yeah.

THE COURT: And basically the way I like to do it is pretty standard. Anything that's proposed as either an alternate to a special or an addition to a special, separate those, the additions and the alternates to the specials, and that's all I want from the defense. Obviously not all of the

other stocks and everything like that.

Then the way I do it is I make the lawyers meet, because sometimes you can make agreements on small changes and things like that. Anything you can't agree on then we settle on the record, and then I decide whether you're going to get the instruction or not. I want from both sides, you know, obviously the stocks don't need to be -- you know, anything that's unusual.

I want an annotated and an unannotated copy. Anything that's typical, just give me an unannotated. Same for the defense, annotated and unannotated. If for some reason you don't get that done that way, it's not a big deal as long as we get a disk or, you know, something like that. Worse comes to worst, we make Sharry retype them. I shouldn't tell you that, but...

MS. STANISH: Word or Word Perfect for you?

THE COURT: We can do either, right? I think we're a Word system, hideous Word system. But I think it will convert. I think we have the ability to convert. If not, it's not, you know, like a huge, huge deal, so.

All right. Then we'll see you all back at 9:30.

(Court recessed for the evening at 5:46 p.m.)

CERTIFICATION

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

AFFIRMATION

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

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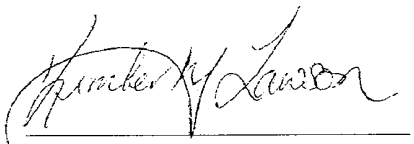

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * * *

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

BEFORE THE HONORABLE VALERIE ADAIR, DISTRICT COURT JUDGE

JURY TRIAL - DAY 37

MONDAY, JUNE 17, 2013

APPEARANCES:

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

RECORDED BY JANIE OLSEN COURT RECORDER
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I N D E X

WITNESSES FOR THE STATE:

E X H I B I T S

LAS VEGAS, NEVADA, MONDAY, JUNE 17, 2013, 9:13 A.M.

* * * * *

(Outside the presence of the jury.)

THE MARSHAL: Judge Valerie Adair presiding. Thank you. Everybody may be seated.

THE COURT: Our last juror just arrived, so -- but then I just heard you had something out of the presence?

MR. WRIGHT: Yeah. Introduction of the report.

THE COURT: Okay. Shut the door. All right. Yes?

MR. WRIGHT: The Health District report.

THE COURT: I'm sorry?

MR. WRIGHT: Admissibility of the --

THE COURT: Right. We have to have a ruling on that because Mr. Labus is -- I've consulted the cases, and while Health District-type reports are admissible in some cases, you know, reading everything, this is not a routine cataloging of information. That's one of the things talked about in the case of United States versus Barry.

One of the things we look at is whether or not the report is prepared, it's likely there's going to be litigation or a criminal proceeding. I think this was a very unique case, and I think that this report is much more akin to an investigative police-type report than it is to an epidemiological report or a public record, which is, you know, as cited by the United States Supreme Court, the routine

cataloging of information. And so for that reason I don't think that the report is admissible in this case.

Now, the next issue are the hepatitis-infected people, the 109 or so people. Are you -- and I haven't fully decided that issue -- will that be something that you're going to be getting to in the -- this morning, Ms. Weckerly?

MS. WECKERLY: Your Honor, I wasn't planning to actually go into that --

THE COURT: Okay. Here's --

MS. WECKERLY: -- on direct.

THE COURT: -- that's -- okay. You and I are on the same page, then.

MS. WECKERLY: Okay.

THE COURT: Here's my sort of preliminary ruling, if you will. The State is precluded from going into it on direct examination. If, however, on cross-examination the defense opens the door by, kind of like what I said with the CDC investigators by, you know, pointing to, oh, it's only these seven people or it's only these eight or nine or however many it was, people, then I think the door can be opened for questioning. You know, there were other people who could not be determined to have been infected by another source, nor could they, you know, scientifically or genetically be linked to the center. So I think it could be opened.

Is that what you're going to say, Ms. Weckerly?

MS. WECKERLY: I was going to say that. There's just a couple of things -- just so it -- on the actual infection days that we have charged, there were ten people on each day that were lost to follow-up.

THE COURT: Okay.

MS. WECKERLY: I was planning on eliciting that on direct examination.

THE COURT: And I think that's fine, that doesn't implicate the confrontation clause --

MS. WECKERLY: Right.

THE COURT: -- because they were lost to follow-up.

MS. WECKERLY: Right. We don't know their outcome, right.

THE COURT: Right.

MS. WECKERLY: I think if there's questions, though, about, you know, the exclusion, you know, maybe it was Lynette Campbell and the saline flush or maybe it was scopes, I think certainly the fact that there were numerous other infections that are at least related or linked, I mean, that -- Mr. Labus uses -- he categorizes it by whether or not there's a risk factor, but there were 105 people that didn't have a risk factor, and I think that lends itself to it not being scopes and it not being a particular employee.

THE COURT: It still could be scopes, though, because didn't you say of the people who are on the case, not all had

colonoscopies? So you've got that same argument whether it's the 100 and -- is that basically what you're saying? Because if they all had the same thing, whether it's 100 people or 10,000 people, if the -- let's just say the scopes were the means of transmission, they could still be infecting that many people.

Do you see what I'm saying? If they're not sterilizing the scopes or the forceps --

MS. WECKERLY: Yeah.

THE COURT: -- or whatever --

MS. WECKERLY: I mean, I think that it's not conclusive, but I think it certainly --

THE COURT: Well, I'm not sure it is -- I mean, I think it could be suggestive if you looked at, okay, well, Lynette Campbell wasn't working these other days, or I think you pointed out already previously in the trial, you know, you can't say it's the colonoscopy instruments when some people had endoscopies.

MS. WECKERLY: Right.

THE COURT: I mean, I think that kind of --

MS. WECKERLY: Right.

THE COURT: -- thing, but just a number alone doesn't tell me anything. Do you see what I'm saying?

MS. WECKERLY: Yes.

THE COURT: And so I think, yes, different procedures

than that would -- or some people had polyps removed so that could implicate the forceps, but some people didn't have polyps removed so that couldn't implicate the forceps.

MS. WECKERLY: Yeah.

THE COURT: Or some people had endoscopies so -- with nothing removed at all, no tissue sampling, so that wouldn't be the same. Do you see what I'm saying? A comparison like that, I think, is meaningful because you're comparing the use of different instruments.

Numbers alone, I don't find particularly meaningful in a vacuum because, like I said, let's just say it's the forceps and you're treating 60,000 people and you tell me, well, it was 100 people. Well, it still could be dirty forceps if all of those people were having polyps removed or biopsies done or something like that. Do you see what I mean?

MS. WECKERLY: I do. There was -- there was, though, at least one case at the other center --

THE COURT: Okay.

MS. WECKERLY: -- and, I mean, that would -- I doubt --

THE COURT: Well --

MS. WECKERLY: -- there's the same scope there or whatever. I guess there could be the same cleaning issues or whatever, but in -- I -- whatever the ruling is, I'll certainly --

THE COURT: I mean --

MS. WECKERLY: -- abide by it.

THE COURT: -- like I said, I can see them opening the door.

MS. WECKERLY: Okay.

THE COURT: If you feel that they have opened the door in some way, then obviously the remedy is to approach the bench --

MS. WECKERLY: Sure.

THE COURT: -- and we may have to -- I may -- we may have to do some questioning of Mr. Labus out of the presence of the jury to establish, you know, what he knows and how he knows it and possibly argument to say -- to link up whether or not, in fact, it is contrary to what has been suggested by a question on cross. Do you see what I mean?

MS. WECKERLY: There is one table from the report that -- I understand the ruling on the report itself, but it goes through what was eliminated as a source of transmission on the 21st that I will seek to admit because it's just narrowed to that infection date.

THE COURT: Any objection to the table --

MR. WRIGHT: Yes.

THE COURT: -- being separately marked as an exhibit?

MR. WRIGHT: Yes, I object to it.

MR. SANTACROCE: Can I see it?

MS. WECKERLY: Sure.

THE COURT: Basis?

MR. WRIGHT: The basis is -- and it's a bigger basis than just the table, and so -- I understand the report is not admissible, and the State is not going to elicit -- I just want to make sure I understand --

THE COURT: Elicit on --

MR. WRIGHT: -- the rules, right?

THE COURT: -- direct examination the infection. That's what Ms. Weckerly said, she does not --

MR. WRIGHT: Right.

THE COURT: -- have the intent to elicit on direct examination the 100-plus other infected patients. But she does intend to elicit that how many people were -- couldn't be contacted, we just don't know.

MS. WECKERLY: Ten on each day -- on each infection day didn't respond. So they were lost. There's no follow-up on them.

THE COURT: I'm fine with that because I don't think that implicates the confrontation clause because --

MR. WRIGHT: Well, the --

THE COURT: -- it is what it is. They were contacted and we just don't know.

MR. WRIGHT: They were subpoenaed?

MS. WECKERLY: Well, we didn't --

THE COURT: They didn't. That was what the whole issue was.

MS. WECKERLY: We don't know who they are.

THE COURT: That was the whole issue with the Health District --

MR. WRIGHT: Certainly, we know who they --

THE COURT: -- Mr. Coffing, who I see is sitting here --

MR. WRIGHT: Certainly.

THE COURT: -- opposed the release of that information. I ruled in the Health District's favor. That was one of the issues, as I recollect.

MR. WRIGHT: There's only 120 patients. We know the names of every one of them. This isn't rocket science. Of course they know who it is, and they can subpoena them. And because they opted not to, I'm supposed to -- if I examine the expert on the information he used to reach his conclusions, I'm opening the door to waiving my confrontation rights?

THE COURT: I don't think that's what anyone is suggesting here. I think -- what I'm ruling, anyway, is kind of what happened with the CDC people, where you sought to suggest that, oh, well, you are basing it on this limited number or something like that, and I said -- I don't remember exactly what the question was -- I don't remember exactly what the answer was, but I said, Look, you can't create a false

impression without opening the door to then the State, you know, addressing that false impression. That's what I said. I think it's the same with Mr. Labus.

So, you know, if you open the door, then the State may be able to get into that. Again, limited to this: By their own self-reporting we did not identify other risk factors, but they could not be scientifically or genetically linked to the center. I mean, that's it. That's what I understand that the evidence would be.

So they can't say that -- in argument -- that they're linked because they never were linked. They can't say definitively they didn't have other risk factors. By their own self-reporting they didn't identify other risk factors. I mean, I think that's what it would open the door to.

Again, you know, I think my ruling is consistent here, that, you know, you can't create a false impression, and if you do, then that may open the door to what really occurred with the testing and interviewing of all of the infected people.

MR. WRIGHT: Okay. So if I open the door, then I get the identity --

THE COURT: Well --

MR. WRIGHT: -- of all of those people and I get the information I need? The State has created this riddle, Judge, and I want to -- I'm not making myself clear. They opted

to --

THE COURT: No, I think you --

MR. WRIGHT: -- put an --

THE COURT: -- are making yourself clear.

MR. WRIGHT: -- no, they opted to put an expert on the stand who has looked at materials and reached his conclusions. And part -- part of his thought process had to have been, oh, I think it's this or that because we sent out letters and we got this many back, and that corroborates it to me this or that happened. And so that's off limits. I can't go to the area that he relies upon because I'm not going to get it, if -- because of the law that says that's --

THE COURT: Well, what if you asked him of his thought process and his thought process was, well, there were 100-and-something other infected patients? I'm not going to tell him, Well, you can't testify about your true thought process.

It's exactly the same situation that was created with the CDC. I'm not going to tell him, well, if Mr. Wright asks you what your thought process was or why you focused on this to the exclusion of something else and that involved 109 other patients, then I'm not going to tell him that he can't answer that question truthfully.

I mean, I guess we are in a bit of a --

MR. WRIGHT: That's good. So I'm -- I'm waiving --

THE COURT: -- conundrum here, but --

MR. WRIGHT: -- I'm waiving my confrontation rights --

THE COURT: No, you're not --

MR. WRIGHT: -- he --

THE COURT: -- waiving your confrontation rights.

MR. WRIGHT: -- certainly I am.

THE COURT: You have your full confrontation rights.

MR. WRIGHT: Of those 106 patients? Get something straight, I dispute that they even have hepatitis. I dispute that they got it at the clinic. I admit nothing. He's relying upon hearsay to make the determination, No. 1, that they are infected. No. 2, that they're clinic-associated because they have no risk factors. And No. 3, he won't disclose who they are. That's the evidence. He won't tell us who they are.

They're putting an expert on the stand who knows something, has it down -- I can't look at what he's looked at, and the State opted to use him as the expert. In any ordinary case like this, you get an expert, you have him read all the transcripts of the evidence that came in, or you have him sit here the whole day so that they have heard the same thing everyone has heard, and then they get up there and opine.

But Mr. Labus has, by law -- by your ruling -- the right to have information that he has relied upon, that he

cannot share with me. And so how do I have the right to confront him on that issue?

MS. WECKERLY: As to --

THE COURT: Ms. Weckerly?

MS. WECKERLY: -- as to the charge days, everybody has access to -- to all of that information, and I don't -- the fact that they sent out letters and didn't get a response from 10 people on each day -- there isn't -- there's nothing there. There's nothing to confront because they didn't get information back from --

THE COURT: He's not talking about that. I am assuming --

MS. WECKERLY: But as --

THE COURT: -- you're talking about the 100-and-some --

MR. WRIGHT: Correct.

MS. WECKERLY: Okay. The other 100 -- the other 105, he can -- I mean, he's certainly, when I've read his depositions, he's very qualified when he talks about that because he says, This is their self-reporting, I can't link them conclusively to the clinic; they may, you know, there's instances where people falsely report. I don't think he relies on those opinions to form his opinion or conclusion about how the transmission occurred on our actual days, but he does rely on the transmission to, I guess, to make the

decision as to how far -- how far back to send out safe-injection practices.

So he -- he saw unsafe-injection practices back in 2005 --

THE COURT: But -- and that doesn't really matter --

MS. WECKERLY: -- but -- but I'm not asking --

THE COURT: -- what --

MS. WECKERLY: -- him about that, so --

THE COURT: -- whether he sent out 30,000 letters --

MS. WECKERLY: Right.

THE COURT: -- or 90,000 letters or 60,000 letters or whatever. I mean, to me that has nothing to do with, you know, whether your defendants, in this case, you know, are guilty or not guilty --

MS. WECKERLY: Right.

THE COURT: -- how many letters he wound up sending.

MS. WECKERLY: Right. But I don't think that he relies on that aspect of the Health District action to reach the conclusion as to the source of transmission. But if he's going to be asked about, you know, why did you send all those out, or boy, you only got seven people out of sending out 47 letters, you know, that's not true. So I think that's where the --

THE COURT: I --

MS. WECKERLY: -- the false impression is.

THE COURT: -- and that's -- that's exactly what I was -- was saying too. Everything else you can -- I mean, I don't see a problem with fully confronting him on the bases of his conclusions, and how, you know, he determined it had to have been the propofol and the CRNAs, and --

MR. WRIGHT: Because they elect to choose him as the witness who has information that he cannot share with me. They -- they didn't have to use him, and so because of that if I cross-examine him fully with my confrontation rights I'm waiving -- I'm opening the door and then in can come evidence that is hearsay, and that I don't have a right of confrontation to --

THE COURT: Well, let's be clear here --

MR. WRIGHT: -- all because the State didn't do it.

THE COURT: Let's be clear here. First of all, they didn't go out and choose Mr. Labus as their expert. Mr. Labus was the employee of the Health District that went out and did the investigation which far preceded any involvement by the District Attorney's Office. Just -- so to me I think it's unfair to somehow suggest that Mr. Labus is in the same exact position of a retained expert and they could have chosen anyone is inaccurate.

I mean, they're -- they're calling Mr. Labus because Mr. Labus was on the front lines of this thing. He was on the ground there doing this investigation, and the District

Attorney's Office had no part in that choice.

Ms. Weckerly?

MS. WECKERLY: Well, I mean, that's true. He's a percipient witness too. He has conversations with people that we intend to bring in because their statements in court, you know, these are prior inconsistent statements. He's a regular witness and he also has expertise, and based on his observations on the day they were there, his collaborative, you know, I guess discussions with the CDC representatives, he reaches a conclusion about how the transmission occurred. And when he rules out the other sources it's based on information he observed or got from the records from those two infection days.

Now, why the notification was as broad as it was is a different decision, so, I mean --

THE COURT: I don't think that's really what Mr. Wright is focusing on, the --

MR. WRIGHT: Right.

THE COURT: -- notification.

MR. WRIGHT: I'm not. I just have the -- and I have a problem with the -- for the two dates in issue, July and September. The -- they're -- they are going to elicit that 10 patients on each day we don't know whether they have hepatitis, is that what I understand?

MS. WECKERLY: Right. Yeah, there's no follow up on

-- they didn't --

MR. WRIGHT: Okay. But --

MS. WECKERLY: -- respond.

MR. WRIGHT: -- okay.

THE COURT: I think what you can't argue -- I mean, I think the evidence will be they didn't respond, that's it.

MR. WRIGHT: To what? The subpoenas?

THE COURT: To the letters.

MR. WRIGHT: The compulsory process? What -- why wasn't the case investigated? So I -- I open the door if I go into these 10? I want to know who they are. I want to know who didn't respond, and that's what I'm going to ask him.

THE COURT: I don't think you open the door to anything --

MR. WRIGHT: Okay. Well, then --

THE COURT: -- there.

MR. WRIGHT: -- I'm going to ask him for those 10 on each day --

THE COURT: And then he can say, well, it was our belief that -- or we were -- or we were told we didn't have to -- or whatever the case may be. I mean, those were the part of the ones that, as I recollect, were litigated. The State subpoenaed the information, as you recall, the Health District filed -- I think they filed that they objected to the service of a subpoena, I believe, so they filed it, I think,

as a motion to quash, if I recall, and they argued that pursuant -- as you -- as you'll remember, pursuant to state statute. They didn't have to disclose that information.

The Court ruled in the Health District's favor, that they didn't have to disclose that information. And so -- now, could the --

MR. WRIGHT: So that --

THE COURT: -- state have done more?

MR. WRIGHT: Yeah, could --

THE COURT: Yes.

MR. WRIGHT: -- is that hard to figure out with 126 patients? They sit on their hands and do nothing to investigate the case.

MS. WECKERLY: But, I mean, even if -- even if we got the people, we still don't know how the Health District classified them. I mean, that's -- you know, yes, we could, but we wouldn't know what the internal classification of the Health District --

THE COURT: Right. But you would -- I mean, hypothetically, had you done the -- I mean, to be fair, had you done the investigation and had you found the people and had you contacted them and had some of them been willing to speak with your investigator, at least some of them may or may not have been tested and some of them may have disclosed the results of those tests.

MS. WECKERLY: Right. I mean, that's how we got --

THE COURT: That's what Mr. Wright --

MS. WECKERLY: -- looked --

THE COURT: -- is talking about. So then you would know, okay, these ten -- of the ten you found five and five were infected with hepatitis -- or two of the five were and the other three weren't, or whatever the case may be. Is that basically what you're saying?

MR. WRIGHT: Correct. And I am viewing it that there are six total -- well, one -- one viral -- not connected, I mean, the one for the two days -- or two.

MS. WECKERLY: Two.

MR. WRIGHT: But I'm viewing that that the state of the evidence is there were seven for the two days combined, seven out of 126 or whatever the number is. And if the State is going to argue that there's seven, or there may be 27 --

THE COURT: Yeah, I don't think that would be --

MR. WRIGHT: -- that -- that --

THE COURT: -- fair. They can't argue that. That would be --

MS. WECKERLY: No, we're going to argue that --

THE COURT: -- totally --

MR. WRIGHT: Well, then why are they --

THE COURT: -- unfair.

MR. WRIGHT: -- bringing it out at all?

MS. WECKERLY: We're -- we're going to argue there's nine because we're -- we count --

THE COURT: Yeah, the --

MS. WECKERLY: -- Lakota Quanah and --

THE COURT: -- Lakota Quanah --

MR. WRIGHT: Oh, that -- that's --

THE COURT: -- that's fine.

MR. WRIGHT: -- what I meant.

THE COURT: You can argue that there's nine. I mean --

MR. WRIGHT: But they're --

THE COURT: -- I don't --

MR. WRIGHT: -- they're going to argue there's --

MR. COFFING: Hold on, one --

THE COURT: -- think you can say --

MR. COFFING: -- at a time.

MR. WRIGHT: -- 29.

MR. COFFING: One at a time.

THE COURT: -- well, we didn't hear from these people, so they, you know, it -- the inference is that they were infected. I mean, it's just as likely they didn't respond to the Health District because they weren't infected, and they thought --

MR. WRIGHT: Well --

THE COURT: -- I'm not infected, why -- why am I

going to bother with this whole thing?

MR. WRIGHT: Right. But the --

THE COURT: I mean, I think that's just --

MR. WRIGHT: -- what --

THE COURT: -- as reasonable an inference --

MR. WRIGHT: -- why -- why is it --

THE COURT: -- as to why.

MR. WRIGHT: -- coming out, other than to draw the inference that there may be others?

THE COURT: I think they can bring it out to explain the blanks on the sheet that -- that we don't know, that the -- is that -- I mean, if that's what they're doing --

MS. WECKERLY: That's -- right, we don't --

THE COURT: -- on the schedule --

MS. WECKERLY: -- know.

THE COURT: -- is to say, look, these were people, the Health District, that we don't know.

MR. WRIGHT: The Health District does, but we don't?

THE COURT: Yeah. I mean --

MR. WRIGHT: And so in a --

THE COURT: -- the truth is the truth --

MR. WRIGHT: -- criminal case we're not --

THE COURT: -- Mr. --

MR. WRIGHT: -- allowed to know. I --

THE COURT: Mr. Wright, there are -- I've said this

over and over again. You know, you didn't weigh in on the issue with the Health District and the State. I'm not saying you had to, but here's the deal, and I've said this over and over again: There are two, you know, just -- this is a, you know, the Health District preventing the spread of disease and studying how disease is, you know, spread and things like that, that's a very strong State-ish interest, and I ruled that that State interest is equal to the State interest in going forward in criminal proceedings.

And so in this case I ruled they didn't have to disclose --

MR. WRIGHT: Okay.

THE COURT: -- that name because you --

MR. WRIGHT: I -- I'd --

THE COURT: -- have to protect the open flow of information with the Health District because their function is to, you know, identify communicable diseases and to try to, I guess, ascertain how those are spread and to prevent the further spread. And so, you know, they have a strong and compelling, in my view, legitimate interest --

MR. WRIGHT: Okay. As --

THE COURT: -- in keeping the -- that information confidential.

MR. WRIGHT: And stronger than my client's right to a fair trial and his compulsory process rights and his rights of

confrontation? I make the demand right now for a Court order. You say the State's balance doesn't tip; I want it -- under compulsory process, my right to confront witnesses and the evidence that is available. I want the information that won't be turned over to the State by the Health District.

MS. WECKERLY: Well, yeah, I don't have it, so...

MR. WRIGHT: No, I'm -- I'm subpoenaing it, I'm demanding it, he's testifying, I am requesting that the witness produce it.

THE COURT: Mr. Coffing, I'm assuming you're here for the Health District?

MR. COFFING: Your Honor, I was here to just be with the witness, Your Honor. I wasn't --

THE COURT: Right. I mean, here's --

MR. COFFING: -- anticipating --

THE COURT: -- the thing. You want to subpoena the information, I guess, subpoena the information. As I recall, the --

MR. WRIGHT: No, I'm requesting --

THE COURT: -- statute, it was pretty much no exceptions. You know, to me the remedy if, you know, you can't get a fair trial with the information is a separate remedy than forcing the Health District to turn over the information. Now, everyone keeps saying that, well, you could have figured out the information other ways. So if that's the

case, then I don't see how the interest of the Health District somehow is minimized when there are alternate routes to find that information.

MR. WRIGHT: I don't have to do any of that.

THE COURT: Well, all I'm saying is, first of all, the State cannot create a false inference to their benefit by virtue of the fact ten people didn't respond. They can explain what the missing people mean on the chart, but they can in no way argue, well, maybe these people would have had hepatitis, we just don't know. That would be improper argument in my view, and you can't do it. So does that alleviate some of your concerns?

MR. WRIGHT: No. I still want the information. I'm -- I don't want to -- I don't want to -- I don't want this on an idea that, okay, if you want it, go subpoena it. The witness is here, and so I am going to request that he produce it. And so I -- I just want a ruling so that --

THE COURT: Do you have the 126 names?

MR. STAUDAHER: They're -- they're on the chart.

MS. WECKERLY: They're on the charts, but we --

THE COURT: On the day?

MS. WECKERLY: -- you know, we redacted them. But I don't --

MR. STAUDAHER: Counsel --

MS. WECKERLY: -- I don't --

MR. STAUDAHER: -- Counsel had the --

MS. WECKERLY: -- know who --

MR. STAUDAHER: -- originals, so they've --

MS. WECKERLY: -- didn't follow up.

MR. STAUDAHER: -- got all that.

MS. WECKERLY: I don't know that. I know who the people are, but I don't know who was lost to follow up because that would only be known to the Health District.

MR. WRIGHT: Oh, so you're -- you're talking about -- I mean, there are -- there are 20 people who didn't respond for the two --

MS. WECKERLY: Right.

MR. WRIGHT: -- days, correct?

MS. WECKERLY: Correct.

MR. WRIGHT: The identity of those 20?

MS. WECKERLY: I don't know that. Only the Health District knows that.

THE COURT: Then how do you know --

MR. WRIGHT: We have patient lists.

THE COURT: -- okay, well, wait. I'm missing something here because if you have -- let's make this easy for us, 100 people, okay? And let's say of the 100 people 8 -- 8 that day were infected, okay? So now you've got 92 people. And of those 92 people, are you saying -- and then, of the 92 people, I understand you knew X, you know, A, B, and C, and D,

weren't infected; is that true?

MR. STAUDAHER: No.

MS. WECKERLY: No.

MR. STAUDAHER: What we have is 126 -- the -- and Counsel had the original, the unredacted information, so both sides have had all the names of the patients that -- those two days, who had procedures done on those two days. Of those 126 people, or whatever, we -- we -- there are apparently a total of 20, 10 for each day, that were lost to follow up by the Health District. So of the --

THE COURT: Right. But you know who was not lost to follow up.

MR. STAUDAHER: No.

MS. WECKERLY: No.

MR. STAUDAHER: If we knew who was not lost to follow up, we would know --

THE COURT: Then you would know who --

MR. STAUDAHER: -- was --

THE COURT: -- right.

MS. WECKERLY: Right.

MR. STAUDAHER: -- and that was all -- that was the information that we were requesting. That was what the Court ruled we could not get. So we don't know which ones the Health District contacted and didn't contact --

THE COURT: So all you know is, okay, of the other,

say 90 people that weren't lost to follow up --

MR. STAUDAHER: We don't know who those people are -- which ones were not lost.

THE COURT: -- right. That -- that none of them tested positive for hepatitis, and that 10 people you don't know and nine people did test positive; that's what you know?

MS. WECKERLY: Right.

THE COURT: And you know the identity of the people who do -- did test positive?

MR. STAUDAHER: That we have linked --

THE COURT: Right.

MR. STAUDAHER: -- and --

THE COURT: Right. And --

MS. WECKERLY: Of the ones that followed up --

THE COURT: -- that's all you know?

MS. WECKERLY: -- we know who they are. We know that the -- we know the ones that are positive.

THE COURT: Right. Which are the ones -- you know that. So the other people, you know that they weren't positive, but you don't know their identities.

MR. STAUDAHER: No, we don't know that they weren't positive. We don't --

THE COURT: I'm not talking about --

MR. STAUDAHER: -- know if they were ever tested --

THE COURT: -- the people who didn't follow up, I'm

talking about --

MR. STAUDAHER: Oh.

THE COURT: -- the people who did follow up.

MR. STAUDAHER: It's our understanding that those people were tested --

THE COURT: And they're negative?

MR. STAUDAHER: -- at some point and they were negative, yes.

THE COURT: Okay. And what Mr. Wright is saying is okay, you know there were 126 patients on that day. You can eliminate the people we already know their identities because they're in this case and they tested positive. Of those other people, what you could do is try to subpoena and contact all of those, and then find out from those who contacted you back, Did you follow up with the Health District or not follow up with the Health District?

Is that essentially what you're saying, Mr. Wright?

MR. WRIGHT: Yes. And it -- it affects on the chart when we have skipped -- the whole skipping and room to room, and presumptions that this -- this person that followed didn't get hep C, now it's going to be left -- well, we -- we don't know if they did or didn't.

THE COURT: How is this different from --

MR. WRIGHT: And --

THE COURT: -- any other case where the defense's

argument is, Look at how poorly investigated this case was. Let's just take a run-of-the-mill robbery case and, you know, somebody says, oh, you know, it was an African-American person that was 5 feet, and then they stop an African-American person on the street and he's 5'7 and they arrest him, and then they shut the whole thing down and they don't bother with fingerprints or DNA or anything else that they could have done that would have potentially exonerated the person that they picked.

And that's what the defense argues, and I know, though, you don't tend to handle those kinds of cases, but trust me on this, that's probably the majority of what we see. You know, how is this any different when the argument is, look, the State didn't do a good job? They didn't do a thorough investigation. They could have done more. You know, where -- where are these other things that they could have done?

MR. WRIGHT: The --

THE COURT: Tell me how this is different.

MR. WRIGHT: The difference is the State of Nevada has the information. They -- the State of Nevada has it. You're saying the District Attorney doesn't. The State has evidence that may be exculpatory. That may help the -- and I can't have it. And you're putting this privacy right of the Health District --

THE COURT: Well, first of all, let's be --

MR. WRIGHT: -- above --

THE COURT: -- clear here, Mr. Wright. You weren't heard on -- you were all here, as I recall, but none of the defense wanted to be heard on the issue with the Health District. So what the Court considered was what the State had presented and what the Health District had presented.

And basically, the issue that was litigated at that time was, well, the State said, well, we, you know, feel like we need to find these things and blah, blah, blah, and, you know, the Health District, as I recall, said there's other ways for them to get it.

And our interests in protecting full and complete disclosure to fulfill the duties of the Health District, you know, are tantamount to -- to their, you know, interests in finding this information. The statute, I thought, was pretty clear -- the State statute -- and so that was the issue before the Court at that time.

The Defense, you know, was here, they, you know, didn't -- didn't choose to weigh in at that point. And so I don't think in some way it's fair to penalize the District Attorneys who are here because they did seek out that information --

MR. WRIGHT: Well, they --

THE COURT: -- from the Health District. I'm not

saying you were obligated to do it.

MR. WRIGHT: Of course, I'm not --

THE COURT: All I'm --

MR. WRIGHT: -- I'm not obligated --

THE COURT: -- no, and I'm not -- and well, just before -- I'm not suggesting that you were, but let me just say that the consideration that, you know, what was -- what was considered by the Court was the arguments from the State, the DA's office, and the Health District at that time, you know, not, you know, some of the arguments that you're making today. So that's all I'm saying.

In any event --

MR. WRIGHT: Because today I'm saying it under compulsory -- compulsory process, and the right of confrontation, I want the evidence that the State of Nevada has and will not give me.

And I don't buy their higher investigative privilege that trumps my client's right to the evidence. There -- these cases come up all the time. The State, if they don't want to turn it over, has the option. They do this in secrecy cases, top secret, don't want to turn over CIA information. The remedy is the case gets dismissed.

You don't just say, oh, sorry, you got to go to trial without it. That's what I am requesting and want, and the State has it. And the Health District, they're

willy-nilly on their obligations. They'll promise confidentiality. I mean, it's right in their -- in Labus's note, they tell someone this is an off-the-record statement, and then turn right around and hand it to the police.

So I don't buy this investigative --

THE COURT: Well, just --

MR. WRIGHT: -- privilege and the public interest.

THE COURT: -- just to be clear, it's not an investigative privilege under the --

MR. WRIGHT: Public health privilege.

THE COURT: -- statute -- it's a patient privilege. It's to get people to disclose these diseases to the Health District, as I -- as I recall it, so that they're not afraid that their identities will be made known, in this case, publicly.

And so, that's what it's for, so that people feel like they can go to the Health District if they've contracted a disease and they don't have to worry about their name being disclosed down the road.

And the -- the State interest is pretty obvious. We need people who are willing to go and disclose these things for the Health District so that the Health District can determine outbreaks and put an end to them. And the idea being, if people know, well, hey, if I go to the Health District, then some criminal defense attorney may get my name

and, you know, the reporter sitting in the back row now is going to know who I am and that I've got hepatitis, or, you know, maybe I went even, you know -- you know, some people may not want it -- want it known they went to the gastro center because maybe they have, you know, Crohn's disease or cancer or some other disease that they don't want known publicly. They don't want their employers to know about it.

And so these are all interests. What if one of those people tested positive for AIDS, HIV, totally unrelated to this case? That's something that's clearly protected. And so there are abundant reasons why that's an important statute that had nothing to do with the proceeding.

But, you know, right now as I'm sitting here I can think, well, gosh, if people know, wow, if I go in and I disclose these things and I'm tested and I have a disease that I don't want people know -- knowing about because it's stigmatized, and it could even be a problem with my employer, you know, what if you're -- then that's going to put a -- put a stop to the flow of information to the Health District.

And I think this right here what we're -- what we're seeing is exactly what they're concerned about. And so, you know, I -- I stand by the ruling in that regard.

So here's what I would suggest going forward. Let's get started. We'll go through the direct of Mr. Labus. If you have a question regarding cross, if that will open the

door, then certainly approach the bench. If we need to take a break or something like that, we'll excuse the jury and take a break.

With respect to this issue with the nondisclosure. This was an issue that's been known for a long time, and so to me, to spring it on, you know, on the Court and ask for an order compelling the Health District to turn over these records in, you know, contravention of the previous order or -- I'm not going to do that.

So, you know, you certainly have the right to raise this issue at a later date, and you can do that, you know, to brief it fully and say that your client's rights were denied --

MR. WRIGHT: Okay.

THE COURT: -- because of the failure of the Health District upon the Court's order to disclose the information, and then the failure of the District Attorney's Office to take alternate steps to try to learn or ascertain the information. You certainly can do that, as, you know --

MR. WRIGHT: Okay. So is it --

THE COURT: -- post-trial remedy, but at this point in time I don't think it's fair to make the motion while the jury is all waiting around to start, when this is an issue that's been known, not for days, not for weeks, but for months. I made that ruling months ago.

So, Mr. Santacroce?

MR. SANTACROCE: Yes, I just needed to make my record, Your Honor. I want to join Mr. Wright's motion objection regarding these 104 patients. In addition, I want to object to State's Proposed 228, which is the chart. This chart lists a bunch of things that the Health District apparently considered and ruled out, and it says, results ruled out.

They go through the IV placements. They go through the scopes. They go through the biopsy equipment. And they say, we've ruled these out for various reasons. And now, the Court's telling me if I go into, for example, Lynette Campbell and the IV placements which they ruled out, then I'm opening the door to these 104 patients? I mean, how -- if you're going to allow this in, and the jury is going to take it back to the jury room --

THE COURT: I didn't say I was -- okay. Go on.

MR. SANTACROCE: -- no, I'm just saying I object to it coming in, unless I can cross-examine on each one of these things that were ruled out without opening the door to the bigger issue. So that's the dilemma I have, and that's why I'm objecting to allowing this to come in.

THE COURT: All right.

MR. SANTACROCE: Or at least give me some direction as to what I can go into without opening the door.

THE COURT: One of the problems the Court's having right now is I don't know what Mr. Labus's answers would be to those questions. And I don't know if Ms. Weckerly knows what Mr. Labus's answers would be to those questions. I mean, I think it's fair, you know, Mr. Santacroce's theory is that it's more likely that the -- that it was transmitted through contaminated saline than it was through, you know, the propofol, which makes sense in -- you know, I think he's -- he's got a good theory he's working with because you got to put the virus in numerous bottles of propofol as opposed to a single bottle of saline.

So, you know, it's -- that's where he is, and he has a right to flesh that theory out, certainly. So, you know, if Mr. Santacroce gets into, you know, why was Lynette Campbell and the saline solution excluded, you know, do you know what Mr. Labus is going to say because I certainly don't?

MS. WECKERLY: I mean, I think he's going to say it's, you know, it's based on their observations at the clinic and their review of the charts. I don't think he -- I mean, I don't think he's going to make reference to the other 105 cases. But he's going to base it on what they observed at their investigation.

THE COURT: Okay. So pretty --

MS. WECKERLY: And all of these conclusions are based on their observations or chart reviews from the --

THE COURT: -- just from those two days.

MS. WECKERLY: -- two infection days.

THE COURT: As long as that's it, then I don't see that opening the door. You can fully cross-examine.

MR. SANTACROCE: Okay.

THE COURT: You know, Ms. Weckerly, I guess what --

MS. WECKERLY: Well, I can get him and ask him.

THE COURT: -- well, you can ask him or, you know, just tell him, look, if some answer is going to call for going into the -- why don't you just, you know, ask him. If that's all he based everything on, then I don't see the door being opened, and we're -- okay?

MS. WECKERLY: Okay.

THE COURT: So if anyone needs -- yes, Mr. Wright?

MR. WRIGHT: Right. I just want it clear. I don't want to ask him in front of the jury. I mean, the state of the record is I have requested the production of the patients that -- the 105, identity of them, and the 20 for the two dates in question.

THE COURT: Right.

MR. WRIGHT: And the -- the privilege precludes the production; is that correct?

THE COURT: I mean, I don't know --

MR. WRIGHT: I mean, I just want the record --

THE COURT: -- I don't know why it --

MR. WRIGHT: -- straight.

THE COURT: -- would be different from you requesting it than it was from the State requesting it.

MR. WRIGHT: Because I have compulsory process --

THE COURT: Well, that wasn't --

MR. WRIGHT: -- and right of confrontation --

THE COURT: -- okay --

MR. WRIGHT: -- and they don't. And I -- and you act like I knew this the entire time. I'm telling you, until we were at a sidebar up there talking about the 105, I did not know they didn't know who those 105 were. We were up there --

THE COURT: Well, the 105, and the 10 are different --

MR. STAUDAHER: Yes, they're completely different.

MR. WRIGHT: Correct.

MS. WECKERLY: They're different.

THE COURT: -- different issues.

MR. WRIGHT: Correct. I understand they're different issues, but I -- I'm telling you, I didn't know they hadn't conducted -- because that's when I was up there squawking about --

THE COURT: Okay.

MR. WRIGHT: -- why didn't they do a criminal investigation. Why did they just take -- handed to them this, and then they turned it into a criminal case? And then I

learned, up there for the first time, that they didn't do anything. That they just --

MR. STAUDAHER: No, that's --

MR. WRIGHT: -- well --

MR. STAUDAHER: -- that's another time, now --

MR. WRIGHT: -- that's a misstatement. I'm -- I don't meant hey didn't -- they accepted the report of the Southern Nevada Health District, and accepted what would be turned over to them, and did nothing further to try to get more information than what was in there. And so, I didn't know all of that from preparation towards the case.

So all I'm saying is now my compulsory process right under the Constitution, I just want it clear that they -- that the privilege, and I -- you articulated it well, and I understand the reasons and the basis for it, and I don't -- and I'm not arguing about your judgment on the call, I'm just saying I want the record clear that it not only trumps the State's demand for it, but it trumps my demand for it for Dr. Desai.

THE COURT: All right. Off -- that issue was not considered at the time I made the ruling.

MR. WRIGHT: Right.

THE COURT: All right. So having said that, you know, I read this months ago. My belief, from memory, would be that there were no exceptions to that. Now, you know, if

you would like -- again, I think it's a little bit unfair to ask for a ruling, you know, right now. My recollection of reading everything and studying it and -- was that there are no exceptions. And again, I'm, you know, I think it's to protect people from, you know, being hauled into court in unrelated matters, and having their private health information disclosed.

And so, you know, I think that the -- the ruling would be the same. And I'll certainly say, this morning I'm not going to order Mr. Labus or the Health District to turn over the information to you.

MR. WRIGHT: Okay. And I wasn't -- I wasn't suggesting there was a statutory exception in there for the --

THE COURT: No. No, I know you --

MR. WRIGHT: -- okay. I'm saying --

THE COURT: -- you're not -- I'm saying, I didn't consider it -- the statutory rule and weighing that, doing any kind of weighing analysis with Dr. Desai's Constitutional rights. And I think you're right, you know, generally if he can't get a fair trial and there's no way to turn over the information or get the information, then the remedy is dismissal. I don't see that as being the case here. I don't see that he's being denied his right to a fair trial because of the absence of the information.

MR. WRIGHT: Okay. But I'm not talking due process

for a trial. I'm talking compulsory process aside from right of confrontation in me cross-examining him. My independent right. I can't even remember the cases on compulsory process, but it's -- there's one Supreme Court case, Oklahoma versus somebody, and there was a statute that precluded turning over certain information, and it was found that compulsory process trumped --

THE COURT: And I'm happy to read that case, and I would have read it had anyone given me a heads-up that we would be arguing this this morning, which is why I'm saying, I don't think it's fair of you, really, to spring this this morning on the State. Ms. Weckerly, did you read that case in anticipation for --

MS. WECKERLY: Not on --

MR. WRIGHT: I didn't either.

THE COURT: -- today's argument? I certainly didn't.

MS. WECKERLY: Not on compulsory process.

THE COURT: So, you know, I'm happy to read it at the lunch break, if someone wants to get me a cite for that case, and consider it; but again, that wasn't what was considered last time, you know, no exceptions to the statute.

I'll reiterate it, the State interests and the public health interests in the statute, I think, are obvious. And as we sit here fighting over these people, and, you know, media being present, I think the reason for the statute,

really, has hit home. And it's quite obvious to the Court.

And so, you know, if these people were hauled into court, I think it would have a chilling effect on future people going to the Health District if they think, gee, I don't, you know, want to be -- I don't want my name being out there in the -- in the public eye. I'm happy to read the case.

MR. WRIGHT: Okay.

THE COURT: Like I said, you know, this is just sprung on me this morning. I didn't read the case. You know, I haven't been reading up on compulsory process and -- and statutes that preclude, you know, dissemination of information. So --

MR. WRIGHT: I haven't read up on it either, Your Honor. It just seems so fundamental to me that a witness can't get on the stand that knows more than I do, and then the State has the information and can't share it with me. I mean, I don't even need cases for that -- to say that proposition doesn't work.

But I understand -- understand the ruling --

THE COURT: Well, he is a percipient witness to this, and frankly --

MR. WRIGHT: I have no problem with his percipient witness -- I want to be clear on that -- I didn't say he couldn't testify. I mean, whatever his percipient thing is, I

got it. I know the issue.

THE COURT: Here's the problem, though, the whole -- I mean, part -- what I'm -- I've heard from the Defense is, you know, this was sort of the whole -- I mean, my words not yours -- this whole sort of rush to judgment and, you know, that they didn't consider everything. Brian Labus was, you know, and the CDC -- the gals from the CDC, it was them. So I don't know how this case could be put on without Brian Labus or someone from the Health District to explain, well, Why did we get to this theory?

Because that's what I'm hearing in the opening statement, it was a rush to judgment, it wasn't a thorough investigation. Then you get the plaintiff's bar involved and it's really, oh, go after the propofol and -- to the exclusion of these other cheaper things, like the saline -- the multiuse saline. And so I don't know how the case could go forward without bringing all of that out.

So let's take a couple-of-minute break, and then I want to get started with the jury.

MR. STAUDAHER: Your Honor, I'm not going to argue anything. I just want to put something on the record, if I may, and it will just take one second.

I know that the Court -- and I'm not quibbling with the order regarding the admission or not of the actual report of the Health District, but I do want to put in that the State

did submit four cases for the Court's review: United States v. Berry, 683 F 3d --

THE COURT: And I think that was the one --

MR. STAUDAHER: -- 1015 --

THE COURT: -- I was quoting from this morning.

MR. STAUDAHER: -- a 2012 case, that was a criminal matter. And then also, Ellis v. International Playtex, 745 F 2d 292. Drayton v. Pilgrim's Pride, which was 472 F 2d 638. And also, the Beechcraft -- or Aircraft Corporation v. Beech Aerospace Services v. Rainey, which was 488 US 153, a U.S. Supreme Court decision.

I didn't indicate -- have any indication that the Defense had ever submitted any cases --

THE COURT: They did not.

MR. STAUDAHER: -- and I don't know what else the Court reviewed, but I did want to have on the record that that was submitted, and --

THE COURT: And I did consider all of them, and --

MR. STAUDAHER: -- at least --

THE COURT: -- and the case I was quoting from this morning was U.S. v. Berry, which was the sole criminal case, and that was the one where the documents that the Court upheld were routine administrative documents, that there was no anticipation of a criminal proceeding.

Other cases have talked about litigation, and, you

know, I don't know the exact timing of all of these events, but, you know, I think it was pretty clear early on, certainly by what was going on in the media, that there could be criminal charges, certainly that there would be civil litigation involved in all of this.

And so I think the record is complete there. Can we get started with the jury?

MR. STAUDAHER: Yes, Your Honor.

THE COURT: Okay.

(Pause in the proceedings.)

THE COURT: Go ahead and bring in the jury, Kenny. Thanks.

Do you have the full name of that Oklahoma case?

MR. WRIGHT: No, but I'll get it.

THE COURT: Doesn't give me a lot -- doesn't give my poor law clerk a lot to work with there.

MS. STANISH: Oklahoma and compulsory process --

MR. WRIGHT: Right.

MS. STANISH: -- U.S. Supreme Court, you'll find it.

MR. WRIGHT: Compulsory process.

MS. STANISH: Westlaw search will work with that.

MR. WRIGHT: It seems like to me it was a statute that preclude -- if you can believe this --

THE COURT: Well, I mean, if it's --

MR. WRIGHT: -- a statute precluded the defendant

from calling a charged accomplice as a witness or something. It was a statute that precluded testimony.

THE COURT: What was the, like, basis for the statute? Like, the public policy behind the statute?

MR. WRIGHT: I don't even -- it wasn't very good. It wasn't as big as the --

THE COURT: Unlike this public --

MR. WRIGHT: -- interest here.

THE COURT: -- policy behind the statute, which is, you know, pretty compelling.

MR. WRIGHT: Correct.

THE MARSHAL: Ladies and gentlemen, please rise for the presence of the jury.

(Jury entering at 10:11 a.m.)

THE MARSHAL: Thanks, everybody. You may be seated.

THE COURT: All right. Court is now back in session. The record should reflect the presence of the State through the Deputy District Attorneys, the defendants and their counsel, the officers of the court, and the ladies and gentlemen of the jury.

And the State may call its next witness.

MS. WECKERLY: Brian Labus.

THE COURT: Mr. Labus, just right up here, please, sir, next to me, up those couple of stairs. And then remain standing, facing this lady right there, who will administer

the oath to you.

BRIAN LABUS, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Brian Labus, B-R-I-A-N, L-A, B as in boy, U-S, as in Sam.

THE COURT: All right. Thank you.

Ms. Weckerly?

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Sir, how are you employed?

A I'm the senior epidemiologist for the Southern Nevada Health District.

Q And how long have you been the senior epidemiologist for the Health District?

A I've been the senior epi for about 11 years; I've been employed there for 12.

Q Okay. And what's your educational background that allowed you to work in that capacity?

A I have a bachelor's degree in biology from Purdue and I have a master's of public health and infectious diseases from UC Berkeley.

Q Prior to having the position you have as the senior epidemiologist, did you hold other positions within the Health District?

A Yes, I was an epidemiologist.

Q An epidemiologist. Were you assigned to investigate the hepatitis outbreak at the Endoscopy Center of Southern Nevada in 2007?

A Yes, I was.

Q Can you explain to the members of the jury how it was that the -- the outbreak itself came to your attention?

A Hepatitis C, when acute cases occur, is reportable to the health authority, and by law we're responsible for investigating those.

Q And what -- what is -- how does the Health District and the CDC define an acute case of hepatitis C?

A An acute case of hepatitis C is defined by a number of lab tests that show the person has hepatitis C, as well as some current liver problems, so an elevated liver enzyme which shows damage to the liver, or bilirubin, which is why you turn yellow and get the symptoms from hepatitis. You have to have a discrete onset of symptoms. So the combination of the lab test and the symptoms are what defines it as an acute case of hepatitis C.

Q And is there a time period where cases are defined as acute, like, from the time of exposure, like, what would be the outer range of what could be considered acute?

A If a person is infected, they'll develop acute disease within six months.

Q And the other cases, I assume, are called chronic?

A That winds up being a little bit of a tricky term. Chronic usually refers to a long-term infection with hepatitis C. So you have a new infection. A small percentage of those people get symptoms, they get sick with the disease. The rest have a subclinical disease. So the virus is in them, it's doing damage, but they don't have any outward symptoms. Some people clear the infection, but most go on to have a long-term infection, which is the chronic hepatitis C.

Q And are chronic cases reported to the Health District?

A All lab reports are reported to us, but chronic hepatitis C is not legally reportable to us.

Q Okay. And typically how many acute cases would be reported to the Health District in a normal year?

A Usually between two and four cases in Clark County.

Q Okay. In Clark County? Now, when you -- when was it that you first learned of this outbreak?

A I learned about it on January 2, 2008.

Q And when you -- did you learn about it, like, because you were assigned to investigate it, or how was it that it came to your attention?

A We had the two cases reported, one was in late

November, one was in December. They were investigated by our investigation staff at the office. And when they identified the common link between the cases it was passed up the chain, and that's when I became aware of it.

Q Okay. So initially you were just aware of two cases that were possibly associated with the clinic?

A That's correct.

Q And based on that, what steps did you take in order to kind of get a plan together to start investigating?

A This was sort of uncommon for us. We don't normally see hepatitis C tied to a medical facility; and when the two cases were identified, they had procedures on different dates. So we had two cases, sort of associated with the same place, and sort of in the same time range, but not on the same date. So we contacted the CDC to talk to them about where should we go with this investigation? What would be the appropriate next steps?

Q So initially, one of the cases you had reported was -- went from July 25?

A That's correct.

Q And then you had another one from September the 21st?

A That's correct.

Q And then based on that they -- they had an association with the clinic, but not much else of a

connection; is that fair, initially?

A Yes. Colonoscopies are a common procedure, and so the fact that both people had them, it was uncommon, but it really -- didn't really make it certain that it was any one particular clinic. It could have just been a coincidence.

Q Okay. And what was -- what was behind the decision to contact the CDC?

A The fact that we had some connection between these two cases, but not a really strong connection, and we wanted to talk to the experts on hepatitis and healthcare-acquired infections to see if this warranted a full investigation.

Q And when -- had you -- have you in previous investigations contacted the CDC for, I guess it's advice or -- or their thoughts on an investigation or an outbreak?

A Yes.

Q And is that something that's frequently done by the Health District?

A Yes, and there's a process in place to do that. There's kind of informal request and formal request, but they're kind of the -- the experts on those diseases. So when we don't know what to do -- if the State doesn't know, then we go up to the CDC.

Q Now, do the -- does the CDC always send an investigative team out, or sometime do they just offer advice

or -- or maybe information, and then the investigation is just done with local officials?

A Most of the time it's more of an informal discussion with CDC where we're just asking for their expertise and they kind of give us their thoughts just as scientists. We occasionally will request a formal investigation from the CDC. There is a document that's requested by our state epidemiologist that goes to the CDC, and there's an official process for having them send somebody out.

Part of it is deciding, is it worth sending somebody out? Is it something where they need to come into the field? Or is it something they can do just by assisting from Atlanta?

Q Okay. In this particular case two people were sent out from the CDC, correct?

A Yes, that's correct.

Q And that's Dr. Melissa Schaefer and Dr. Gayle Fischer, now, Langley?

A Yes, that's correct.

Q Okay. When was it that those two doctors came out?

A They arrived on January 9.

Q And prior to them coming on January 9, what -- what did you do in terms of the investigation?

A Well, on the 2nd we were discussing things with

CDC, and we identified a third case. And the third case with acute disease also had a procedure on September 21. So now we had two cases that were on the same day, a third case on a different day. Clearly there was something going on with that clinic because that's more than we'd expect in a typical year, basically.

Q Sure.

A So we began just to -- to get whatever documents we had on -- on the clinic; we talked to the Bureau of Licensure and Certification because they are the group responsible for regulating that facility. So the first question was, are they responsible; we contacted them, they said that they were responsible, and then we coordinated our response with them.

We both decided to wait until CDC arrived to launch our field investigation.

Q Okay. And then the CDC obviously gets there?

A Yes.

Q And do you -- are you the one that actually makes the call over to the clinic on the 9th to inform them that you're coming over?

A Yes.

Q And how -- how much in advance of your arrival at the clinic did you make that phone call?

A It was about 30 minutes.

Q Okay. And when -- when you all went over on the 9th, do you recall if it was in the morning, afternoon?

A It was in the afternoon.

Q And it was yourself, Dr. Schaefer, and Fischer, and who else?

A And we had two people from the Bureau of Licensure and Certification.

Q Was the -- was the investigation of the Bureau of Licensure coordinated with your investigation at all, or was it a separate one, or how would you describe it?

A I would say it's a parallel investigation. They had their own investigative process. There were things that they had to look into when they were out there. They were doing basically a complaint response, essentially, and they had certain things they had to do that -- that we didn't and vice versa.

So CDC was there to assist us, and the BLC was doing a parallel investigation at the same time.

Q Okay. So it's fair to say you worked pretty closely with the CDC and less so with the -- the Bureau of Licensure?

A We were all in the same room, but a lot of it -- they were looking at some other things that we weren't particularly interested in, and they looked at a lot of the paperwork; do -- do the employees all have licenses, do they

have up-to-date TB tests, a lot of just the normal things they do as part of the -- the regulation of the clinic. Things that didn't matter to us as part of the outbreak, really.

Q Okay. And so it's pretty close by, right -- the -- where the Health District was at that time versus the location of the clinic?

A Yes, the clinic was right across from the Health District; my office was another block up the street.

Q Okay. So you -- did you just walk over there --

A Yes.

Q -- on the 9th, all of you?

A Yes.

Q And who do you meet up with when you get to the clinic on the afternoon of the 9th?

A We met with Tonya Rushing. We met with Dr. Carrol. And then they had a few other people join us. Jeff Krueger was in and out, and Katie Maley.

Q And who was it of your group that explained to the clinic staff why you were there?

A I did.

Q And what did you tell them?

A Basically what I've told you. We identified three cases of hepatitis C, we had this common connection, they were acute cases, we, you know, we don't know what's causing it, but we're here to do an investigation, figure out

why this occurred, and what steps, if any, are needed to prevent additional cases in the future.

Q Did you make any requests of the clinic in terms of your next steps in the investigation?

A Yes, we started to ask for documents and those sort of things. They took us down and gave us a quick kind of walk through the clinic just to give us an overview, and we started talking about what kind of documents they had so that the next day we could start to get the -- the paperwork we needed to go through.

Q And what was the -- the paperwork that you were looking for?

A We wanted the -- the logs that had a list of every person that was seen on those days, and then we wanted the charts from all the people that had procedures on those days, as well as the -- I believe the three or four days prior to the -- their procedures as well.

Q Okay. You didn't get -- you didn't review those charts on the first day you were there, though; is that fair?

A No, we were at the clinic maybe an hour, hour and a half. We had a meeting with them, they gave us the overview, and that was -- we got there at the end of the day, 4:00 or so, so it was already late in the day. We planned to come back the next morning at 8:00 and start our -- our document review at that time.

Q Did you observe any procedures at all that first day on the 9th, or was it just sort of a walk-through?

A We didn't really observe procedures. We could see what was going on; I think it was the last patient of the day, or they were just finishing up. So there really wasn't much to see at that point. It wasn't a -- an observation of their procedures, more just kind of a looking around and getting a feel for how the clinic worked.

Q Okay. Obviously you go back on the 9th?

A The 9th was the Wednesday, we went --

Q I mean, the 10th, sorry.

A Yes, that's correct.

Q And did you go in the morning at this -- at that point?

A Yes, we did.

Q And is it the same group of people that you described, the BLC, the two doctors from the CDC, and yourself?

A Yes, as well as a couple additional investigators from my office. We had a lot of documents to go through, so I -- we had different people at different times assisting us go through and abstract the information.

Q Okay. And what were the -- what did you first do when you -- when you got there on that second day?

A We were requesting documents on that day, and so

they started to bring us those documents. They showed us to a conference room and let us get set up in there so we could start to review things. Then we started going through all the -- the paperwork that they had, the patient logs, the charts; we started requesting things, like their policies and procedures. BLC was doing the same thing at the same time, so we made a lot of requests of them for paperwork, basically.

Q Between yourself and other representatives from the Health District and the CDC, did you all develop sort of information you were looking to extract from each patient file on those days, or how did you go about categorizing that information?

A The CDC came up with a questionnaire that we could use to extract the information on the document, so collect the patient names, demographic information, then all the -- the details of the procedure: What time did it start? What time did it end? Which people were involved. Basically so we got consistent information out of the charts and could put a big table together of everything we collected.

Q And was that to do sort of a comparison to see if you could see any, I guess, commonalities?

A Right. We were looking for whatever common links we could identify between the cases.

Q Now, at the time you were there and extracting information from the charts, did you have at that time, in

your head, an idea of how you thought the hepatitis C could have been transmitted in this case that early on?

A We had a number of possibilities going in, just knowing what had happened in previous outbreaks, but we didn't know what happened in this particular clinic.

Q And when you say you had a number of ideas, are part of those or were part of those ideas based on just the nature of the disease itself?

A No, they were based more on the nature of previous outbreaks that had happened over the last 10 or 15 years that CDC investigated and had been published in the literature. So we knew what sort of things others had found doing these types of investigations, so those were kind of the main things that we expected to look at in our investigation.

Q Okay. And those were -- I mean, I think you just said it, those were things you were going to look at, but not to the exclusion of other options or other possibilities; is that fair?

A That's correct.

Q So as -- as you're reviewing the charts on the second day, did you or any members of your team or the CDC start to observe procedures at all?

A At the end of the day we went in and we did a meeting with the staff, and explained why we were there. We saw part of one procedure, and I believe they walked us

through the scope-cleaning process that day and showed us how they did things.

Q The procedure that you just mentioned, was that one that you personally observed?

A Yes, I was in the room.

Q And who -- who was the CRNA, I guess, on that procedure; if you recall?

A That day it was Linda Hubbard.

Q And at the time you observed that procedure, was there anything that you took notice of in terms of how she handled the procedure or administered the sedation?

A I noticed that she was only wearing one glove, instead of two. Other than that, it was just the very end of the procedure, I believe. She had already given the injection, so there wasn't really that much to observe. We were just there for part of that procedure, not the entire one. So it was just a little bit of that on that particular procedure.

Q And I think you also said that you observed the scope cleaning on that day?

A Yes.

Q And was that something you personally observed?

A Yes.

Q And can you describe what you saw of that procedure, or of that aspect of the practice?

A They walked us through step by step from when a scope came into the room, through the manual cleaning process, through the automated reprocessing of the scopes, just kind of step by step how they did everything.

Q From your observations of that, did you -- did you see any deficiencies or anything that you were concerned about in terms of the scope cleaning?

A The one that we noticed was that they used the detergent solution for two scopes. It was labeled for use on a single scope or set of instruments. But that was the only one that jumped out as not following the manufacturer's instructions.

Q And the -- the fact that you'd seen that deficiency, how did that play into your assessment as to whether that was the -- the reason why hepatitis C was transmitted at this clinic?

A I guess it was a cause for concern, and so we asked the CDC -- their experts on scope cleaning what they thought of it.

Q Okay. And was that discounted at some point or at that point?

A At some point after discussion, the people at the CDC felt that there was a cleaning process in place --

MR. SANTACROCE: I'm going to object as to hearsay.

MS. WECKERLY: Well, it's already been testified to

by them, but --

MR. SANTACROCE: Well, it's still hearsay.

THE COURT: Well, that doesn't mean it's not hearsay.

MS. WECKERLY: Okay.

BY MS. WECKERLY:

Q Well, based on -- based on your investigation collectively at some point, did you discount that?

A Yes.

Q Now, was that -- you sort of saw the end of -- or a little bit of one procedure that day, and then you observed the scope cleaning, and did anything else happen that day aside from additional possible chart review?

A No, it was mostly chart review. Every day we were meeting with the clinic multiple times to let them know what we found. I believe on the first day we identified one or two more additional cases. We had the -- the list of recent cases that we've been notified of, and we were able to cross-reference those with the clinic patient list. So we did identify -- I'm not sure which day it was, but we -- I know we identified one on that day, and I don't know exactly when the rest of them were.

Q So it's -- as you're there investigating, you learn of at least one or two more cases from the September 21st date?

A Yes, that's correct.

Q And so at that point you're kind of at a bigger number even than when you started?

A Yes, that's correct.

Q You go back the next day? I guess that would be the 11th; is that right?

A Yes, Friday the 11th.

Q Okay. And what -- what do you do on that day?

A We spent the morning observing procedures. So we had a number of us in the rooms observing procedures, while other people were still back abstracting information from the records.

THE COURT: How many people, total, went in with you from the Health -- at that time?

THE WITNESS: On that day we had myself, the two people from CDC, one or two BLC investigators were there, we also had two or three other people from the Health District doing the record abstraction at that point.

THE COURT: All right. Go on, Ms. Weckerly. Sorry.

BY MS. WECKERLY:

Q You personally observed procedures on that day, that Friday?

A Yes, I did.

Q Who did you observe doing procedures?

A I observed -- Linda Hubbard was the CRNA and Dr. Carrol was doing the procedures that morning.

Q And how did you -- what was the observation of Linda Hubbard's practice with regard to administering propofol?

A She would inject the patient with the propofol, and when the procedure was done, any remaining propofol that was in the vial stayed on the table she had set up for all her equipment, and after several patients she took several syringes and filled them from the existing vials of propofol.

Q Okay. So she would fill, like, one syringe from a couple different vials?

A Yes. She had multiple vials out there, and she basically just removed all the propofol from those four or five vials that were sitting there into multiple syringes.

Q Did that get your attention or cause you concern?

A Yes.

Q Why is that?

A Propofol is labeled for single-patient use. It was being treated as a multidose medication at that point, and so that's one of the concerns with injection-safety issues, the use of essentially multidose vials -- or single-dose vials incorrectly as multidose vials.

Q On the day that -- that you were there, do you remember the size of the vials that were being used?

A I believe the ones that we saw were all 20cc

vials.

Q Did you observe the preop area of the clinic at all on Friday or any of the other days?

A Yes, that was kind of the main area, so you had to walk through that to go to anywhere else.

Q From your observations of the preop area, did you see any deficiencies in terms of saline flushes or administering heplocks, anything that caused you concern?

A There was a separate room where they did the IV setup, and so that wasn't in the main preop area, that was a separate room, and I didn't do observations of that particular room.

Q Okay. The CDC investigators with you, did one of them observe that area?

A Yes.

Q Now, when you were at the clinic, did you have any conversations with any of the employees who were there?

A Yes.

Q Was one of them -- a conversation you had with Vince Mione?

A Yes.

Q Did he tell you anything about syringes?

MR. SANTACROCE: I'm going to object to hearsay.

MS. WECKERLY: It's a prior inconsistent statement.

THE COURT: All right. Go ahead.

BY MS. WECKERLY:

Q You can answer. What did he tell you?

MR. WRIGHT: I join the objection.

THE COURT: I'll see counsel up here for a minute.

(Off-record bench conference.)

BY MS. WECKERLY:

Q Sir, I was asking you about the conversation you had with Mr. Mione. Before you tell me what was said, can you -- do you remember what day it was that you had the conversation with him?

A Yes, it was Friday right before lunch, and we were observing procedures.

Q So obviously it was at the -- obviously it was at the clinic. Was anyone else present besides yourself and Mr. Mione?

A Yes, Melissa Schaefer and I were standing there talking to him.

Q And was it in a procedure room, or just kind of in the hallway, or how would you describe the area?

A It was just outside the door of the procedure room, so it was kind of in the -- the more common area.

Q And the comments that he made to you, were they prompted by a question that you asked, or was it just something that he said in the course of another conversation?

A No, we were asking a few questions.

Q Okay. Do you remember what you -- what you asked him?

A Melissa was asking the questions, so I didn't ask him. I remember the general tenor of the conversation, but not the specific questions.

Q Do you remember if he said anything about syringes?

A Yes.

Q What did he say?

A He said that they were instructed to reuse syringes, but that he didn't do it.

Q Okay. And he didn't indicate who instructed him; is that fair?

A That's correct.

Q When you -- when you were told that information, did it cause you concern about a source or a means of transmission?

A Yes, it did.

Q And why -- why would that be?

A With the reuse of the propofol vials that we've seen, plus the reuse of syringes to access those vials, there would be the potential for a disease transmission between patients.

Q Okay. How long were -- were you and your investigators and the CDC at the clinic in days? How many

days were you there?

A Five or six days.

Q And during those five or six days, were all the -- the charts reviewed from July the 25th and September the 21st?

A Yes, they were.

Q And based on your -- your interviews that you personally did, as well as the CDC interviews and your review of the charts and your own observations, did you eventually personally reach a conclusion about how you believe the hepatitis outbreak occurred in this particular case?

A Yes.

Q And -- I mean, did I leave any -- well, let me ask you this: What was that conclusion?

A That the reuse of propofol vials for multiple patients and the reuse of syringes to access those vials for an individual patient provided the greatest risk of transmission of blood-borne pathogens between patients.

Q And you, I think, talked about earlier that you -- or you considered other possible means of transmission; is that fair?

A Yes.

MS. WECKERLY: May I approach?

THE COURT: Mm-hmm.

BY MS. WECKERLY:

Q Sir, I'm showing you what's been marked as State's Proposed Exhibit 228. Is this a chart that you prepared in association with this investigation?

A Yes, it is.

Q In order to prepare this chart, did you rely on your -- the investigation you conducted with the CDC?

A Yes.

Q And your observations at the clinic on the days you were there?

A Yes.

Q Any -- like, the records or anything else that you may have relied on?

A The clinic propofol records as well, and the -- some of the purchasing records the clinic had as well.

Q Okay. And the patient files, is that --

A Yes.

Q Okay.

MS. WECKERLY: State moves to admit 228.

MR. WRIGHT: Objection.

MR. SANTACROCE: Objection.

THE COURT: Yeah, let me see it.

MR. WRIGHT: May we approach --

THE COURT: Sure.

MR. WRIGHT: -- after you look at it?

(Off-record bench conference.)

BY MS. WECKERLY:

Q Now, let's talk about State's Proposed 228. Was this a chart that -- that you personally prepared?

A Yes, it is.

Q And in terms of -- without reading what the content is, with regard to the top of the chart and the conclusion that you drew, on the first box there, was that based on personal observations or the collective investigation or -- can you let us know what that was based on?

A It was based on laboratory results that I reviewed, and -- I guess both of them would be lab results that I reviewed.

THE COURT: Can you speak up? I didn't hear that last --

THE WITNESS: Both were laboratory results that I reviewed.

THE COURT: Okay. Laboratory results from where? The Health District, or the --

THE WITNESS: It was a combination. The first one was done -- the lab results -- the specimens were collected by the Health District. The second one, the specimens were collected by the Health District or their commercial labs and tested at the CDC.

THE COURT: Okay. And then when you say "reviewed," is that you sitting there and looking at the -- at the results

yourself?

THE WITNESS: Yes.

THE COURT: Okay.

BY MS. WECKERLY:

Q And then the --

THE COURT: And just, sir, so you know, just sort of generally, so I don't have to keep interrupting, if it's not something that you did, let's say, you know, it's somebody else at the Health District who did that, just, you know, say who that person was as opposed to "we" did that because that doesn't really mean anything to us, you know?

THE WITNESS: Okay.

THE COURT: Okay.

BY MS. WECKERLY:

Q And the -- the second conclusion, can you tell us what that was based on, or -- or how you formulated that opinion?

A I analyzed the data that was collected by the team, extracted from the charts, and did the calculations to see if that was a risk.

Q Okay. So that was your own calculation and your own analysis of the data, but the data might have been gathered by others, is --

A That's correct.

Q In addition to yourself, though, probably too?

A Yes, that's correct.

Q Okay. And then the -- sorry, the third box?

A Same thing. The data was collected by the group; I did the analysis myself.

Q Okay. So that's your own conclusion?

A Yes.

THE COURT: I have a question, I'm sorry. How was the data recorded by the group, meaning, did they just have their notes and you all sat and discussed it, or did they all, then, prepare their own written report of what the -- their data was; or how was that, I guess, conveyed to you? Was it conveyed through conversation or a meeting or what?

THE WITNESS: We had standard forms that we used to --

THE COURT: Okay.

THE WITNESS: -- extract the data from the chart. Once it was on the forms, the data was entered to a -- into an Excel spreadsheet, and that -- I went back and recollected some of the data and updated and corrected things, so at the end we had one Excel spreadsheet that we could use to do the data analysis.

THE COURT: Okay. And that was a compilation of all of the chart -- the charts?

THE WITNESS: Yes, that's correct.

THE COURT: All right.

BY MS. WECKERLY:

Q Okay. And the fourth box?

A The fourth box, the same thing. It was a data analysis that I performed on data collected by the group.

Q Okay. And the next one?

A Same thing. It was a data analysis that I did on data collected by the group.

Q Okay. The -- is this the sixth box are we on here?

A Yes.

Q Okay.

A That was a review of the data collected by the group that I performed.

Q Okay. And that particular data was collected from patient charts; is that fair?

A It would have been the procedure charts from --

Q The procedure charts.

A -- the endoscopy center. There were two sets of charts. The patient charts were the -- kind of the medical chart of all the -- all the things that patient had; then there was a chart specific to the procedure that was in the endoscopy center, not the gastroenterology center.

Q Okay. The next one?

A Again, that was an analysis I did of the group data.

Q Okay. This is the third box up from the bottom.

A That was also an analysis I did of the data collected by the group.

Q And the second-to-the-last one?

A The first part was an observation by the CDC -- actually, the whole thing was the -- the observations by the CDC.

Q Okay. And the last one?

A Let's see. The first one was my observation -- it was a CDC observation, my observation, my conversation --

Q Okay.

A -- and then my review of the data collected by the group.

Q Okay.

MS. WECKERLY: With that, Your Honor, the State moves to admit 228.

THE COURT: All right. That is admitted.

(State's Exhibit 228 admitted.)

BY MS. WECKERLY:

Q Can you see that on your screen up there, sir?

A My -- I don't think my screen is on.

Q Oh. Thank you.

A It's on now. Yes.

Q Can you see it now? Okay.

A Yes, I can.

Q Looking at the top of what's been admitted as State's 228, it looks like the chart goes through possible modes of transmission from September the 21st of 2007 --

A Yes --

Q -- correct?

A -- that's correct.

Q Okay. Now, the first one is -- the first column appears to be possible modes of transmission, the middle column appears to be your conclusion regarding it, and the third column on the right appears to be the -- the rationale or your thought process for the conclusion that you drew?

A Yes, that's correct.

Q Okay. So let's talk about a possible transmission source of staff to patient. What were your conclusions regarding that as a possible source of transmission?

A We ruled it out because none of the staff members were positive for hep C. We reviewed the records we had in the database to see if any of the former staff, those were names that we couldn't test, were in there as previously being positive for hepatitis C. And so that was -- initially we ruled it out, and then we had the genetic testing later and could identify the source patient, and that definitely ruled out the staff as a source of hepatitis C.

Q Okay. And you -- not to pick on you, you said

we ruled it "out," but did you personally rule it out?

A I guess I'm speaking as the leader on behalf of the team, but I ruled it out personally --

Q Okay.

A -- yes.

Q So if -- I just want you to be clear if these are your actual conclusions as we go through the --

A It's a little difficult because we work as a team all the time, but yes --

Q -- yeah.

A -- I was the leader of that team; these are my conclusions.

Q Okay. Thank you. And the next possible -- next possibility was, I guess, like, a physician transmitting the hepatitis C, that was considered?

A Yes.

Q And ruled out. Why was that?

A We identified multiple physicians that treated the patients that were infected. We did -- I did a statistical analysis and evaluated if any one of those physicians put the patient at higher risk of being infected, and none was found.

Q Okay. And what -- when you say you did a statistical analysis, saying -- I guess, looking at whether one physician put someone more at risk of -- risk of

contracting the disease, what do you mean by that? Because I know Margaret is going to want to know the math here.

A Okay. This is a calculation called relative risk.

Q Okay.

A And so you look at the -- the risk of disease in the exposed people, and you compare that to the risk of disease in the nonexposed people. So you'd say, the risk of being infected for Physician A, versus the risk of being infected -- or not being infected from everybody else. It's a comparison of the different risks there. So it's -- you do a calculation, then, where it's -- the infection rate in one divided by the infection rate in the other, and you can get a statistical significance on it if you set the -- the P, the probability that it happened by chance at 0.05, the -- kind of the accepted standard, it has to be less than 0.05 to be considered statistically significant.

Q Now, is that -- is that something that epidemiologists do all the -- all the time to kind of assess risks or possible factors that caused transmission, or -- or how do -- I mean, how does that fit in the --

A We use that all the time. When you see on the news that -- whatever the newest thing that's going to kill you is 10 times more likely to kill you than whatever, those are the kind of calculations they're talking about. So it's

the risk of disease, giving it exposure, compared to the risk of disease not having that exposure.

Q Okay. And in my head I -- I would say that that -- does the genetic link that we learned later from the CDC affect that at all as well, or --

A Well, in this case we're talking about a physician -- something that was specific to a physician's procedure. So not --

Q I see.

A -- not the physician -- their blood going to the patient, that would fall under staff to patient. So is it some particular practice of one doctor --

Q Okay.

A -- that made it more likely to transmit hep C because of something that doctor did.

Q All right. Thank you. The next was provider, meaning, the CRNA?

A And this was the same sort of evaluation. We ruled out any one particular CRNA. The patients that had a CRNA were at no greater risk for any of the CRNAs compared to the other CRNAs.

Q Okay. Technician?

A The same is true for that. There was no one technician that created a greater risk for the patient than others.

Q Okay. And what about biopsy equipment?

A Not all infected patients had a biopsy, so that would make it very difficult to transmit it by biopsy equipment, though there's always the potential for cross-contamination. So we -- we did look at the statistics -- or I did look at the statistics as well, and there was no increased risk of disease based on having a biopsy or not.

Q Okay. And when you look at those type of statistics, is there a point in the statistics where it becomes, like, statistically significant, or -- or how do you -- how do you measure that?

A Yeah, there's a probability value that you can calculate, and so it's -- they call it a P value and it's between 0 and 1. So it's the probability that something happened by chance alone.

Q Okay.

A If it's a -- if it's unlikely to have happened just by chance alone, the P value is smaller and smaller and smaller. Anything over 0.05, so 5 percent, is considered not significant.

Q Okay. And that was the statistical outcome of the biopsy equipment, essentially?

A Yes.

Q How about the endoscope?

A This one the -- there were a number of different scopes that were used. Because of the large number of scopes, there weren't enough to really do any meaningful calculations, but the patients all had scopes that appeared to be different from the source patient. We had some problems with the records and some duplicates and things like that. So it's difficult to say for certain, but it didn't appear that there was one scope used on all the infected patients.

Q Okay. How about procedure type?

A There was no increased risk based on an upper or lower endoscopy. The same statistical calculations I performed.

Q And reuse of -- sorry. Reuse of bite blocks?

A This is basically the same as a procedure type. The bite blocks are used only in one of those two procedures. There was no risk from the -- the upper endoscopy procedure, so there can't be the same risk from the bite blocks.

Q Okay. That one seems like you could do without math, but I don't know. No?

A It's the same thing. We still do the calculations just to make sure.

Q Okay. And IV placement?

A In this case, it was the observations on how the IVs were set up by the -- the clinic staff.

Q Okay. And sedation-injection practices?

A So in this case this is the one we did not rule out. We observed the staff reusing propofol vials. The clinic records clearly indicated that they used fewer vials each day than they would have needed for one per patient. So there was vial reuse. And then there was also the observation that the syringe was used to re-access the vial by the CDC.

Q And that was the observation made of Ms. Langley by -- of Keith Mathahs? Is that the observation you're referring to?

A Yes.

Q Okay.

A As well as the conversations with Vincent Mione that said he was told to reuse the syringes but didn't. So it was the idea that that was going on at the clinic at some point.

Q Okay. Now, you talked about the -- the propofol records, I -- you made an allusion to that or you made reference to the propofol records versus the number of patients. Was that something that you personally looked into?

A Yes, it is.

Q And -- and what were your -- what was your assessment or what were your findings regarding that?

A For each day that we looked at we looked at the number of vials that were checked out, the number of vials that were returned, so we could determine how many vials were

used on a typical day in the clinic. For each day that we looked at there were roughly 60 patients a day, and there were fewer than 60 vials being used. It varied day-by-day depending what was going on, and the size of the vials as well.

But from that it was clear that they weren't using the same number of vials, at least, as patients.

Q So there had to be some propofol reuse on multiple patients?

A Yes.

Q Now, when you -- you and the CDC were there, were you able to determine which patients were in which one of the procedure rooms?

A No, we were not.

Q And was that ever something that -- that you, I guess, incorporated in your conclusions as you sit here today, or how does that fit in with your conclusions?

A Several months later something came to our attention that allowed us to try and split it up. The board of medical examiners told us about in their investigation they had a comment from one of the staff members that there was a -- a date error on the bottom of some of the charts, and that could be used to split it out.

So we went back and looked at the date-error issue, and found that that date error did exist at the time of the

procedure. I was able to contact the provider of one of the patients on September 21 and get a copy of the chart that was faxed over right after their procedure.

The date error was obvious at that time. So we know that it happened at that point in time when the procedure was performed, not later. And from that some charts had the date error, some didn't, and that came from a computer system. So we were able to -- if that showed that one room had the error and the other didn't, it allowed us to split up the two rooms.

Q Now, the -- the fact of that date error, did that at all affect your conclusions at all?

A No, it did not.

Q And were you able to reach your -- were you able to reach a conclusion regardless of -- of knowing that piece of information?

A Yes, we were.

Q In -- in your knowledge of -- of hepatitis C and hepatitis C transmission, are people exposed -- that are exposed to hepatitis C, do they necessarily contract the disease even with the direct exposure?

A No. With just about any pathogen, when you expose somebody to a virus or bacteria, some people will become sick; others didn't get sick for whatever reason, or didn't develop an infection for whatever reason.

Q Okay. And are there some people who are exposed

to hepatitis C -- and I think you said this at the beginning of your testimony, that -- that don't even know they have it, and don't experience any symptoms at all, even though they may be positive?

A That's actually the vast majority of patients, 85 to 90 percent of people never have symptoms of it and they wouldn't know unless they were tested.

Q Okay. Now, in this particular case, with the conclusions that -- that you drew, is -- are your conclusions premised on the idea that there was just one infected vial of propofol that was responsible for this on the 21st?

A No.

Q Can you explain how the transmission -- or the -- the ways that you see the transmission occurring on that day?

A Well, there's multiple ways that it could have occurred. Because we didn't observe what happened on the 21st, we can't say exactly what happened. It's possible that it could have came from one vial. There was -- looking at the -- the dose that was recorded for each patient, there would have been enough propofol in one vial to give a little bit to each one, but that wasn't really a realistic scenario.

You would have a -- there were 50cc vials, so that would potentially be used for multiple patients, much more than a 20cc vial, obviously.

Q Sure.

A So that vial could have moved back and forth and it could have been one vial. Or you could have had fresh propofol drawn from that vial, and basically contaminated a second vial when they went in to draw the rest of it, or through, basically using it on a patient, then going into a second vial.

So they could basically recontaminate a second or third vial, as many as needed for that to happen.

Q Okay. And in -- is there any way -- would there be any way for you to determine in that type of scenario if the -- if the virus or there's -- if the virus dilutes it all, or the virus, you know, somehow gets less and less in each vial, or is -- is that impossible?

A It's likely that some dilution would occur, especially if you're talking about going from one vial to a second. But we didn't know how much blood was introduced. We didn't know the patient's viral load. And we didn't know what happened from vial to vial exactly. So there's no way we can say step by step exactly what happened.

Q What was the -- the year that you issued your conclusion regarding the -- the outbreak in this case, and how it was your conclusion regarding the mode of transmission?

A The final report was released in 2009.

Q Okay. And that was the -- the conclusion was

the -- sort of the combination of reusing propofol vials and the reuse of syringes on single patients?

A Yes, that's correct.

Q It's several years later; have your conclusions changed at all since you issued your report?

A No.

Q Has anything come to your attention that makes you question your conclusion that you made back in 2009?

A No.

Q Thank you.

MS. WECKERLY: I'll pass the witness.

THE COURT: All right. Ladies and gentlemen, before we move into cross-examination, let's go ahead and take our morning recess. We'll be in recess until about 11:15.

During the recess you're reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch, listen to any reports of or commentaries on the case, any person or subject matter relating to the case, and please don't form or express an opinion on the trial.

Notepads in your chairs, and follow the bailiff through the rear door.

And, Mr. Labus, during the break please don't discuss your testimony.

THE WITNESS: Okay.

(Jury recessed at 11:01 a.m.)

THE COURT: I'm just waiting for them to get out of the hallway. And, sir, if you want to take a break, you're free to go out that door.

THE WITNESS: Thank you.

(Court recessed from 11:02 a.m. to 11:15 a.m.)

(Outside the presence of the jury.)

THE COURT: Are you going to be first, Mr. Wright?

MR. WRIGHT: Yep, I think.

THE COURT: And you -- this is going to take two days?

MR. WRIGHT: I don't think --

THE COURT: Ms. Weckerly took an hour.

MR. WRIGHT: -- I don't think so.

THE COURT: Almost exactly an -- a little less than an hour.

MS. STANISH: That's not long.

THE COURT: It was, like -- it was, like, no, that's what I'm saying --

MS. WECKERLY: I'm the quickest.

THE COURT: -- it was 50 minutes. I mean, so --

MR. WRIGHT: No, I don't --

THE COURT: -- how do you turn --

MR. WRIGHT: -- think so.

THE COURT: -- Ms. Weckerly's 50 minutes into 2 days?

MR. WRIGHT: I didn't know what it was going to be.

THE COURT: Right.

MR. WRIGHT: So I don't think it --

THE COURT: I mean, it was almost --

MS. WECKERLY: Got more narrowed, admittedly, this morning, but --

THE COURT: -- so.

MR. WRIGHT: So, no, I don't see it being as long as I had forecast.

THE COURT: All right. In other words, Ms. Weckerly, be prepared to have another witness for tomorrow.

MS. WECKERLY: We will -- yes, try to get someone together. It will -- it will in all likelihood be an insurance person.

THE MARSHAL: Ready, Judge?

THE COURT: Yeah. Mr. Labus, come on back up to the witness stand. The bailiff is going to bring in the jury.

MS. WECKERLY: Also, I did the email, everybody -- draft instructions.

THE COURT: Oh, great.

MS. WECKERLY: So everybody can...

(Off-record colloquy.)

THE COURT: Bring them in.

THE MARSHAL: Ladies and gentlemen, please rise for the jury.

(Jury entering at 11:17 a.m.)

THE MARSHAL: Thank you, everybody. You may be seated.

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

MR. WRIGHT: Thank you.

CROSS-EXAMINATION

BY MR. WRIGHT:

Q Good morning, Mr. Labus. I'm Richard Wright. I represent Dr. Desai.

A Good morning.

Q In preparation for your testimony here, what have you reviewed?

A I went through my report, I went through some of the notes I had from -- that I had taken in the clinic, as well as an -- a number of research articles.

Q Okay. Did you read any of your testimony?

A My grand jury testimony.

Q Okay. Anything else?

A No, that's all that comes to mind.

Q Okay. And are you a hepatitis expert?

A No.

Q The -- your -- the definition you utilized for acute hepatitis C -- well, strike that.

We've had experts in here testify regarding the distinction between acute hepatitis C and chronic hepatitis C, and symptomatic hepatitis and nonsymptomatic hepatitis C, and they have talked about the acute/chronic distinction as being one of duration. In other words, acute hepatitis C is short term, and chronic long term. Do you agree with that?

A Yes.

Q Okay. And they talk about acute hepatitis C as -- all hep -- let me put it this way, all -- when I contract hepatitis C, whether I know I have it or not, I have acute hepatitis C for the first, say, six months, and I will either be symptomatic or not symptomatic; does that make sense?

A Yes.

Q Okay. And I had understood your definition of acute hepatitis C, it seems like you were viewing acute hepatitis C as newly acquired hepatitis with symptoms -- symptomatic?

A Yes, that's correct.

Q Okay. So that's -- that's your definition of it, correct?

A No, that's the -- the national case definition that we use for public health surveillance. The Council of State and Territorial Epidemiologists comes with -- comes up with definitions, so there's one for acute hepatitis C, and then there's another one they call past or present. And it's

because of that challenge in determining is it a newly acquired nonsymptomatic case, or is it something the person had for decades.

So for surveillance purposes and for outbreaks we use the -- the acute disease with symptoms as the definition for acute disease.

Q Okay. The -- so that when we're talking about -- because some -- some of those other experts said the acute hepatitis C has nothing to do with the severity of the disease. But for your purposes, when we say, like, in Clark County there are two to four reported cases a year; is that about accurate?

A Yes.

Q Of acute hepatitis C, we're talking about someone newly acquired hepatitis and they are symptomatic, jaundiced, sick, everything that happens in those first six months, if -- if it's symptomatic, correct?

A Yes, the cases I'm talking about, it's the public health case definition. They're taking the medical approach which they need for treatment. So it's kind of two views of the same thing.

Q I got it. And so the -- how many -- and you -- you testified that acute hepatitis C with symptomatic, okay? I'm -- I just got it and I'm sick.

A Yes.

Q That's reportable by physicians by law?

A Yes, it is.

Q Okay. And the first two cases that are November, December were reported by physicians?

A Yes, that's correct.

Q Okay. And how many -- aside from physicians reporting acute hepatitis C, the Health District also gets reports from all the labs around here of positive hepatitis results, my -- my terminology.

A Yes, that's correct.

Q Okay. And so every -- every one that gets a blood test at any time, for whatever reason medically in Clark County, if it -- if they test positive for hepatitis, that's reported to the Health District?

A Yes, it is.

Q Okay. And then the Health District keeps a record of all of that?

A Yes, we do.

Q Okay. A registry of hepatitis C?

A More of a list of just positive lab results, but that kind of idea, yes.

Q Okay. And how many -- how many hepatitis -- when you get -- how many do you get a day from a lab, average?

A I can't say for -- per day. I'd say for -- per month we get 2 to 3,000 probably. We get thousands of results

a month; it's a very large number.

Q Okay. I didn't hear you. Say that again?

A I said we get probably 2 to 3,000 a month, a very large number.

Q Okay. So 2 to 3,000 a month reports come in of positive blood tests for hepatitis C?

A Yes.

Q Okay. In Clark County?

A Yes.

Q I mean, is that -- that's your jurisdiction -- Southern Nevada Health District is co-terminus with Clark County, correct?

A Yes, it is.

Q Okay. And are -- are those new reports or duplicates because someone keeps getting blood tests?

A It would be both of those.

Q Okay. Both of those? Because you get -- say you get 3,000 this month, some of them you may already have in your database?

A Yes, that's correct.

Q Okay. When I say "you," I'm talking about the Health District, obviously.

A Yes, that's correct.

Q And so it's -- of those -- say it's -- it's 3,000, so we're, like, talking about -- say 100 are reported

tomorrow, come it -- does -- does anyone contact those people or do anything with that?

A No, we don't.

Q Okay. And do -- you don't know if it's newly acquired -- well, you -- you would know if it's newly reported, correct?

A Yes.

Q Okay. But you wouldn't know if the person just got hepatitis C, and you wouldn't know if they have symptoms?

A Without a physician report on just the lab tests, no, we wouldn't.

Q Okay. So when -- when this -- these first two reports came in, and then we're back to January 2008 now, okay? And that -- that was your initial involvement?

A Yes, that's correct.

Q Okay. And it was passed up to you because you're an epidemiological investigator; is that right?

A Yes.

Q Okay. And already the two reports that had come in had been investigated in the sense of your office -- or the health -- someone in the Health District contacting the two people, correct?

A Yes, that's correct.

Q Okay. And talking to them either by phone or in person to determine risk factors?

A Yes, that's correct.

Q Okay. And do you -- you also independently test them?

A Generally, we won't, unless there's some additional reason to do so. If we have a lab test from a commercial diagnostic lab, there's no reason to do additional testing.

Q Okay. And that's -- that's reliable information? I mean, you -- you have the -- it's reported by a physician, and then the -- the lab tests are there showing that it's positive for hepatitis C?

A Yes.

Q And then the -- the person is contacted and they are symptomatic, and they're interviewed for the common risk factors you all have developed, correct?

A Yes, but I'd say we also determine if they're symptomatic. Just because a physician reports it as an acute case, it may not meet our definition. It may be a misdiagnosis. It may be he only had partial information. So that's part of it as well.

Q Okay. And so someone else did that in the Health District?

A Yes.

Q Okay. And they confirmed that the people are -- were sick, had been hospitalized or whatever and they were

symptomatic with acute hepatitis C?

A Yes, that's correct.

Q And then the -- the background -- the interview of them for risk factors, that takes place, correct?

A Yes.

Q And as I understand it from testimony we've had here, the -- the risk factors for newly acquired acute hepatitis C, but symptomatic, is not as thorough an analysis; is that fair?

A That's correct, we can't consider every possibility.

Q Right. I mean, it's newly acquired, so just by definition we know, like, within the last six months they got the hep C?

A Right. When we do the interviews we ask about those risk factors and the six months prior to the onset of their symptoms, so we limit it to the -- the incubation period of the disease.

Q Okay. As opposed to other people, if I just test positive hep C, and I -- I just found out; I took a blood test and just learned I had hep C and didn't even know it, an interview on me on risk factors goes all the way back, correct?

A Yes, that's correct.

Q The -- to -- and the most common risk factors

are the -- I'm not sure I'm saying it right. The most -- what's the most dangerous conduct? How do you rank the risk factors?

A For newly acquired disease, the majority of cases it winds up being IV drug use, so that's the big question. When you look at the older cases, a lot of it was blood transfusion, so before they started screening the blood supply for it accurately in 1992 there was a risk of hep C, and especially going back into the '70s the way they -- they got blood donors. At one point they had paid blood donors and it tended to attract people that were more likely to have hepatitis.

And so there were risks from mostly blood or medical procedures back then. More recently, though, it's more IV drug use, and a lot of them are undetermined still.

Q And so now it's confirmed by your -- by the Southern Nevada Health District, we have two reported cases, and at that time you had the common link which was a same clinic, correct?

A Yes.

Q And the -- that -- that's what caused it to come to your desk to start looking into it?

A Yes, that's correct.

Q Okay. And just -- I guess, just those two isn't the correct word, but, I mean, with -- with only two reported,

that in and of itself sends up big red flags when they are connected to a common facility?

A Yes, for an uncommon disease like hep C.

Q Right. And so with -- with those two, who do you reach out to first?

A I'll talk to my boss, I'll talk to other epidemiologists or the lab, as necessary. In this case it was mostly talking to my boss, and then contacting the CDC.

Q Okay. And your boss is?

A Patricia Rowley.

Q Okay.

A Or was my boss; not anymore, but she was at the time.

Q Okay. And what is her position?

A She was the manager of the epidemiology office.

Q Okay. And how many of you epidemiologists are in there?

A There's around a half-dozen over that time period. There's a couple that do infectious disease and the other ones do chronic disease, injury, all sorts of things that are totally unrelated to any outbreak investigations.

Q Okay. 'Cause you guys go in and look at the restaurants and all that stuff that we see on T.V.?

A That's the environmental health inspectors, but if there's an outbreak there we do the restaurant outbreaks as

well.

Q Okay. And you were -- when this -- how did this end up on your desk or your computer -- what would -- end up on your computer?

A Yes, I got an email from my boss that just had the details, so the -- the supervisor over the disease investigators that did the interviews notified the office manager, who told me about it.

Q Okay. And you -- were you selected -- do you specialize in this type of investigation?

A We only had two infectious disease epidemiologists and I was the senior person. So I -- I tend to find out about most things, or at least at the time I did.

Q Okay. And had -- had you previously done a -- and is an investigation the correct word in your --

A Yes.

Q -- okay.

A Yes, it is.

Q The -- had you previously done an investigation involving hepatitis C transmission?

A No.

Q Had you previously investigated an ambulatory surgical center for a viral outbreak?

A No.

Q Okay. And by "viral outbreak", I'm talking

about a virus as opposed to, like, bacterial infection, right?

A That's correct. I haven't -- I haven't done any ASC investigations before this one.

Q Okay. And the -- and had -- had you investigated any hepatitis cases?

A Yes.

Q Okay. What type?

A I've done hepatitis A and hepatitis B.

Q Okay. And hepatitis A is generally transmitted how?

A Hepatitis A is typically food borne, and hepatitis B is the same sort of transmission generally as hepatitis C.

Q Okay. And were those in clinics, hospitals, or what?

A No.

Q They were not?

A That's correct.

Q Okay. So when -- when this initially came and it -- it -- you guys deal -- that relative risk, the statistics you all were talking about, that -- that had to be up there high, the two within a couple of months same -- precisely same clinic, correct?

A Well, I would say a red flag was there, but I wouldn't say relative risk. We use that in a different

context, basically.

Q Okay. The -- and so you -- did you talk to your boss, and then initially contact CDC that very day?

A Yes.

Q Okay. And so this is January 2nd, if I recall correctly?

A Yes, that's correct.

Q And so you get in touch with CDC and you tell them what you have, correct?

A Correct.

Q Okay. And are you at that point requesting this epi -- what they called an Epi-Aid?

A Not at that point. Not initially.

Q Okay. You are contacting them looking for guidance and expertise?

A Yes, that's correct.

Q Okay. And so -- and that -- that first day while you were contacting them, a third case gets reported?

A Yes.

Q Okay. And once again, that was physician-reported?

A Yes, it was.

Q And it was vetted -- I mean, it was confirmed it's hepatitis, it's acute, and no risk factors, and lo and behold same clinic and same date as one of the others?

A I believe one or two of the cases also had a dental procedure in the six-month window as well, but all three of them had that -- that same endoscopy center link.

Q Okay. And so you reported that to CDC?

A Yes.

Q Okay. And then the -- the plans -- how -- what happened between the 2nd and the 9th?

A We started discussing with CDC, was an Epi-Aid appropriate? Did they have people available to come out and assist us, and -- and then it was a question of which branches at CDC. So we spoke with the hepatitis branch and the branch that does healthcare-acquired infections, DHQP is their acronym, it's Division of Healthcare Quality and Promotion.

So we were having discussions with them, trying to figure out what the next steps were going to be. We made our official Epi-Aid request, probably the -- the third, probably that next day. They got their team together and said they'd be able to arrive the following Wednesday.

Q Okay. And the Epi-Aid request, I mean, that's part of the bureaucracy of government, you have to officially have someone ask them?

A Our state epidemiologist has to make an official letter of request to the CDC; and then the CDC comes up with kind of a plan of why are they coming out, what are they looking for, and what's the reason for the trip. Then that

gets approved and they find hotels and flights and all that sort of stuff. But it's a pretty standard process that's used all over the country, and we've had Epi-Aids before; it's not a first time we've used it.

Q Okay. And so the -- the state epidemiologist -- is that?

A Yes.

Q Who is that?

A That's Dr. Ihsan Azzam.

Q Okay. And so he -- he was in the loop and forwarded the request?

A Yes, that's correct.

Q Okay. And so they -- they come out and they -- they, from the CDC was Melissa --

A Dr. Schaefer --

Q -- Schaefer --

A -- and Dr. Fischer.

Q -- okay. And they arrive on the Wednesday the 9th?

A Yes.

Q And you all have a meeting with them, before going over to the clinic?

A Yes, that's correct.

Q And at that meeting, yourself, Dr. Fischer, and Dr. Schaefer from CDC, and people from BLC?

A As well as a number of other Health District people.

Q Okay. It -- so they're -- your -- your agency?

A Yes.

Q Okay. And at that time had you been -- had you made any initial determinations in your own mind as to what you thought the probable cause was --

A No.

Q -- going in?

A No, I didn't.

Q Okay. Do you recall that your initial belief was that it was scope-related because it was a clinic and that's what you all, meaning the Health District, thought was the most likely cause?

A I believe my boss sent an email that it was concerned about the scopes because it was an endoscopy clinic --

Q Okay.

A -- and that was just the initial thought, based on the type of the clinic.

Q And it -- and it was the CDC that said, no, we think that injection practices is the most likely cause, based upon our past outbreak investigations?

A I don't think they said it was the most likely cause, they said it was more likely that it was an injection

safety issue than the scopes, but it really could be anything going into there.

Q Okay. But they said the first thing we want to look at is injection practices?

A I don't know if it was the first thing they said, it was something they wanted to look at, though.

Q Okay. The -- I read a conversation you had with somebody called Nachos?

A It's NACCHO. It's the National Association --

Q NACCHO.

A -- of County and City Health Officials.

Q Okay.

A Yes, they get that --

Q Well, it's --

A -- all the time. It's a running joke with them.

Q -- N-A-A-C-H-O [sic], NACCHO?

A N-A-C-C-H-O, NACCHO.

Q And it -- and -- do you recall the conversation?

A I remember talking to them a number of times over the years.

Q Okay. But the -- do you recall a conversation with yourself, Dr. Sands, the -- everyone involved in this with the NACCHO representatives after this outbreak and investigation had occurred in which you were sharing with them, your -- your -- what had occurred?

A Vaguely.

Q Okay. Do you recall -- because I recall reading in there that you stated that your all's initial presumption or assumption was that it was scope related, but that's why we call in the experts because they said the first thing we want to look at is injection practices. And I -- I'm summarizing it, but --

A It doesn't sound incorrect. I don't specifically remember the conversation, though.

Q Okay. And it -- it does not sound incorrect. That sounds like that's accurate about the mindset on going in the door.

A In a general sense, yeah. The scopes were on the list, and I would say the injection safety was probably the top of the list of things that we were looking at.

Q Okay. And so you all had waited for CDC to arrive, and that was one week, correct?

A I think they officially approved the request on Friday, so it was several days, yes.

Q Okay. The -- oh, I mean, from -- from the 2nd to the 9th you all made the determination to wait, get CDC, BLC involved, and don't notify the clinic until everything is in place?

A Yes.

Q Okay. And that's just part of the way

investigations are properly done, correct?

A Yes.

Q Okay. Because the -- you want to -- to your knowledge, no one at the clinic had any idea of this outbreak until you called on the -- on Wednesday the 9th?

A As far as I know, that's correct.

Q Okay. And you called that afternoon, and told them -- did you tell them on the phone?

A I think we gave them a brief overview that we had a number of hepatitis C cases that were potentially linked to the clinic, and we were initiating an investigation, and we wanted to come over and meet with them right away.

Q Okay. And do you remember who you spoke with on the phone?

A I got passed around to a couple of different people, and I think the final person I really spoke to was Tonya Rushing.

Q Okay. And so -- and then you all, within a half-hour, walked across the street and --

A Yes.

Q -- into the clinic. Had you ever been there before?

A No.

Q Okay. And you ultimately met with Tonya Rushing, correct?

A Yes.

Q Okay. Dr. Cliff Carrol?

A Yes.

Q Okay. And Jeff Krueger or Katie Maley may have been present at the first meeting?

A Jeff was present for most of it; Katie was kind of in and out.

Q Okay. So most likely Jeff Krueger first meeting?

A Yes.

Q And at -- at that meeting you had the two -- two BLC people, two CDC people, and yourself?

A Yes.

Q Okay. And did you tell them of the three cases?

A Yes, we did.

Q Okay. And it's hepatitis C, acute, symptomatic --

A Yes.

Q -- positive? And what -- what was the response or reaction?

A They were surprised and offered whatever assistance we needed in the investigation. They were very accommodating when we talked to them.

Q Okay. And what -- you had set up with CDC a game plan for the investigation, correct?

A Yes.

Q Okay. And so you told them, here's what we will need when we come back tomorrow?

A We started to because we didn't know what documents existed. So the first question is what do they have, and then we can decide what sort of things we wanted to look at. We -- I think we had some general categories, but without visiting the clinic we didn't know exactly what to ask for.

Q Okay. And so in visiting it -- and you actually did a walk-around, correct?

A A brief one, yes.

Q Okay. And you were aware that there was a -- what we've called the -- the gastro side, which was medical offices, and then there was actually the procedure clinic, I -- endoscopy side?

A Yes.

Q Okay. And you learned that they had a patient log -- patient list for both days, correct?

A Yes.

Q And patient charts, that would be, like, the patient's file for those days?

A Well, there were two patient charts. So there was the procedure chart on the endoscopy side, and then there was the general medical chart of the patient on the -- the

gastro side.

Q Okay. And essentially -- and whether it was all learned right at that very first afternoon -- Wednesday afternoon, you became aware of all of those charts, the doctor side and the procedure side, and those were presented for all of the patients for July 25th and September 21st, correct?

A As well as a couple additional days. I think -- I think July 25th was a Monday, so I don't think we got any charts from prior to that, but we got the -- the two or three days prior to September 21st as well.

Q Okay. And to get -- so going -- so a number of days, three or four, before the September 21st?

A Yes.

Q Okay. Now, at that first meeting Wednesday afternoon, they -- they give you an overview verbally of their operation?

A Yes.

Q Okay. Like, number of procedures, types of procedures, types of scopes, types of processing, types of medication?

A They talked about the number of patients and the general setup. I know we talked about the medications. I don't know that we went into the types of scopes and how those were processed. That was maybe a little more detailed than the first meeting.

Q Okay. And at that first meeting they -- they talked about medications that they used, administered, on the patients, correct?

A Yes.

Q Okay. And they talked about anesthesia?

A Yes.

Q And that they used several narcotics?

A Yes.

Q And used propofol?

A Yes.

Q And used lidocaine with propofol?

A Yes.

Q Okay. And they explained at that first meeting that the lidocaine and propofol came from multidose vials?

A I know they explained the lidocaine did, I don't know that they said it was a propofol multidose vial. I don't remember specifically what they said. But I believe the conversation they said they used one vial per patient, that they weren't using multidose propofol vials.

Q Okay. You think they said they were not multidosing propofol?

A From what I remember with the conversation, Tonya said if -- if you check the Sharps container there'll be, you know, vials in there with a bunch of propofol left in them from the procedures.

Q Did you do a -- what do you call this report I'm going to show --

A I can't see it. I don't know. Those look like the incident command forms from --

Q Okay.

A -- each day.

Q And incident command forms. Did you prepare incident command forms for this investigation?

A Yes.

Q I'm going to show you --

MR. WRIGHT: Can I approach, Your Honor?

THE COURT: Sure.

BY MR. WRIGHT:

Q -- page 9 and 10, which I think is January 9, 2008. Look at those, tell me if that refreshes your recollection regarding that they told you that they used lidocaine and propofol from multidose vials.

A (Witness complies.) That's what I have in the note here. It still doesn't sound like exactly what happened. The lidocaine was from multidose vials. The propofol, as far as I knew, was not. It's not clear from the way this is written, but that was the -- the conversation.

Q Okay. When you say, "was not," I understand that the vials say -- I mean, ultimately, when you investigate, the vials say single dose; but what I'm asking

is, did they tell you that they used propofol multi -- multipatient?

A I don't believe that they did.

Q Okay. What -- do you read that differently than I do?

A Yes, it was a -- quick notes that I jotted all this down at the end of the day to kind of log everything. And I should have been clearer on what I wrote there, but I -- I wrote it as, Propofol with lidocaine is the primary anesthesia used, and comes from multidose vials. The lidocaine came from multidose vials, but the propofol, as far as I knew, did not.

Q Okay. Have you looked at the BLC -- when you ultimately prepared a report, did you look at their report?

A I've read their report, yes.

Q Okay. Did you look at their notes of this first meeting?

A When I read the entire report, but it's been five or six years since I read it, so --

Q Okay.

A -- that's not something I recall.

Q Are you aware that -- do you know who Dorothy Simms is?

A Yes.

Q Okay. Was she present at this first meeting?

A Yes.

Q Okay. And she states that Jeff Krueger said that they use multidose vials of propofol?

A Okay. If that's in the report, I can't disagree with it.

Q Okay. Well, does that explain why you would put in your January 9th incident status summary that, Propofol with lidocaine is the primary anesthesia used, and comes from multidose vials?

A It could be.

Q Is there any -- strike that.

After this first meeting on Wednesday, in the afternoon, you all make plans to come back the next morning?

A Yes.

Q Okay. And you return the next morning, and that's all of -- all of the same people, plus several more from your office?

A I believe so. I think it was the same two BLC investigators, plus one additional BLC person as well. I think they had three people on the first day that -- that BLC came back.

Q Okay. And that -- that first full day would have been Thursday the 10th?

A Yes.

Q And that was almost exclusively devoted to

records review?

A Yes.

Q And you all set up in a conference room, and they brought in the patient's logs -- patient lists for the relevant days, and started bringing in all of the charts, hospital -- or the -- ASC, the procedure records and the doctor records?

A Yes, that's correct.

Q Okay. And you all started going through those to put together your -- your chart, looking for commonalities?

A Yes.

Q And that -- that took place most of Thursday?

A Yes.

Q Okay. And anything else on Thursday that was relevant?

A Well, there was a staff meeting we attended, where we told them what was going on, and that we'd be observing in the clinic because we planned to do observations the next day, so we wanted them to know --

Q Okay.

A -- why we were there.

Q Okay.

A We also caught the end of a procedure, and then saw the scope reprocessing that day, I believe.

Q Okay. And so the -- the staff meeting, we're

talking about the clinic staff, correct?

A It was the endoscopy center staff.

Q Okay. Right. Procedure -- the procedure clinic's staff, and it was explained to them who you all were, and why you would be lurking in the background --

A Yes.

Q -- watching?

A Right.

Q Okay. And so then you all came back on Friday, and started your observations, correct?

A Yes.

Q And you were doing observations of procedures that morning?

A Yes, that's correct.

Q And you were watching Linda Hubbard --

A Yes, I was.

Q -- CRNA? And what doctor; do you recall?

A The -- Dr. Clifford Carrol.

Q Okay. And did you watch a number of procedures?

A Yeah, a half-dozen or so.

Q Okay. Were they uppers or lowers or do you know?

A I think it was a mix of the two. I remember the colonoscopies. It was just a -- is a longer procedure, and so there was a little more to observe. But it was just kind of a

mix of whatever was scheduled in whatever order. We didn't choose any certain type. We just, you know, whatever they brought in is what we observed.

Q Okay. And you are observing with whom?

A I was in the room with Melissa Schaefer, and BLC people were kind of in and out.

Q Okay. And so as you're watching -- you're watching Linda Hubbard's injection practices?

A Yes.

Q Okay. And she knows -- you're there, Melissa is there?

A Yes.

Q And possibly another BLC or two?

A Yes.

Q Okay. And so with you all watching her, she is drawing propofol and doing patient injections?

A Yes, that's correct.

Q Okay. Did you see any -- we'll get to the number of propofol vials, but just on her injection practices, did you see anything unsafe?

A Specifically, on hers, I think on one of them it was the way -- or she didn't wipe the top of the vial with alcohol or something like that, but nothing -- nothing major, just the kind of minor, typical things that you expect to see if there's, you know, slight problems here or there.

Q Okay. And so as far as her -- they were using syringes to draw up the propofol, correct?

A Yes.

Q And so she would get a new needle, new syringe, draw up propofol, inject a patient, correct?

A Yes.

Q Okay. And then, if the patient needed a second dose of propofol, she would get a new needle, new syringe, draw up, and dose the patient a second time?

A Yes.

Q Okay. And so -- and then she was taught throwing away her needles and syringes in the Sharps container?

A I don't know that she was taught, but that's what we observed.

Q Okay.

A We did observe her recap a needle at one point, which was a concern more for her safety than anything else, but it wasn't a risk to the patient.

Q Okay. And so what is "recap a needle"? In other words --

A So you have the -- the plastic cap on the needle, you pull it off, you do the injection, taking the cap and putting it back on the needle. Kind of like putting a cap on a pen. You have a -- you should just put the whole thing

right in a Sharps container instead of accidentally poking yourself while you're doing that.

Q Okay.

A So it's more of a workplace safety issue for the staff than it would be -- we also saw her remove the cap for one needle, put it in her mouth and pull it off with her teeth, and then do it that way. So again, that's a no-no.

Q Okay. Like this?

A Yes.

Q Okay. And so that's -- the danger in that is...

A Well, there's a contamination risk from that, and then, she could also poke herself with it as well. It's just a bad practice all around.

Q Okay. And so other than those -- I don't want to call them trivial, but not -- not serious transgressions by Linda Hubbard, all of her injection practices, meaning, clean needle, clean syringe, injection into patient, not reusing needles and syringes, on all of that she was fine?

A Yes.

Q Okay. And what you did observe her doing was taking propofol, using it on a patient, but there's still some left in the vial, and so she'd set it aside --

A Yes.

Q -- correct? And so then a new patient comes in and she starts with a new propofol vial and injects them

safely, and then sets aside another partially emptied one?

A Yes, that's correct.

Q And so after a number of procedures she had four or five vials, all with a little bit of propofol in them, still sitting there, correct?

A Yes.

Q Okay. And so then she took a syringe -- needle and syringe and filled up a needle and syringe by taking the remnants out of the four or five propofol vials?

A It was multiple syringes, but yes, that basic idea.

Q Okay. So she filled a couple of brand new, clean needles and syringes out of the four or five propofol remnants?

A Yes.

Q Okay. And so you -- you were observing her multi-using -- using propofol on multiple patients out of one vial --

A Yes.

Q -- is what would have occurred --

A Treating the vial --

Q -- right?

A -- like a multidose vial, basically --

Q Okay.

A -- yes.

Q And she -- she was doing that, knowing that you all are standing there watching her, correct?

A We were in the room, so I assume so, yes.

Q Okay. And so then did -- did you talk to her at that time?

A No.

Q Okay. Her, meaning Linda Hubbard. And the -- this -- using propofol as a multidose vial, it caused you concern?

A Yes.

Q Okay. Now, you had -- you had already known that from Wednesday, correct?

A Potentially, yes.

Q Okay. And so now you're actually seeing it, correct?

A Yes.

Q And did -- did you -- other than Linda Hubbard on that Friday, did you observe other CRNAs?

A I did not, no.

Q Okay. So you -- your sole observations were Linda Hubbard on Friday morning?

A Yes, that's correct.

Q Okay. And I know you came back a number of times during the next couple of weeks to the clinic for various purposes. Did you come in and do any other procedure

observations?

A No, it was all records review when I came back.

Q Now, your -- you had a conversation with Vincent Mione?

A Yes.

Q Okay. And is that after your observations of Linda Hubbard?

A Yes, it was.

Q Okay. And did you -- did you observe any procedures of Vincent Mione?

A I did not, no.

Q Okay. Can you describe Vincent Mione?

A Average height, I believe he had gray hair, I think it was shaved kind of like a buzz cut, from what I remember.

Q It was what?

A Shaved kind of -- a short haircut, from what I remember.

Q Okay. Like a --

A It's been a long time. I don't really remember him that well.

Q -- okay. Well, you -- there's a couple of Vinnie's that were CRNAs; is that correct?

A Yes.

Q Okay. And do you know which Vinnie you talked

to?

A I believe we spoke with Vincent Mione. I think Vincent Sagendorf came in at a different time. I don't think he was working. I think he came in that afternoon, and they had talked to him, but he wasn't working at that clinic on that day.

Q Okay. The -- could it be you have your Vinnie's mixed up?

A I'm sure it's possible, but I -- from what I remember on the notes and the things I took, it was Vincent Mione.

Q Okay. I didn't see it in your notes.

A I --

Q Do you have some notes I haven't seen--

A I'd have to look back --

Q -- is what I'm saying.

A -- what I have. It's been a long time since that conversation. So it's possible that the two were mixed up, but I don't think so.

Q Well, do you have any -- did you write anything down anywhere regarding that conversation with Vincent Mione?

A I don't know if I did or not. If it's not in the notes, then -- then maybe I didn't. It was a brief conversation. It was 30 seconds or a minute or so.

Q Okay. Well, I -- the -- don't take my

representation for it when I tell you it's not in the notes. The -- I didn't see it, but I don't know that I have all of your notes, okay? Do you think anywhere you made a note of that? Have you seen anywhere your conversations where you noted it on January 11 with Vincent Mione?

A I really don't remember.

Q Okay. Now, are you aware that Vincent Mione denies the conversation with you?

A No.

Q Okay. The -- and who else was present?

A Melissa Schaefer.

Q Okay. Now, in your -- one of your interviews, I believe the one -- you were interviewed by the Metropolitan Police Department, correct?

A Yes.

Q Okay. Have you read that transcript lately?

A No, not lately.

Q Okay. My recollection of that is when you were trying to determine who the Vinnie was you may have talked to, you said it was the Vinnie who was brand new there.

A I don't remember that. It's possible.

Q Okay. Do you know which Vinnie was new -- had been recently hired?

A No, I don't.

Q Well, the evidence has been that it's -- it -- I

mean, Mr. Mione testified in here and Mr. Sagendorf testified in here -- the two Vinnies, okay? And Mr. Mione had worked for a number of years at the clinic, mainly Burnham, and Mr. Sagendorf had just been hired in October 2007.

A Okay.

Q Do you remember which of the two you talked to?

A This far after? No, I don't.

MR. WRIGHT: Page 28, Metro.

BY MR. WRIGHT:

Q This is a transcript from your interview Metropolitan Police Department, on May 19, 2008.

A Okay.

Q Look at page 28. Look at that to yourself.

A (Witness complied.) Okay.

Q Does that refresh your recollection as to which Vinnie you talked to?

A From the conversation here it was the newer one, and I don't know enough details to say if that was Mione or Sagendorf.

Q Okay. But the -- this was in May 2008?

A Yes.

Q So this was literally four months later, correct?

A Right.

Q And you couldn't remember the last name of the

Vinnie you talked to, correct?

A That looks correct.

Q And what you believed was that -- whoever is the newer Vincent, the one who had been there a short amount of time, correct?

A That looks correct, yes.

Q So if -- if the evidence is that the person who has been there the short amount of time is Vincent Sagendorf and not Vince Mione, that would have been the person you spoke with; is that fair?

A Possibly, yes.

Q Okay. Well, is that correct?

A Like I said, it's been a long time. I don't remember exactly which one it was.

Q Okay. And you made no report of it and no notes whatsoever?

A None that I remember, but I haven't looked at it in a long time -- or haven't looked at -- for that particular item in a while.

Q Mr. Sagendorf testified in here, and he also denies any such conversation with you.

A Okay.

Q Have you spoken to Melissa Schaefer -- is that her name? I get them mixed up --

A It's still Melissa Schaefer, yeah, she has the

same name.

Q -- Melissa Schaefer, about this?

A About this? No.

Q Okay. She does not recollect any such conversation.

A Okay.

Q Have you read her grand jury testimony?

A Years ago.

Q Okay. Could -- you could be mistaken about this because of the passage of time?

A Mistaken about what, specifically?

Q This conversation.

A That it happened?

Q Yes.

A I don't believe so.

Q Okay. But you don't know who it was with?

A I may have the incorrect Vincent, that's correct.

Q And the -- and the conversation was what?

A It was a -- just a brief conversation about the injection practices, about the reuse of propofol, and the reuse of syringes to access vials, and he said the -- they were told to reuse the syringes, but he didn't do it.

Q Okay. And at -- at that point it seems to me you know that propofol is being multiused, correct? Treated

as a multidose?

A In general, yes.

Q Okay. Well, in general, it had been stated to you all, and you all had observed it, correct?

A Yes, that was the general practice of the clinic.

Q Okay. And at this time of this conversation with a Vinnie, there hadn't been any observations of any syringe reuse, correct?

A Not by me, that's correct.

Q Not by anyone at that point that you knew about, correct?

A That I knew about at that time?

Q Yes.

A That's correct.

Q Okay. So it seems to me if an employee is actually saying -- discussing reuse of syringes, that's the first time you all are hearing it, that would be some significant seminal event.

A I don't know about a seminal event, but it was significant, yes.

Q Okay. But you made no -- no notation, no report, it's not in your -- what do you call this thing?

A The ICS forms?

Q Right. Correct?

A That's correct.

Q When did -- you learned that Gayle Fischer had observed Mr. Mathahs, CRNA, reusing a syringe to redose a patient, correct?

A Yes.

Q You learned about it that afternoon, correct?

A Yes.

Q And you all then have a meeting about it?

A It was in the conference room where we were all working together, so we were just discussing things in general throughout the afternoon.

Q Okay. And would you -- when you were there looking for unsafe practices, and/or trying to determine how this transmission could have occurred, you would bring to the attention of the clinic, management, anything you saw wrong, correct?

A Yes.

Q Okay. Because the whole -- you weren't conducting, like, a criminal investigation, correct?

A That's correct.

Q Okay. You were looking to see how -- how in the world did this happen, and if we can -- how can we correct it and prevent it so it's not happening again?

A Yes, that's correct.

Q Okay. And so, like, on that Friday who did you

meet with to tell them about propofol multiuse and syringe reuse?

A Friday was Tonya and Dr. Carrol, I believe.

Q Okay. And you would share everything with them, correct?

A Yes. We met with them each day and told them what we found, and any new information, kind of what the next steps were.

Q Okay. And so they would then implement changes to prevent those things from happening again, correct?

A That was our request of them, yes.

Q Okay. And to your knowledge, they did that, correct?

A Yes.

Q Okay. And so, like, it was -- these are -- don't use propofol for more than one patient, correct?

A Yes.

Q Okay. And on syringes don't use the same syringe on the same patient to redose, correct?

A Yes.

Q Okay. And there was never anything about reuse of syringes or needles -- I'm calling them as one unit, but reuse of the needle and syringe multipatient, correct?

A That's correct.

Q Okay. And by multipatient I'm talking about,

like, if a CRNA injected one patient and then used the same needle and syringe on a different patient?

A Yes, that's correct.

Q Nothing like that was ever observed, seen, heard, talked about --

A Correct.

Q -- correct? And so was it your understanding that as of Friday the 11th in the meeting going forward, these changes would take place?

A Yes, we met with them late on Friday and they said they would correct things for when they reopened on Monday.

Q Okay. And the -- did you discuss with Gayle Fischer what she had observed with CRNA Keith Mathahs?

A Yes.

Q Okay. And did you understand that the observation was that he was using a needle and syringe, brand new, dosing the patient with propofol and/or lidocaine -- I'm just skipping over that -- but basically dosed the patient, and then when the patient needed a redose, Mr. Mathahs was taking out a brand-new needle, removing the dirty needle from the syringe, placing a clean needle on the syringe, and then going into propofol and drawing a second dose and then injecting the patient?

A That's correct.

Q Okay. And did you discuss with her the practice of changing the needle?

A We discussed all of those things, I guess, in --

Q Okay.

A -- throughout the day.

Q And what does that do, changing the needle?

A It doesn't really reduce risk of infection because the blood can be in the syringe itself, so the needle itself -- changing the needle really doesn't make a difference.

Q Okay. And did you have any discussions with -- you -- with Mr. Mathahs about his belief that that was a safe injection practice by changing the needle?

A No, I did not.

Q Are you aware that Gayle Fischer did?

A I know she talked to him, but I don't know what the details of the conversation were exactly.

Q Okay. Now, what Keith Mathahs was observed doing was an unsafe injection practice; is that fair?

A Yes.

Q Okay. And was he observed using propofol as a multidose vial?

A Yes, I believe he was.

Q Okay. You believe he was?

A Yes.

Q And so if -- if he was, and that was observed, that was immediately stopped?

A Yes. I know, Gayle said she spoke to him after that procedure and -- so there wasn't an ongoing risk of patients that are -- from using a contaminated vial.

Q Okay. And the -- if he was not using propofol as a multidose vial, and was simply using needle and syringe to redose a patient, okay, that would not cause any transmission of hepatitis C?

A That's correct.

Q Okay. And so it was determined by you in your ultimate conclusion that the likely method of transmission on the dates in question was a combination of using propofol as a multidose vial, and at the same time reusing syringes on individual patients?

A Yes, that's correct.

Q Okay. And if that occurred, there was a chance that a virus in the source patient could contaminate the vial of propofol, right?

A Yes.

Q And that that could be -- that vial could then be used on other -- another patient or patients?

A Yes, that's correct.

Q And, I think you've called that the serial contamination of vials theory?

A Not just one. You would have to then take it from a contaminated vial, and then essentially contaminate a second vial from the --

Q Okay.

A -- first contaminated vial.

Q Okay. And you explained this morning that theoretically this -- if the transmission occurred in the way you believe it could have, that it could either have been one 50cc propofol vial was contaminated, correct?

A Yes, theoretically.

Q Right. And that one vial could have contaminated all of the patients that were contaminated on the 21st of September because there was enough volume in it that it could have been used on every contaminated patient, if a little bit was used each time?

A Yes, that's correct.

Q Okay. And that was one -- that's just a single vial contamination theory?

A Correct.

Q Okay. And then your alternative was the serial contamin -- S-E-R-I-A-L contamination theory, correct?

A Yes.

Q And for your serial contamination theory, your conclusion of likely -- this likely serial contamination, this is the first time anyone has ever come up with such a theory,

correct?

A I don't know that that's true or not. I haven't reviewed all the literature to say that nobody else has thought of that idea.

Q Okay. Well, you have looked at the literature and couldn't find any?

A I didn't look at the literature specifically for that. I didn't do a search for any of those types of things, so it's possible it's out there, I don't know.

Q Okay. Well, to your knowledge no one else has ever come up with this serial contamination theory, correct?

A I guess that's true. I never really looked for it, so, no -- to my knowledge, no.

Q Okay.

MR. SANTACROCE: Your Honor, I'm having trouble hearing him.

THE COURT: All right. Well, this actually may be a good time to take our lunch break, and I think some of the jurors are hinting they needed a break.

Ladies and gentlemen, we're going to go ahead and take our -- excuse me, our recess. For the lunch break we will be in recess until 1:40.

During the lunch break you are reminded that you're not to discuss the case or anything relating to the case with each other or with anyone else. You're not to read, watch,

listen to any reports of or commentaries on this case, any person or subject matter relating to the case. Don't do any independent research by way of the Internet or any other medium, and please do not form or express an opinion on the trial.

Notepads in your chairs. Follow the bailiff through the rear door.

(Jury recessed at 12:50 p.m.)

THE COURT: And during the break, do not discuss your testimony with anybody else.

THE WITNESS: Can I leave the -- my notebook?

THE COURT: Sure.

All right. It's lunch.

(Court recessed from 12:31 to 1:43 p.m.)

(Outside the presence of the jury.)

THE COURT: Come on back. Make sure Kenny knows I meant for him to bring the jury in.

(Off-record colloquy.)

THE COURT: Bring them in. We're ready.

THE MARSHAL: Ladies and gentlemen, please rise for the presence of the jury.

(Jury entering at 1:47 p.m.)

THE MARSHAL: Thank you, everybody. You may be seated.

THE COURT: All right. Court is now back in session.

And, Mr. Wright, you may resume your cross-examination.

MR. WRIGHT: Thank you.

BY MR. WRIGHT:

Q I want to go back to the Friday afternoon, January 11, 2008, when you report to the clinic that a propofol issue and a reuse of syringe issue, you all had determined that you had figured out the method of transmission, correct?

A At that point it was a concern; I don't know that we figured out everything about the method of transmission yet at that point.

Q Okay. Did -- do you recall testifying:

Question: My understanding is that you had already reached your 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?

You answered, Yes.

A I don't specifically remember that, but okay.

Q Let me show you -- so you can confirm I read it right -- the deposition on February 24, 2009. And I'm looking at page 211.

A (Witness complied.) Okay.

Q Is that correct?

A That's what it says.

Q Having made that determination on Friday, January 11, I -- I'm now going to jump back to where I was before we took lunch recess.

I was asking you if there were anyone, to your knowledge -- well, let me put it this way: You're the first person, to your knowledge, who has ever come up with a serial contamination theory of -- as the mechanism of spreading a virus through vials, correct?

A To my knowledge, yes.

Q And you have looked for any other cases, asked CDC about other cases, looked in the literature to see if there was ever any reported case of serial contamination like you have theorized, correct?

A No, I have not reviewed the literature for that specific item. I haven't done a full study to see if anybody else has ever published that.

Q Okay. Well, you were previously asked in 2009 in your deposition if you were aware of any articles or cases supporting your theory, correct?

A Yes.

Q And you said you were not aware, correct?

A That's correct.

Q And did you then ask the CDC, right after that

deposition, to determine if there were any articles or studies or anything to support your position?

A I believe I did.

Q Okay. And they couldn't find any, correct?

A That seems to be correct.

MR. WRIGHT: Can I just have my next in order?

BY MR. WRIGHT:

Q Look at page 2, 3 of Q1 -- Propcsed Q1, tell me if you recognize that?

A (Witness complied.)

Q Do you recognize that?

A Yes.

Q Is that the email from CDC?

A Yes.

MR. WRIGHT: Move the admission of Q1.

THE COURT: Any objection to Q1?

MS. WECKERLY: Yes.

THE COURT: I'll see Counsel at the bench, and I'll see the exhibit.

(Off-record bench conference.)

THE COURT: I mean, isn't that the import of the email basically?

BY MR. WRIGHT:

Q Judge -- is that an accurate record from Southern Nevada Health District emails?

A It looks to be.

Q And that is to you, reporting the results of their search for publications regarding serial contamination of vials, correct?

A Yes.

MR. WRIGHT: Move its admission.

THE COURT: Well --

MS. WECKERLY: Same objection.

THE COURT: For right now that's overruled, but you can certainly ask him what they found, how many studies they found, and whether or not he looked into the study they found, or publication.

MR. WRIGHT: Can we approach?

THE COURT: Sure.

(Off-record bench conference.)

BY MR. WRIGHT:

Q Did you call Melissa Schaefer on about March 24, 2009, and ask her if the CDC was aware of any articles in the published literature that document serial contamination of vials as you presume happened in Las Vegas?

A Yes.

Q Okay. And you stated you want to cite an article in your report to describe this, correct?

A Yes.

Q Okay. And at the time your report is not

completed?

A That's correct.

Q And then a response came from CDC containing one article, correct?

A Yes.

Q And the CDC told you that it seems like there's enough information --

MS. WECKERLY: Objection. Hearsay.

THE COURT: Well, go ahead and ask the question.

BY MR. WRIGHT:

Q The CDC --

MS. WECKERLY: Objection, Your Honor. This is the content of the email.

THE COURT: Well, if the point is that's the only article or why he was directed to that particular article --

MS. WECKERLY: That's not the --

THE COURT: -- he can answer.

MS. WECKERLY: -- content.

THE COURT: Go ahead.

BY MR. WRIGHT:

Q Did the -- did the CDC form you -- tell you, pardon me. Did the CDC state that the article and -- that with the article, it seems like there's enough information here and from your investigation to show that this is clearly a plausible explanation?

A Yes.

Q Okay. And the "plausible explanation" they're talking about, is showing your -- your serial contamination theory as the mechanism of transmission, correct?

A Yes.

Q And then the article they sent you involved a pooling -- P-O-O-L-I-N-G, a pooling outbreak, correct?

A Yes.

Q Okay. And it really wasn't applicable to your serial contamination theory, correct?

A I'm not sure exactly which article that is, so I couldn't say.

THE COURT: Did you follow up and actually pull the article and read the article?

THE WITNESS: I likely did, yes.

THE COURT: Do you -- I mean, don't guess because we tell everyone don't speculate. If you don't remember, then don't guess or speculate as to what you did.

THE WITNESS: Then I don't remember.

THE COURT: All right.

BY MR. WRIGHT:

Q Now, this is -- this is in February 2009, and your report is completed in December 2009, correct?

A This was actually March, but yes.

Q Okay. March, I'm sorry. March 2009, and you

completed your report December 2009?

A Yes.

Q Okay. By -- by then you -- you had already had published an article about the outbreak, with other authors --

A Yes.

Q -- correct?

A Yes.

Q And your theory of contamination?

A Yes.

Q And you have become a speaker at conferences?

A Yes.

Q Discussing your theory of contamination?

A Among other things, yes.

Q Okay. And had you become a celebrity within the epidemiological group?

A No.

Q Okay. You were -- you would go to conferences to discuss the Brian Labus serial contamination theory, correct?

A I think you're the first person that's ever said that, so I would say no.

Q Okay. Ever said what?

A The Brian Labus serial contamination theory. There isn't a conference on that, and it's not a topic of discussion at the conferences, really.

Q Okay. You didn't go put on a PowerPoint and presentation of this?

A Yes, I did. And this was one piece of it, but it wasn't about just serial contamination. It was the -- the outbreak, the response, kind of the -- the entire thing from beginning to end.

Q Okay. And so you -- you had published an article, gone to conferences, plural; how many?

A I think I presented on this three or four times at conferences, maybe.

Q Okay. All before you got your report out, correct?

A No, I've presented on it since then as well, but --

Q Pardon?

A No, I've presented on it since then as well, but it -- there were presentations before the report was completed.

Q To this date, 2013, are you aware of any other cases of serial contamination, or any other articles other than your own?

A No, I'm not.

Q Now, having reached the determination by -- by Friday, January 11, in the evening, as to the method of transmission, you all started then working with the clinic on

a plan for notification; is that correct?

A No, the decision to notify came after that, probably not until February.

Q Okay.

A We worked with a clinic to remediate the situations we found that were problems in the clinic.

Q Okay. To correct everything?

A Yes.

Q Okay. And the -- you on -- on your side were planning a patient notification, correct?

A Not at that point.

Q Okay. Well, you'd made a determination that there were unsafe-injection practices?

A Yes.

Q Okay. And so the -- the question was really the scope of the notification, not whether you would notify, correct?

A We didn't have discussions about that notification yet. We needed to complete the investigation before we moved into that phase, and the investigation on that date still wasn't completed.

Q Okay. You had made your conclusion as to what it was, correct?

A Yeah, we moved that to the top of the list.

Q Okay. Well, did I read accurately that you had

concluded it by January 11?

A Yeah, you did.

Q Okay. And your main -- and your -- aside from correcting what had happened so it stops, your other major concern as the Health District is to get notification to anyone who could have potentially been infected by the practices that preexisted your inspection, right?

A At some point, yes, but not at that early date.

Q Okay. So your -- your belief is you waited until February to start determining are we going to notify patients?

A The extent of a notification that was needed, and how many people, and how to do it, yeah, that -- that waited a little later.

Q So you -- the determination -- ultimately you decided to notify all patients of what we call Shadow Lane and Burnham clinics, okay, from -- for the previous four years, correct?

A Yes, it was split up in different phases, but yes, ultimately that's what we decided.

Q Okay. And that determination for notification was made solely based upon the unsafe-injection practices and the multiuse -- or the use of propofol as a multiuse vial, correct?

A Well, I wouldn't say "solely," I'd say the fact